

2012 Comprehensive HIV Services Plan

Ryan White HIV/AIDS Part B



UTAH DEPARTMENT OF
HEALTH

Utah Department of Health
Division of Disease Prevention and Control
Bureau of Epidemiology
Treatment and Care Services Program

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Table of Contents

Introduction	9
Executive Summary	9
I. Where Are We Now?	10-60
A. Utah HIV/AIDS Epidemic	10-14
i. CY 2010 Epi Profile	
ii. Unmet Need Estimate for 2010	
iii. Early Identification of Individuals with HIV/AIDS (EIIHA)/Unaware Estimate for CY 2009	
B. Current Continuum of Care	14-27
i. Ryan White Funded HIV Care and Services Inventory	
ii. Non Ryan White Funded HIV Care and Services Inventory	
iii. How Ryan White Funded and Non Ryan White Funded Care and Services Interact to Ensure Continuity of Care	
iv. How the Continuum of Care has been Affected by State and Local Budget Cuts, and How the Ryan White Program has Adapted	
C. Description of Need	27-40
i. Care Needs	
ii. Capacity Development Needs in Historically Underserved Communities and Rural Communities	
D. Priorities for the Allocation of Funds	40-45
i. Size and Demographics of the Population of Individuals with HIV/AIDS	
ii. Needs of Individuals with HIV/AIDS	
E. Gaps in Care	45-46
F. Prevention and Service Needs	47-50
G. Barriers to Care	50-54
i. Routine Testing	
ii. Program Related Barriers	
iii. Provider Related Barriers	
iv. Client Related Barriers	

H. Evaluation of 2009 Comprehensive HIV Services Plan	54-60
i. Successes	
ii. Challenges	
II. Where Do We Need To Go?	60-68
A. Plan to Meet 2009 Challenges Identified in the Evaluation of the 2009 Comprehensive HIV Services Plan	60-61
B. 2012 Proposed Care Goals	61-62
C. Goals Regarding Individuals Aware of Their HIV Status, but Not in Care (Unmet Need)	62-63
D. Goals Regarding Individuals Unaware of Their HIV Status (EIIHA)	63
E. Proposed Solutions for Closing Gaps in Care	63-64
F. Proposed Solutions for Addressing Overlaps in Care	64
G. Proposed Coordinating Efforts With the Following Programs	64-68
i. Part A Services	
ii. Part C Services	
iii. Part D Services	
iv. Part F Services	
v. Private Providers (Non Ryan White Funded)	
vi. Prevention Programs Including:	
• Partner Notification Initiatives	
• Prevention with Positives Initiatives	
vii. Substance Abuse Treatment Programs/Facilities	
viii. STD Programs	
ix. Medicaid	
x. Medicare	
xi. Children’s Health Insurance Program	
xii. Community Health Centers	
III. How Will We Get There?	68-89
A. Strategy, Plan, Activities, and Timeline to Close Gaps in Care	68-73
B. Strategy, Plan, Activities, and Timeline to Address the Needs of Individuals Aware of Their HIV Status, But are Not in Care	73-75

C. Strategy, Plan, Activities, and Timeline to Address Needs of Individuals Unaware of Their HIV Status	75-77
D. Strategy, Plan, Activities, and Timeline to Address the Needs of Special Populations	78-81
i. Youth	
ii. Injection Drug Users	
iii. Homeless	
iv. Transgender	
v. Rural	
E. Activities to Implement the proposed Coordinating Efforts with the Following Programs to Ensure Optimal Access to Care	81-84
i. Part A Services	
ii. Part C Services	
iii. Part D Services	
iv. Part F Services	
v. Private Providers (Non Ryan White Funded)	
vi. Prevention Programs	
• Partner Notification Initiatives	
• Prevention with Positives Initiatives	
vii. Substance Abuse Treatment Programs/Facilities	
viii. STD Programs	
ix. Medicaid	
x. Medicare	
xi. Children’s Health Insurance Program	
xii. Community Health Centers	
F. How the Plan Address Healthy People 2020 Objectives	84-87
G. How the Plan Reflects the Statewide Coordinated Statement Need	87
H. How the Plan is Coordinated With and Adapts to Changes that Will Occur with the Implementation of the Affordable Care Act	87-88
I. How the Plan Addresses the Goals of the National HIV/AIDS Strategy (NHAS)	88-89
J. Strategy to Respond to Any Additional or Unanticipated Changes in the Continuum of Care as a Result of State of Local Budget Cuts	89

IV. How Will We Monitor Progress?	90-93
A. Plan to Monitor and Evaluate Progress in Achieving Proposed Goals and Identified Challenges	90-93
i. How the Impact of the Early Identification of Individuals with HIV/AIDS (EIIHA) Initiative will be Addressed	
ii. Timeline for Implementing the Monitoring and Evaluation Process	
iii. Process for Tracking Changes	
• Improved Use of Ryan White Client Level Data	
• Use of Data in Monitoring Service Utilization	
• Measurement of Clinical Outcomes	

Tables

Table 1	Unmet Needs Estimates Listed by Population	12
Table 2	Treatment and Care Service Ratings: Responses from the Entire Sample	27-28
Table 3	How Soon Did You Enter Into Medical Care After Learning About Your HIV+ Status	29
Table 4	Do You Have One Place You Go For Medical Care?	29
Table 5	Have You Received Primary Care Within the past 12 Months?	30
Table 6	What is Your Method of Payment for Medical Care and Medication?	31
Table 7	Have You Ever Skipped or Stopped Taking HIV/AIDS Medication?	31
Table 8	Do You Have A Case Manager?	32-33
Table 9	Is There Someone Else (Not Case Manager) Who Helps You Get Services?	33
Table 10	How Long Has It Been Since You Last Saw Your Case Manager?	34
Table 11	Adolescents & Adults Living With HIV by Age Group & Sex, Utah, 2010	41
Table 12	Adults & Adolescents Living With HIV by Race/Ethnicity, Utah, 2010*	41
Table 13	Adults & Adolescents Living w/ HIV by Age Groups, Utah, 2010*	42
Table 14	Percentage of Adults & Adolescents Living w/ HIV by Transmission Category, Utah, 2010*	42
Table 15	Highest Disease Burden Among People Living With HIV/AIDS in Utah	43
Table 16	Priority Setting – HIV Services 2012	44-45
Table 17	HIV Prevention Service Needs	47
Table 18	Treatment and Care Barriers to Service Ratings	53-54

Appendices

Appendix A	Ryan White Part B 2012 Budget	94
Appendix B	Ryan White Part C 2012 Budget	95
Appendix C	Ryan White Part D 2011 Budget	96
Appendix D	Ryan White Part F - AIDS ETC 2011 - 2012 Budget	97
Appendix E	Priority Setting Worksheets – 2011 Treatment and Care Planning Committee	98-99

Introduction

The Utah Department of Health, Bureau of Epidemiology is the lead state agency in Utah for coordination of care, treatment, and prevention strategies addressing the HIV/AIDS epidemic. As the Grantee for funding provided through the Part B HIV CARE Grant of the Ryan White Treatment Modernization Act, the Ryan White Part B Program is responsible for Part B funded care and treatment programs and services, and for overseeing administration of the Part B HIV CARE Grant and development of Utah's Comprehensive HIV Services Plan.

The Comprehensive Plan, based upon the needs outlined in Utah's 2012 Statewide Coordinated Statement of Need (SCSN), provides an update of the issues created by a changing epidemic and the unmet health care needs of those not currently in care. The Comprehensive HIV Services Plan will outline strategies and proposed solutions to accomplish the following Health Resources and Services Administration (HRSA) expectations:

- Ensure the availability and excellence of critical HIV-related core services statewide;
- Eliminate disparities in access to services and related support services among disproportionately affected subpopulations and historically underserved communities;
- Develop strategies for identifying individuals who know their HIV status but are not in care, informing them about available treatment and services, and assisting them in accessing those services; and
- Address the primary care, treatment, and prevention needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system.

Executive Summary

The Comprehensive HIV Services Plan identifies multiple issues and challenges confronting the delivery of HIV-related services in Utah. The Plan was developed in conjunction with the 2012 Utah SCSN using shared knowledge and experiences, a review of available data, and in-depth discussions of policy and service delivery issues that emerged through the comprehensive planning process. This document presents a framework for the continued development and improvement of Utah's comprehensive service delivery model over the course of three years. Recommended strategies seek to build upon the existing continuum of HIV care and treatment. The Comprehensive HIV Services Plan is intended to be a living document, continually monitored to ensure effective implementation and modified as needed to reflect emerging issues, budgetary constraints, and trends.

I. Where Are We Now?

A. Utah HIV/AIDS Epidemic

i. CY 2010 Epidemiological Profile

Number of people living with HIV (non-AIDS)

At the end of 2010, there were a reported 1,169 individuals living with HIV. The majority (69%) of HIV (non-AIDS) positive individuals were White; Hispanics comprised 18% of the cases; Black persons comprised 10% of the cases; American Indians comprised 1% of the cases; Asian/Pacific Islanders comprised 1% of the cases; and unknown race/ethnicity comprised 2%.

As of December 31, 2010, there were 980 (84%) males and 189 (16%) females reported with HIV. The most common exposure category for HIV was men who have sex with men (MSM); this category comprised 636 of the cases (54%). The following were the rankings of the remaining exposure categories for HIV (non AIDS): men who have sex with men/injection drug users (173 cases, 15%), injection drug users (109 cases, 9%), and heterosexual risk (99 cases, 9%). The other/undetermined exposure category included 152 cases (13%). Over the last eight years (2003-10), there has been a significant increase in the number of HIV cases reported among White males who have sex with men and inject drugs. This increase is likely correlates with the increased use of methamphetamines in the MSM community. For women, the major risk factors were heterosexual contact and injection drug use.

Starting in 2003, the number of HIV infection reports has exceeded the number of AIDS case reports over the last eight years. This trend may be due to an increase in the number of HIV tests performed, the introduction of the HIV rapid-testing in mid-2003, and more effective anti-retroviral drugs which keep an HIV positive person in the HIV (non-AIDS) category longer.

Number of people living with AIDS

At the end of 2010, there were a reported 1382 individuals living with AIDS. The majority (70%) of individuals reported with AIDS were White; Hispanics comprised 19% of the cases; Black persons comprised 8% of the cases; American Indians comprised 2% of the cases; and Asian/Pacific Islanders comprised 1% of the cases. Although most HIV and AIDS cases in Utah occurred among White males, the number of cases that

occurred among Black and Hispanic persons was disproportionate to the size of these two populations; thus, the risk for HIV and AIDS is higher in these populations.

Most AIDS cases reported were in the risk group MSM (782 cases or 57%), followed by injection drug users (187 cases or 14%), MSM/IDU (175 cases or 13%), heterosexual contact (126 cases or 9%), and risk not specified (112 cases or 8%). The risk factors for women by order of magnitude were heterosexual contact, injection drug use, and risk not specified.

Number of new AIDS cases reported within the last two years (2009-2010)

From January 1, 2009 through December 31, 2010, a total of 56 new AIDS cases and 152 HIV cases have been reported to the Utah Department of Health. During these two years, 28 individuals (50%) diagnosed with AIDS were White, 23 individuals (41%) were Hispanic, four individuals (7%) were black, one individual (2%) was Asian/Pacific Islander, and no individuals (0%) were American Indians or had an unknown ethnicity/race. Of the 56 individuals with AIDS, 49 (88%) were male and 7 (13%) were female. The most common risk group for HIV/AIDS cases was MSM (59%), followed by MSM/IDU (9%), and injection drug users (5%).

ii. Unmet Need Estimate for 2010

The unmet need results listed by population are presented in Table 1. The combined population results indicate that there are 289 (11.4%) HIV+/aware individuals in Utah that are not in care. This number includes 250 PLWH and 39 PLWA. The PLWH population demonstrated a higher level of unmet need ($n = 250$; 23.4%) than the PLWA population ($n = 39$; 2.6%). One possible explanation is that PLWH are not as likely to experience symptoms that would persuade them to seek primary medical care. As a result, PLWH have a higher level of unmet need. The opposite is true for the PLWA population. PLWA are more likely to experience symptoms that would persuade them to seek primary medical care.

Table 1: *Unmet Need Estimates Listed by Population*

Variable	PLWH			PLWA			HIV+/aware Population		
	Prevalence	In-care	Unmet Need	Prevalence	In-care	Unmet Need	Prevalence	In-care	Unmet Need
	1068	818	250	1472	1433	39	2540	2251	289
Total	100.0%	76.6%	23.4%	100.0%	97.4%	2.6%	100.0%	88.6%	11.4%

iii. Early Identification of Individuals with HIV/AIDS (EIIHA)/Unaware Estimate for CY 2009

The Ryan White Part B Program has developed a strategy for the early identification of individuals with HIV/AIDS (EIIHA). The EIIHA strategy is comprised of goals that are designed to make individuals who are unaware of their HIV status aware of their status. The Ryan White Part B Program, which is part of the Treatment and Care Services Program at the Utah Department of Health (UDOH), has been working together with the Communicable Disease Prevention Program to develop an EIIHA strategy that take into consideration the goals of the Surveillance, Communicable Disease Prevention, and Treatment and Care Services Programs.

The following are preliminary goals of the strategy:

Goal One: Actively collaborate with the Prevention Program, Surveillance Program, and other stakeholders to develop a statewide HIV Plan.

Goal Two: Provide funding resources for Early Intervention Services when possible, with an emphasis on identifying HIV positive unaware individuals and linking HIV positive individuals to care.

Goal Three: Evaluate the HIV testing and referral process currently used by HIV test sites, private clinics, and at outreach events. Identify weaknesses or gaps in the referral process.

Goal Four: Provide technical resources that include quality management and data analysis to the Prevention Program, Surveillance Program, and other community organizations to strengthen the EIIHA process of identification, informing, referring, linking, and data collection.

Goal Five: Strengthen relationships and share information with community organizations and local health departments that are directly engaged in HIV testing and/or provide services to individuals engaged in high-risk HIV behaviors.

Each of the five goals of the strategy is consistent with making individuals who are unaware of their HIV status aware of their status. The goals address identifying, informing, referring, and linking individuals who are unaware of their status. The five goals of the strategy are also consistent with the National HIV/AIDS Strategy (NHAS) goals.

As part of the EIIHA strategy, the Ryan White Part B Program will continue to collaborate and coordinate with other programs and community efforts. The Part B Program has strong relationships and directly funds two organizations that are critical in Utah for identifying HIV positive unaware individuals. The first organization is Clinic 1A at the University of Utah, which is the main provider of HIV medical care in Utah.

Approximately 60% of PLWHA in Utah receive medical care at Clinic 1A. Last year the Ryan White Part B Program helped to facilitate meetings between Clinic 1A and the Communicable Disease Prevention Program, which resulted in Clinic 1A becoming a first time contractor with the Prevention Program. Clinic 1A will be implementing a “prevention for positives” intervention that includes the partners of HIV positive individuals, which is the number one priority group for the Prevention Program.

The second organization that the Part B Program has developed a close relationship with is the Utah AIDS Foundation (UAF). The UAF receives funding for case management from the Part B Program and the UAF is active in community planning meetings and the ADAP Advisory Committees. The UAF is important in the EIIHA strategy because UAF offers HIV testing on a routine basis and has one of the highest numbers of HIV tests performed each year. The UAF reaches out to gay men and other MSM, which are specific groups being emphasized in the EIIHA matrix.

The Part B Program will also work other organizations that house high-risk individuals such as the correctional facilities. The bi-annual Needs Assessment Survey for PLWHA is conducted with the assistance of the prison and through this survey and other community meetings, the Part B Program is able to determine availability, importance and satisfaction with services that link and retain PLWHA into care. In the past, the Part B Program has supported testing efforts in hospitals.

In 2008, a study to estimate the prevalence of HIV/AIDS in Utah was conducted by the Utah Department of Health and the Infectious Disease Clinic at the University of Utah Hospital Emergency Department (ED). Using an Oraquick Advance rapid HIV screening test provided by the Part B Program, 1,005 individuals were screened for HIV over eight months. At the end of the screening, there were no positive HIV tests – not even a false preliminary positive. At the beginning of the screening project, the Utah Department of Health team was encouraging other hospital EDs throughout the state to conduct their own HIV screening efforts, but based on the results of no positive HIV tests at the University of Utah Hospital ED, other hospital EDs have not been interested in conducting screening.

As of December 31, 2009, it was estimated there were 2,540 living individuals diagnosed with HIV in Utah. Using 21% as the national proportion of persons undiagnosed with HIV, the estimate of HIV positive individuals unaware of their HIV status is 675 individuals [$2540 * (0.21/0.79) = 675$].

B. Current Continuum of Care

i. Ryan White Funded HIV Care and Services Inventory

See Appendices for complete program budgets for Ryan White Part B (Appendix A), Ryan White Part C (Appendix B), Ryan White Part D (Appendix C) and Ryan White Part F – AIDS ETC (Appendix D).

CORE SERVICES:

1. Outpatient/Ambulatory Medical Care
 - \$322,552 (RW Part B)
 - \$391,260 (RW Part C)
 - \$215,009 (RW Part D)
2. AIDS Drug Assistance Program (ADAP)
 - \$2,320,323 (RW Part B)
 - \$931,936 (RW Part B - ADAP Shortfall Relief)
 - \$72,000 (RW Part C)
3. Medical Case Management
 - \$299,236 (RW Part B)
 - \$118,377 (RW Part C)

- \$53,230 (RW Part D)
- 4. Health Insurance Premium & Cost Sharing Assistance
 - \$450,000 (RW Part B)
- 5. Mental Health Services
 - \$73,856 (RW Part C)
- 6. Oral Health Care
 - \$25,000 (RW Part C)
 - \$6,500 (RW Part D)
- 7. Substance Abuse Services
 - Not RW funded
- 8. Early Intervention Services
 - Not RW funded
- 9. Medical Nutrition Services
 - Not RW funded
- 10. Home Health Care
 - \$500 (RW Part B)

SUPPORTIVE SERVICES:

1. Case Management (non-medical)
 - \$68,765 (RW Part B)
 - \$74,245 (RW Part C)
2. Medical Transportation Services
 - \$3,325 (RW Part B)
 - \$9,800 (RW Part C)
 - \$540 (RW Part D)
3. Food Bank/Home Delivered Meals
 - Not RW funded
4. Psychosocial Support Services
 - Not RW funded
5. Emergency Financial Services (food vouchers)
 - Not currently funded, however the Ryan White Part B program pre-purchased food vouchers in 2006 and is able to utilize these vouchers for clients who are experiencing a financial emergency. They are one time distributions of \$60.

6. Treatment Adherence Counseling
 - Not RW funded
7. Health Education/Risk Reduction
 - \$173,300 (RW Part F)
8. Outreach Services
 - \$500 (RW Part D)
9. Referral for Health Care/Support Services
 - \$21,073 (RW Part C)
 - \$10,561 (RW Part D)
10. Rehabilitation Services
 - Not RW funded
11. Linguistics Services
 - Not RW funded
12. Legal Services
 - Not RW funded
13. Child Care Services
 - Not RW funded
14. Respite Care
 - Not RW funded

ii. Non Ryan White Funded HIV Care and Services Inventory

CORE SERVICES:

1. Outpatient/Ambulatory Medical Care
 - There are other doctors within the community who see HIV patients, but no other programs that we are aware of that offer funding to help cover these costs.
2. AIDS Drug Assistance Program (ADAP)
 - Clients who are eligible for the Ryan White programs, but are placed on a waiting list for services can apply with individual pharmaceutical companies for patient assistance programs to cover their medications until they are placed on the ADAP program. A denial letter from the ADAP program is required by the pharmaceutical companies for placement on these programs.
3. Medical Case Management
 - No other assistance available

4. Health Insurance Premium & Cost Sharing Assistance

- No other assistance available

5. Mental Health Services

- Division of Substance Abuse and Mental Health - Ensures that substance abuse treatment services are available throughout the state. The Division contracts with local county governments (Local Substance Abuse Authorities, or LSAAs) to provide these services. LSAAs are listed by county:
 - Bear River Mental Health
90 East 200 North, Logan, UT 84341; (435) 752-0750
 - Weber Human Services
237 - 26th Street, Ogden, UT 84401; (801) 625-3700
 - Davis Behavioral Health
934 S Main Street, Layton, UT 84041; (801) 544-0585 or (801) 773-7060
 - Salt Lake County Behavioral Health Services
2001 S State Street, Ste S2300, SLC, UT 84190; (801) 468-2009
 - Valley Mental Health - Tooele
100 S 1000 W, Tooele, UT 84074; (435) 843-3520
 - Valley Mental Health - Summit
1753 Sidewinder Drive, Park City, UT 84060; (435) 649-8347
 - Northeastern Counseling Center
1140 W 500 S, PO Box 1908, Vernal, UT 84078; (435) 789-6300
 - Central Utah Counseling & Substance Abuse Center
255 W Main, Mt. Pleasant, UT 84647; (435) 462-2416
 - Four Corners Community Behavioral Health, Inc.
105 W 100 N, PO Box 867, Price, UT 84501; (435) 637-7200
 - Southwest Behavioral Health Center
474 W 200 N, St. George, UT 84770; (435) 634-5600 or (800) 574-6763
 - San Juan Counseling
356 S Main, Blanding, UT 84511; (435) 678-2992
- Volunteers of America – Cornerstone Counseling Center - Free counseling and support services for people who: inject drugs; sell sex or sexual services; are active in “PNP” (party and play); use drugs/alcohol & want to cut back or quit; are HIV positive and would like support; are sex partners with someone who is HIV positive; want someone to talk to about high-risk sexual behavior; have had a

sexually transmitted infection during the past year; and/or have unprotected sex with multiple partners.

660 S 200 E, Ste 308, SLC, UT 84111; (801) 355-2846 or (801) 355-2846

- Substance Abuse and Mental Health Services Administration (SAMHSA) – Online mental health services locator (by state and specific address):
<http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx>
- The following individuals and organizations provide mental health counseling and support specifically geared towards individuals with HIV and/or LGBTQ issues.

Clients would need to call for fee schedules – some do offer sliding scales:

- Beckstead, Lee, PhD - Aspen Grove Counseling
1433 S 1100 E, SLC, Utah 84105; (801) 581-0422
- Bell, Jeff, LCSW
1399 S 700 E, Suite 2, SLC, Utah 84105; (801) 364-5700, Ext. 2
- Borrelli, Sandra, MFT
699 E. South Temple #145, SLC, Utah 84102
(801) 415-9158
- Buie, Jerry, LCSW
124 S 400 E, Ste 230, SLC, UT 84111; (801) 595-0666
- Burgess, Victoria D., PhD
604 E Willmington Ave (2180 S), SLC, UT 84105; (801) 359-9255
- Busch, Terri, LCSW
1208 W 500 N, SLC, UT 84116; (801) 264-9048
- Dansie, Kirk R., Psy.D., M.S.C.P. - Licensed Psychologist, Master's in Clinical Psychopharmacology -UDC Approved Sex Offender Treatment Provider - Innovative Clinical Services, P.C.
5691 S Redwood Road, Ste 15, Taylorsville, Utah 84123; (801) 750-4374
- Durtschi, Jason, LCSW
1399 S 700 E Ste 2, SLC, Utah 84105; (202) 695-6958; jdurtschi@gmail.com
- Freed, Anne, LCSW - Reflections Group
4505 Wasatch Blvd, Ste 320, SLC, Utah 84124; (801) 556-2430
- Helmbrecht, Larry, PhD - Weber State University
1114 University Circle, Ogden, Utah 84408; (801) 626-6406

- Kuhn, Colleen M., Ph.D. - Clinical Child and Adolescent Psychologist - One Haven at Comprehensive Psychological Services
1208 E 3300 S, SLC, UT 84106; (801) 483- 1600 ext.221
- Lambert, Kate, LCSW
1399 S 700 E Ste. 2, SLC, UT 84105; (801) 474-2349
- Le, Phuong, LCSW RPT
4055 S 700 E Ste 102, SLC, Utah 84107; (801) 450-7658
- Lehman, Mary Eileen, LCSW
4055 S 700 E, Ste 102, SLC, Utah 84107; (801) 201-7661
- Limberakis, George J., M.Ed. - Licensed Professional Counselor
1399 S 700 E, Ste 12E, SLC, Utah 84105; (801) 487-4298;
george@georgelimberakis.com
- Lyons, Susan, LCSW
124 S 400 E, Ste 301, SLC, Utah 84111; (801) 364-3723
- MacDougall, Mindy, LCSW
124 S 400 E, Ste 301, SLC, Utah 84111; (801) 322-3923
- McQuade, Shannon, LCSW - Real Caring at Comprehensive Psychological Services
1208 E 3300 S, SLC, Utah 84102; (801) 712-6140; www.RealCaring.com
- Pederson, Kim, LCSW
86 North B Street #3, SLC, UT 84103; (801) 521-7646;
kim.echo11@gmail.com
- Posner, Kara, LPC - SLC Counseling
77 S 700 E, Ste 200, SLC, UT 84105; (801) 948-0944;
SLCcounseling@gmail.com
- Randall, Ryan C., LCSW - *PERSPECTIVES*
24 S 600 E #6, SLC, UT 84102; (801) 580-3823; (801) 521-0688
- Rosen, Deanna, LCSW
970 E. Murray-Holladay Blvd, Ste 2E, SLC, Utah 84117; (801) 288-1062
- Scott, Lynn K., LCSW
275 E. South Temple, Suite 101, SLC, Utah 84111; 801-531-7389 X4
- Sommers, Jania, LCSW
1731 S 1400 E, SLC, UT 84105; (843) 345-4940; janasommers@gmail.com

- Spadaro, Nina, PhD - Impact Education & Therapy, LLC
11710 Sanders Circle, Sandy, Utah 84092; (304) 319-4041
- Struve, Jim, LCSW
1399 S 700 E, #2, SLC, Utah 84105; (801) 364-5700, Ext. 1
- Taylor, Nancy, MS, LPC - Ascent Counseling, Inc.
1343 S 1100 E, SLC, UT 84105; (801) 891-6123;
ascentcounseling@yahoo.com
- Thornhill, Denise, PhD
715 E 3900 S, Ste 202, SLC, UT 84107; 801-261-5141
- Williams, Sheri, LCSW
3098 S. Highland Drive Suite 347, SLC, UT 84106; (801) 505-3133;
www.sheri-williams.com
- Wolf, Janet, LCSW
370 E South Temple #550, SLC, Utah 84105; (801) 256-4923;
jwolfcsw@gmail.com

6. Oral Health Care

The following dental providers have worked with the Ryan White Part B Program in the past and are willing to see HIV+ patients. If funding for Part B dental services becomes available, these providers would be the first the Program would contact to sign provider agreements. Several of them will currently see patients at a reduced fee for service.

- Brigham City Dental
14 North 100 East, Suite 200, Brigham City, UT 84302
- W. Landon Bye, DDS
15 W South Temple, Ste 440, Salt Lake City, UT 84101
- Central City Dental Clinic
461 South 400 East, Salt Lake City, UT 84111
- Bryant Cornelius DDS – Moab Dental Health
2700 South Highway 191, Moab, UT 84532
- Clifford Daines, DDS
5974 South Fashion Pointe Dr., #230, South Ogden, UT 84403
- Emergency Dental Care
484 West 800 North, Ste 202, Orem, UT 84057
OR 2816 West 3500 South, West Valley City, UT 84119

- Mountain Ridge Dental
1256 South State Street, Suite 103, Orem, UT 84097
- Gregory Larsen, DDS
7370 South Creek Road, #104, Sandy, UT 84093
- Mountain Lands CHC
215 West 100 North, Provo, UT 84601
- Oquirrah View Dental
4745 South 3200 West, Salt Lake City, UT 84118
- Gregory Perkins, DDS
1275 E. Ft. Union Blvd., Suite 215, Midvale, UT 84047
- Stephen Ratcliffe Dental Clinic
1365 West 1000 North, Salt Lake City, UT 84116
- University Hospitals & Clinics - Dental Clinic #7
50 North Medical Drive, Salt Lake City, UT 84132

7. Substance Abuse Services

- Division of Substance Abuse and Mental Health - Ensures that substance abuse treatment services are available throughout the state. The Division contracts with local county governments (Local Substance Abuse Authorities, or LSAAs) to provide these services. LSAAs are listed by county:
 - Bear River Health Department
655 E 1300 N, Logan, UT 84341; (435) 792-6420
 - Weber Human Services
237 - 26th Street, Ogden, UT 84401; (801) 625-3700
 - Davis Behavioral Health
934 S Main Street, Layton, UT 84041; (801) 544-0585 or (801) 773-7060
 - Salt Lake County Behavioral Health Services
2001 S State Street, Ste S2300, SLC, UT 84190; (801) 468-2009
 - Valley Mental Health - Tooele
100 S 1000 W, Tooele, UT 84074; (435) 843-3520
 - Valley Mental Health - Summit
1753 Sidewinder Drive, Park City, UT 84060; (435) 649-8347
 - Northeastern Counseling Center
1140 W 500 S, PO Box 1908, Vernal, UT 84078; (435) 789-6300

- Central Utah Counseling & Substance Abuse Center
255 W Main, Mt. Pleasant, UT 84647; (435) 462-2416
- Four Corners Community Behavioral Health, Inc.
105 W 100 N, PO Box 867, Price, UT 84501; (435) 637-7200
- Southwest Behavioral Health Center
474 W 200 N, St. George, UT 84770; (435) 634-5600 or (800) 574-6763
- San Juan Counseling
356 S Main, Blanding, UT 84511; (435) 678-2992
- Volunteers of America @ Cornerstone Counseling Center - Free counseling and support services for people who: inject drugs; sell sex or sexual services; are active in “PNP” (party and play); use drugs/alcohol & want to cut back or quit; are HIV positive and would like support; are sex partners with someone who is HIV positive; want someone to talk to about high-risk sexual behavior; have had a sexually transmitted infection during the past year; and/or have unprotected sex with multiple partners.
660 S 200 E, Ste 308, SLC, UT 84111; (801) 355-2846 or (801) 355-2846
- Substance Abuse and Mental Health Services Administration (SAMHSA) – Online substance abuse services locator (by state and specific address):
 - <http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx>
- The following individuals and organizations provide substance abuse support specifically geared towards individuals with HIV and/or LGBTQ issues.
 - Acceptance – Gay & Lesbian Alcoholics Anonymous Group. Meets at the Utah Pride Center at 3:00 PM every Sunday.
355 N 300 W, SLC, UT 84103
 - Acceptance AI-Anon - Gay & Lesbian AI-Anon Group. Meets every Tuesday at 8:00 PM at St. Paul's.
261 S 900 E, SLC, UT 84102
 - Crystal Meth Anonymous - Gay & Lesbian support group. Meets every Saturday at 7:30 at the Utah Pride Center.
361 N 300 W, SLC, UT 84103
 - Crystal Queer - 12-Step recovery program for anyone in the LGBTQI tribe who thinks they may have a problem with crystal meth and/or other drugs. Meets Saturdays from 5:30-6:30 and Wednesdays from 6:30-7:30.
231 E 400 S, room 208, SLC, UT 84103; (801) 859-4132

- Free To Be Me – Gay & Lesbian Alcoholics Anonymous Group. Meets every Saturday at St. Mary's in Provo at 6:00 PM.
50 W 200 N, Provo, UT 84601
- Gay Queer Women's AA Meeting at Community Legal Center – The *G/Q Women's A.A. Meeting* welcomes all alcoholics (and those who may be) who *havelived, or currently live*, under the cultural sign "Woman": Gay, Queer, and Lesbian Women, Dykes, MTF, FTM, AGs, Butches, Grrlz, Boiz, Bi s, and those who are questioning. Regular Meeting Time is Mondays at 8pm.
205 N 400 W, SLC, UT 84103; (801) 884-6325
- Gay Men's Stag – Gay & Lesbian Alcoholics Anonymous Group. Meets at the Utah Pride Center every Monday at 8:00 PM.
361 N 300 W, SLC, UT 84103
- I Promise Foundation –Intensive Outpatient substance abuse treatment and mental health therapy. Offers peer to peer groups for women with trauma issues. Very affordable and customized multi-dimensional solution design recovery. Offers consulting services to assist the individual in the LBGT community with resources that are specific to their needs and how to navigate the treatment world. Also has expertise in sentencing alternatives if client is facing jail or prison. Regular Meeting Time: open
961 W Center St, Orem, UT 84058; (801) 472-9780
- Live and Let Live – Gay & Lesbian Alcoholics Anonymous Group. Meets every Tuesday at St. Paul's at 8:00 PM.
261 S 900 E, SLC, UT 84102
- Project Reality – Harm reduction materials, Bleach kits, and safer smoking kits. Individuals are encouraged to call for more information.
154 E 700 S, SLC, UT 84111; (801) 364-8080
- Sober Today – Gay & Lesbian Alcoholics Anonymous Group. Meets every Wednesday at Washington Terrace at 7:30 PM.
4601 S 300 W, Ogden, UT 84405
- Stonewall AA – Gay & Lesbian Alcoholics Anonymous Group. Meets every Friday at 8:00 PM at St. Paul's.
261 S 900 E, SLC, UT 84102

8. Early Intervention Services

- No other assistance available.

9. Medical Nutrition Services
 - No other assistance available.
10. Home Health Care
 - No other assistance available.

SUPPORTIVE SERVICES:

1. Case Management (non-medical)
 - No other assistance available.
2. Medical Transportation Services
 - No other assistance available.
3. Food Bank/Home Delivered Meals
 - Utah AIDS Foundation offers a weekly food bank as well as home delivered meals for HIV clients with failing health.
 - Catholic Community Services, located in Ogden, offers a weekly food bank for HIV+ individuals.
 - Local food banks – Online services for food banks and food pantries, listed by county: http://www.foodbanksofutah.org/find_list.html
4. Psychosocial Support Services
 - No other assistance available.
5. Emergency Financial Services (food vouchers)
 - Workforce Services – online application can determine if a client is eligible for food stamps, financial help, and/or child care assistance.
<http://jobs.utah.gov/customereducation/apply/forms.html>
 - Catholic Community Services
 - Salt Lake Location: St. Vincent's DePaul Resource Center
437 W 200 S, SLC, UT 84101; (801) 363-7710 x1418
 - Ogden Location: Joyce Hansen Hall Food Bank & Social Services
2504 F Avenue, Ogden, UT 84401; (801) 394-5944
 - Sharehouse Emergency Assistance – (801) 363-7710 x1417
 - People With AIDS Coalition of Utah (PWACU) - Some emergency assistance available.
 - Deseret Industries (operated by the Church of Jesus Christ of Latter Day Saints) – Often assists clients with needed household items.

- Royal Court of the Golden Spike Empire (RCGSE) – Some emergency assistance available, once in a lifetime basis.
6. Treatment Adherence Counseling
 - No other assistance available.
 7. Health Education/Risk Reduction
 - Northern Utah AIDS Coalition
 - Project Reality
 8. Outreach Services
 - Free testing sites include: Utah Pride Center, Planned Parenthood of Utah, Salt Lake Valley Health Department, Utah AIDS Foundation, Northern Utah AIDS Coalition
 9. Referral for Health Care/Support Services
 - People With AIDS Coalition of Utah (PWACU)
 10. Rehabilitation Services
 - No other assistance available.
 11. Linguistics Services
 - Translation services are available through the University of Utah Health Care System, the Asian Association, and Catholic Community Services.
 12. Legal Services
 - Rainbow Law Clinic at the Utah AIDS Foundation - The Utah Pride Center, The S.J. Quinney College of Law Pro Bono Initiative, and the OutLaws offer an ongoing legal clinic for LGBT-related employment, estate planning, and family law issues. This clinic is free to the low income public.
 - Disability Law Center - services are available statewide and without regard for ability to pay.
 13. Child Care Services
 - Workforce Services – online application can determine if a client is eligible for food stamps, financial help, and/or child care assistance.
<http://jobs.utah.gov/customereducation/apply/forms.html>
 14. Respite Care
 - No other assistance available.
 15. Housing Services
 - Salt Lake Community Action Program

- HOPWA short-term housing assistance. Provides short-term rent/mortgage assistance, emergency utility payments, access to longer term HOPWA housing voucher subsidies, and suitable affordable housing listings for client placement. The program strongly encourages its participants to seek and follow through with HIV related medical care and treatment.
- Emergency Assistance Program - These funds are provided to families in crisis when the family can demonstrate that a default or arrears (mortgage/rental) was caused by circumstances beyond the family's control, which significantly affected the family's ability to pay. This circumstance must have made them unable to resolve the delinquency within a reasonable time, or unable to make a full payment.
- Home Energy Assistance Target Program (HEAT) - Provides winter utility payment assistance to low-income households, targeting those who are truly vulnerable - the lowest-income households with the highest heating costs: the disabled, elderly, and families with preschool-age children. Utah received about \$32 million in federal funds for the HEAT program last fiscal year.
- Catholic Community Services (Ogden location) - Homeless Prevention Services provides rent and utility assistance for those in need.

iii. How Ryan White Funded and Non Ryan White Funded Care and Services Interact to Ensure Continuity of Care

The number one goal for all Ryan White programs is to ensure all individuals affected by HIV disease have access to medical and supportive care. The Ryan White Part B Program works very closely with our client's case managers to make sure the client's needs are being met. All Ryan White Programs in Utah collaborate and coordinate with each other as well as outside community programs and agencies. Ryan White funded and non-Ryan White funded programs collaborate frequently at committee meetings, public forums, trainings, and community/awareness events. When there is a gap in services not available through the Ryan White programs, we work very hard to locate resources in the community to fill in these unfunded areas.

iv. How the Continuum of Care has been Affected by State and Local Budget Cuts, and How the Ryan White Program has Adapted

The State of Utah does not fund any direct care services for people living with HIV/AIDS. The Ryan White Programs have seen indirect effects from state budget cuts. Medicaid cuts have resulted in this program no longer covering any dental services. This has been a huge gap in services for Ryan White clients. With no Ryan White funding available for dental services, many clients go without services, hoping funding will become available at a later date. Dental services are a top priority for the Ryan White Part B Program and when funding permits, this program will reopen for as long as possible. At the end of the grant year from November 2010 through March 2011, the Ryan White Part B Program determined it would have some additional funding available and was able to open the dental program for this limited short period of time.

C. Description of Need

i. Care Needs

During the Fall of 2008, the Utah HIV/AIDS Treatment and Care Program together with the HIV/STD/Viral Hepatitis Prevention Program conducted a needs assessment of People Living with HIV/AIDS (PLWHA). The primary goal of this study was to enable the HIV/AIDS Treatment and Care Program, HIV/STD/Viral Hepatitis Prevention Program, and each of their respective planning committees to make evidence-based decisions concerning the needs of PLWHA in Utah. Other goals were to identify disproportionate need between demographic groups and to identify barriers to service that PLWHA might encounter.

Survey participants were asked to indicate whether or not they used certain treatment and care services. Participants were also asked to rate these services according to their perceived importance and satisfaction.

Table 2 - Treatment and Care Service Ratings: Responses from the Entire Sample

Service	Rank	Usage (%)	Importance (Ave. Rating)	Satisfaction (Ave. Rating)
Doctor visits for HIV/AIDS	1	97.5	2.9	2.7
CD4 count or Viral Load Test	2	96.7	2.8	2.7
HIV/AIDS medications (pharmacy, ADAP, etc.)	3	89.3	2.9	2.6
Information about treating HIV/AIDS	4	85.8	2.0	2.4
Case management	5	85.2	2.5	2.1

Table continued on next page

Table 2 continued

Service	Rank	Usage (%)	Importance (Ave. Rating)	Satisfaction (Ave. Rating)
Information about how HIV is spread	6	85.2	1.9	2.5
Dental Care	7	78.9	2.3	2.0
Help taking HIV/AIDS medications and dealing with side effects	8	77.8	1.9	2.4
Food bank	9	57.3	2.1	2.1
Psychiatrist visits/mental health counseling	10	53.7	1.9	1.9
Help paying for health insurance (COBRA, HIP, copays, etc.)	11	52.1	2.2	1.8
HIV/AIDS support group	12	51.8	1.8	1.6
Help with housing	13	50.1	2.1	1.8
Emergency financial assistance	14	46.6	2.2	1.5
Transportation (bus, Trax, shuttle, taxi, van, etc.)	15	46.0	1.9	1.5
Emergency Food vouchers	16	41.1	2.1	1.5
Legal assistance	17	37.3	1.9	1.4
In-patient/out-patient substance abuse treatment	18	20.6	2.1	1.7
Medical care in your home	19	16.4	1.9	1.8
Alcohol or drug abuse detox	20	16.2	1.8	1.6
Women's health (OBGYN, pregnancy testing, prenatal care, etc.)	21	14.5	2.3	2.1
Child medical care (immunizations, well checks, sick care, etc.)	22	10.7	1.9	2.1

Note: Information presented in this table represents the survey responses. Rank was established by ranking services by usage and then by importance. "Ave. Rating" is the average rating for a particular service category. The rating scales are described in Table 2.2.

Source: 2009 Utah HIV/AIDS Treatment and Care and HIV Prevention Need Assessment Report

The top five services were: 1) doctor visits for HIV/AIDS, 2) CD4 count or viral load test, 3) HIV/AIDS medications, 4) information about treating HIV/AIDS, and 5) case management. The percentage of the entire sample that used these services was high (%) and the average ratings for importance and satisfaction for these services was also high. When comparing the most used services from the 2008 HIV/AIDS Needs Assessment Survey with those from the 2006 Survey, the list is almost identical. The top three services are the same and information about treating HIV/AIDS replaced case management as the fourth most used service. The fifth service is now case management and dental care moved from fifth to seventh in reported usage.

Medical Care

Medical care needs encompass the top four services: doctor visits for HIV/AIDS, CD4 count or viral load test, HIV/AIDS medications (pharmacy, ADAP, etc) and information about treating HIV/AIDS. The needs assessment asked survey participants several

questions regarding access to medical care. The following tables illustrate the responses representing the entire sample (365 participants). Please note percentages might not add up to 100% due to the exclusion of non-responses. Respondents could have selected more than one category.

Table 3: How Soon Did You Enter Into Medical Care After Learning About Your HIV+ Status?

Group	<u>Within 6 months of diagnosis</u>	<u>More than 6 months from diagnosis</u>
IDU (not MSM)	40.0%	40.0%
MSM, color	68.7%	21.9%
Entire Sample	78.7%	21.3%
Rural	78.4%	21.6%
Youth	80.0%	20.0%
Hetero, White	79.0%	19.3%
MSM/IDU	75.0%	17.8%
MSM, White	79.8%	17.0%
Men, Color	76.2%	15.3%
Women, White	84.4%	12.5%
Women, Color	84.2%	5.3%
Hetero, Color	84.8%	3.0%

Source: 2009 Utah HIV/AIDS Treatment and Care and HIV Prevention Need Assessment Report

Participants from subgroups of IDU, MSM from communities of color, and participants from rural communities were more likely to wait more than six months after diagnosis to receive care. Women and those not injecting drugs were more likely to seek medical care quickly.

Table 4: Do You Have One Place You Go For Medical Care?

Group	<u>Yes</u>	<u>No</u>
Hetero, Color	93.9%	6.1%
Women, Color	94.7%	5.3%
Men, Color	94.9%	5.1%
Women, White	96.9%	3.1%
MSM, Color	97.0%	3.0%
Rural	97.3%	2.7%
Entire Sample	96.2%	2.2%
MSM, White	98.4%	1.6%
IDU (not MSM)	90.0%	-
Youth	100.0%	-
MSM/IDU	100.0%	-
Hetero, White	100.0%	-

Source: 2009 Utah HIV/AIDS Treatment and Care and HIV Prevention Need Assessment Report

Those participants who were more likely to report they did not have one place to go for medical care included heterosexuals from communities of color, women from communities of color, and men from communities of color.

Table 5: Have You Received Primary Care Within the past 12 Months?

<u>Group</u>	<u>CD4 Count</u>	<u>Viral Load Test</u>	<u>Antiretroviral Therapy</u>
Hetero, White	100.0%	100.0%	85.0%
MSM/IDU	100.0%	100.0%	71.4%
Women, White	100.0%	100.0%	77.4%
MSM, White	98.4%	97.8%	81.2%
MSM, Color	97.0%	96.9%	77.4%
Entire Sample	96.2%	95.6%	78.6%
Rural	94.7%	94.6%	73.0%
Women, Color	94.7%	94.7%	89.5%
Hetero, Color	93.9%	97.0%	90.3%
Men, Color	91.7%	94.7%	76.4%
IDU, (not MSM)	90.0%	90.0%	70.0%
Youth	90.0%	90.0%	60.0%

Source: 2009 Utah HIV/AIDS Treatment and Care and HIV Prevention Need Assessment Report

A person is considered to have received primary medical care if s/he has received a CD4 count, a viral load test, or antiretroviral therapy. IDU and youth were slightly less likely to have received primary medical care overall. Youth were the least likely to have received any of the three: CD4 count, a viral load test, or antiretroviral therapy.

Survey participants were given the opportunity to explain why they had not received primary medical care within the past 12 months. Responses were voluntary, and most respondents chose not to provide an explanation. One reason for a lack of responses was that a majority of the sample was receiving primary medical care. Fourteen (3.8%) had not received a CD4 count or viral load test and when asked why not one respondent indicated that they could not afford it. Another respondent indicated that it was because s/he was newly diagnosed. Sixty-seven (18.9%) of all respondents indicated that they did not receive antiretroviral therapy in the last 12 months. When asked why, nineteen respondents said that they did not need antiretroviral therapy or that their viral load was still at low levels. Furthermore, eight respondents said they did not know why they had not received primary medical care within the past 12 months, seven respondents said they were following a doctor's orders, and four respondents were unable to afford primary medical care.

Table 6: What is Your Method of Payment for Medical Care and Medication?

<u>Group</u>	<u>Ryan White (incl. ADAP)</u>	<u>Medicaid</u>	<u>Medicare</u>	<u>Private Health Ins</u>	<u>HIP</u>	<u>Other</u>	<u>None</u>
Hetero, Color	87.9%	21.2%	15.2%	12.1%	-	12.1%	6.1%
Women, Color	84.2%	15.8%	15.8%	21.1%	-	10.5%	5.3%
Men, Color	78.3%	8.3%	8.3%	16.7%	1.7%	13.3%	10.0%
MSM/IDU	75.0%	25.0%	25.0%	3.6%	3.6%	7.1%	3.6%
Women, Coloe	75.0%	28.1%	15.6%	34.4%	3.1%	15.6%	3.13%
MSM, Color	72.7%	6.1%	12.1%	18.2%	3.0%	15.2%	9.1%
Youth	70.0%	10.0%	10.0%	40.0%	-	-	-
Hetero, White	69.4%	21.0%	14.5%	24.2%	6.5%	17.7%	4.8%
Entire Sample	68.2%	18.4%	19.5%	20.0%	6.6%	13.2%	4.9%
MSM, White	66.5%	19.2%	21.8%	20.2%	9.0%	13.3%	3.2%
IDU (not MSM)	60.0%	10.0%	-	10.0%	-	10.0%	10.0%
Rural	57.9%	18.4%	18.4%	23.7%	7.9%	15.8%	5.3%

Note: "ADAP" is the AIDS Drug Assistance Program. "HIP" is the State High Risk Insurance Pool.
Source: 2009 Utah HIV/AIDS Treatment and Care and HIV Prevention Need Assessment Report

IDU men from communities of color, and MSM from communities of color had higher uninsured percentages as compared to the entire sample. MSM/IDU had a much lower private insurance percentage, as compared to the entire sample.

Table 7: Have You Ever Skipped or Stopped Taking HIV/AIDS Medication?

<u>Group</u>	<u>Yes</u>	<u>No</u>
IDU (not MSM)	60.0%	30.0%
MSM/IDU	51.9%	48.1%
Rural	45.9%	54.1%
Youth	40.0%	60.0%
Women, White	36.8%	63.2%
Women, Color	36.8%	63.2%
MSM, White	36.0%	64.0%
Hetero, White	34.4%	65.6%
Entire Sample	33.2%	64.4%
MSM, Color	27.3%	72.7%
Hetero, Color	28.1%	71.9%
Men, Color	22.0%	78.0%

Source: 2009 Utah HIV/AIDS Treatment and Care and HIV Prevention Need Assessment Report

IDU (not MSM), MSM/IDU, and respondents from rural communities had higher percentages within their respective groups, as compared to the entire sample, that reported that they had skipped or stopped taking HIV/AIDS medication at least once. Heterosexuals from communities of color, and men from communities of color had lower percentages within their respective groups, as compared to the entire sample that reported that they had skipped or stopped taking HIV/AIDS medication at least once.

Survey participants were given the opportunity to explain why they had ever skipped or stopped taking their HIV/AIDS medications. Responses were voluntary and eight respondents chose not to provide an explanation. All of the explanations were read to identify common themes in the responses. The most common theme in the responses was that they simply forgot to take the medications (27 respondents). The second most common theme was the negative side effects of the medications (16 respondents). Respondents also identified the cost of the medications or a lack of insurance (15 respondents) as a reason for skipping or stopping the medications. Other reasons included doctor's recommendation or other medical reasoning for taking a break (13 respondents), illegal drug use (9 respondents), travel or vacation (8 respondents), and depression or other mental issues (6 respondents).

Case Management

Case management was identified as the fifth most important HIV service by survey participants. Eighty-five percent of participants indicated they currently use this service, although only 77.5% reported they have a case manager. The following tables illustrate the responses representing the entire sample (365 participants). Please note percentages might not add up to 100% due to the exclusion of non-responses. Respondents could have selected more than one category.

Table 8: Do You Have A Case Manager?

<u>Group</u>	<u>Yes</u>	<u>No</u>	<u>I don't know</u>
MSM, Color	90.9%	6.1%	3.0%
Hetero, White	86.9%	8.2%	4.9%
Women, Color	84.2%	10.5%	5.3%
Men, Color	81.4%	11.9%	6.8%
Hetero, Color	81.3%	12.5%	6.3%
Youth	80.0%	-	20.0%
MSM/IDU	78.6%	17.9%	3.6%

Table continued on next page.

Table 8 continued

Women, White	78.1%	12.5%	9.4%
Entire Sample	77.5%	12.6%	7.9%
MSM, White	77.5%	13.9%	8.6%
Rural	78.4%	13.5%	8.1%
IDU (not MSM)	60.0%	20.0%	10.0%

Source: 2009 Utah HIV/AIDS Treatment and Care and HIV Prevention Need Assessment Report

MSM from communities of color, White heterosexuals, and women from communities of color, all had higher percentages within their respective groups, as compared to the entire sample, that reported that they have a case manager. Respondents from rural communities and white MSM had higher percentages, within their respective groups, as compared to the entire sample, that reported that they do not have a case manager. Youth had the highest percentage within their group, as compared to the entire sample, that reported that they did not know if they had a case manager.

Survey participants were given the opportunity to explain why they did not have a case manager. Responses were voluntary and many respondents chose not to provide an explanation. All of the explanations were read to identify common themes in the responses. The four themes were: 1) the respondent did not know case management was available (8 respondents), 2) the respondent feels like s/he does not need a case manager (8 respondents), 3) there is no case manager available where the respondent receives services (6 respondents), 4) the respondent did not like the case manager who was assigned to their case (4 respondents), and 5) too many changes among case management personnel (4 respondents).

Table 9: Is There Someone Else (Not Case Manager) Who Helps You Get Services?

Group	<u>Yes</u>	<u>No</u>
MSM, Color	29.0%	71.0%
Men, Color	28.3%	71.7%
MSM/IDU	25.0%	75.0%
Women, White	22.6%	77.4%
Hetero, Color	24.1%	75.9%
Youth	20.0%	80.0%
Hetero, White	19.7%	80.3%
Entire Sample	17.8%	78.9%
MSM, White	16.0%	84.0%
Rural	16.2%	83.8%
Women, Color	10.5%	89.5%
IDU (not MSM)	10.0%	80.0%

Source: 2009 Utah HIV/AIDS Treatment and Care and HIV Prevention Need Assessment Report

MSM from communities of color, men from communities of color, and MSM/IDU had the highest percentages within their respective group, as compared to the entire sample, that reported that they had someone other than a case manager who helps them get services.

Survey participants were given the opportunity to identify who helps them get services. Responses were voluntary and many respondents chose not to provide an explanation. All of the explanations were read to identify common themes in the responses. The most common theme was that they obtained services directly from doctors or medical staff (21 respondents). Respondents also identified service organizations (14 respondents), others (11 respondents) or family and partners (4 respondents) as individuals who help them obtain services.

Table 10: How Long Has It Been Since You Last Saw Your Case Manager?

Group	<u>Within 6 Months</u>	<u>6-12 Months</u>	<u>Over a Year</u>
Hetero, Color	83.4%	6.7%	0%
Women, Color	83.3%	5.6%	0%
MSM, Color	78.2%	6.3%	6.3%
Rural	77.8%	5.6%	5.6%
Men, Color	72.0%	7.0%	8.8%
MSM/IDU	70.3%	7.4%	14.8%
Youth	70.0%	20.0%	-
IDU (not MSM)	70.0%	10.0%	-
Hetero, White	67.8%	20.3%	5.1%
Entire Sample	64.9%	12.9%	9.6%
Women, White	63.4%	26.7%	-
MSM, White	62.6%	15.0%	13.9%

Source: 2009 Utah HIV/AIDS Treatment and Care and HIV Prevention Need Assessment Report

White heterosexuals, white women, and white MSM were the least likely to have seen their case manager within the last six months. Heterosexuals from communities of color, women from communities of color, and MSM from communities of color were the most likely within their respective groups to have seen their case manager within the last six months.

Survey participants were given the opportunity to explain why they have not seen their case manager. Responses were voluntary and many respondents chose not to provide

an explanation. All of the explanations were read to identify common themes in the responses. The most common response was that they had missed appointments as a result of a change or transition in case management that either caused delays or confusion regarding a new case manager (11 respondents). The second most common response was that they felt no need to see their case manager (10 respondents). Other reasons why respondents had not seen their case manager were because they did not know that a case manager was available or did not know who their case manager was (7 respondents), they had communicated via telephone (4 respondents), and because they had personal distaste for case management or the clinic providing case management (3 respondents).

Survey participants were given the opportunity to explain what they thought would help improve case management services. Responses were voluntary and many respondents chose not to provide an explanation. All of the explanations were read to identify common themes in the responses. The majority of respondents said that they are satisfied with case management services and nothing needs to be done to improve these services (69 respondents). The second most common response was better and more frequent communication (36 respondents), followed by being unsure of how to improve the service (24 respondents). Other suggestions were to increase the training and level of knowledge that case managers have (19 respondents), to increase availability and accessibility (17 respondents), to have a stronger focus on the client (12 respondents), to increase funding (9 respondents), to add more case managers (8 respondents), to provide more information on services available (8 respondents), to obtain a case manager or inform them of who their case manager is (5 respondents), and to have more consistency in case management personnel (4 respondents). A small group of respondents suggested improving services, specifically financial support, home services, transportation, housing, therapy, and medication assistance.

ii. Capacity Development Needs in Historically Underserved Communities and Rural Communities

Youth

According to the 2009 Needs Assessment, youth consistently responded they were more likely to engage in high risk behavior that put them at risk for contracting HIV disease. Some of these high risk behaviors included:

- Youth reported they were more likely to have sex under the influence of drugs and/or alcohol, as compared to the entire sample.
- Youth reported they were more likely, as compared to the entire sample, to report that they never ask the HIV status of their internet or non-internet sex partner.
- Youth had higher percentages within their group reporting that they did not know whether or not they had had unprotected sex within the past 12 months with a primary, internet, or non-internet sex partner who has HIV or AIDS. An interesting trend is among youth and rural groups; as the sex becomes more anonymous, the likelihood of asking about HIV status decreases.
- Youth reported they were more likely, as compared to the entire sample, to trade sex for money during the last 12 months.

In regards to Treatment and Care, youth reported through the 2009 Needs Assessment Survey that they were less likely to have received primary medical care and were less likely to have received antiretroviral therapy, as compared to the entire sample. Youth were the most likely to report they didn't know if they had a case manager, as compared to the entire sample. Complicating treatment and care efforts even further, youth were more likely to report that they have been homeless at least once during the past 12 months.

The 2012 SCSN explored the current trends and emerging needs of youth and identified the following list of issues that need to be addressed:

- Prevention education, especially because disease transmission is not taught in public schools;
- Issues of exploitation (getting into bars, underage drinking);
- Issues related to "survival sex" (sex for food, shelter, drugs, etc.);
- Trust & confidentiality issues specific to this population;
- Substance abuse services (specifically injection drug use);
- Youth friendly testing sites for testing, education and counseling;
- Easy access to condoms and increasing the condom distribution sites; and
- Realizing that adolescent issues are likely underreported and the need is actually much higher than we have data for.

Injection Drug Users

Injection drug users (IDU) appeared more likely to wait more than six months after diagnosis to receive medical care, were less likely to remain in primary medical care, and were less likely to have received antiretroviral therapy, according to the 2009 Needs Assessment results. IDU also had higher percentages reporting that they had skipped or stopped taking HIV/AIDS medication at least once. IDU were more likely to be uninsured and IDU were the group most likely to have been in prison or jail, stayed in a hotel or motel, been homeless or in a shelter, or been in a half-way house. They were also least likely to have rented or owned a home.

IDU were less likely to have a case manager, and those who did have a case manager were the least likely to have seen their case manager within the last six months. This population was more likely to have someone other than a case manager who helps them get services, as compared to the entire needs assessment sample.

Approximately 31.0% of the entire needs assessment sample report having used injection drugs at least once. Not surprisingly, MSM/IDU (60.7%), white MSM (34.9%), IDU (not MSM) (33.3%), and youth (33.3%) had substantially higher percentages within their respective groups indicating that they had used injection drugs within the past 12 months and MSM/IDU were more likely to have shared needles at least once, compared with the entire sample. IDU populations also responded they were more likely to either “most of the time” or “some of the time” have sex under the influence of drugs than the entire sample.

The 2012 SCSN explored the current trends and emerging needs of injection drug users and identified the following list of issues that need to be addressed:

- Lack of substance abuse counseling and treatment option available;
- No needle exchange programs in Utah;
- Lack of resources for basic needs;
- Relapse and cross addiction issues (coupling GhB and methamphetamines);
- Lack of social network and support;
- Issues of exchanging sex for drugs/money – doing things normally wouldn’t do;
- Lack of motivation for change; and

- Lack of advocates for IDU – lack of understanding of specific problems of this special population.

Homeless

Several of the other special populations discussed during this SCSN committee meeting can also fit into either temporary or permanent classifications of homelessness.

According to the 2009 Needs Assessment report, IDU, women from communities of color, MSM/IDU, heterosexuals from communities of color, and youth were more likely, as compared to the entire sample, to report that they have been homeless at least once during the past 12 months. A trend in the data was that communities of color were more likely to have been homeless at least once during the past 12 months, as compared to the entire sample. Respondents in rural areas and respondents that were white were more likely to own a home, as compared to the entire sample. IDU were the group most likely to have been in prison or jail, stayed in a hotel or motel, been homeless or in a shelter, or been in a half-way house. They were also least likely to have rented or owned a home.

The 2012 SCSN explored the current trends and emerging needs of homeless HIV+ individuals and identified the following list of issues that need to be addressed:

- Options for permanent affordable housing;
- Treatment for mentally ill individuals;
- Drug and alcohol abuse treatment;
- Transportation, especially when it comes to medical care and treatment adherence;
- Lack of support system;
- Some individuals may face language barriers;
- Education opportunities (difficult to contact them, may have distrust of authority); and
- Lack of job/income.

Transgender

Unfortunately there is little data to report the needs of transgender in Utah. Possible explanations to this discrepancy could be this population does not feel comfortable identifying themselves as transgender or we as a program are not doing a good job of

making them feel understood. It is important to further explore this issue and make sure reports, surveys, applications, etc. include a transgender option for this population to identify with, and to further break that option down into identifying as a male or identifying as a female.

The 2012 SCSN explored the current trends and emerging needs of transgender individuals and identified the following list of issues that need to be addressed:

- Issues of trust;
- Not currently being identified appropriately in applications, etc.;
- Not currently targeted for testing;
- Training for providers to understand their issues;
- Drug and alcohol abuse treatment; and
- Prevention education – don't see themselves as at risk for HIV.

The SCSN committee also discussed that the transgender population is a fairly large community and mentioned they have a large Facebook network. There is a new Transgender Clinic located in Midvale (a Salt Lake City suburb) and there are provider trainings available at the Utah Pride Center. Transgender people of color are also a special subpopulation that has specific needs to be addressed in future SCSN meetings and Needs Assessment Surveys.

Rural

Rural areas are any areas that are not considered to be along the Wasatch Front. The Wasatch Front consists of four neighboring counties in Utah (Salt Lake, Weber, Davis, and Utah) that comprise the urban center, where the majority of the state's population resides. According to the 2009 Ryan White Part B Comprehensive HIV/AIDS Plan, people living with HIV/AIDS in rural communities face particular problems in accessing medical care. Approximately 10% of the PLWH/A, in Utah, live in rural communities and the majority of these individuals come to Salt Lake City for their medical treatment. The need to come to Salt Lake City creates financial and logistical issues with transportation and overnight lodging.

The 2009 Needs Assessment Report identified additional concerns from respondents from rural areas. Respondents from rural areas were less likely to have received

primary medical care, including CD4 Count, viral load test, and antiretroviral therapy as compared to the entire sample. Those from rural areas were more likely to be uninsured, less likely to have a case manager, and had higher reported percentages skipping or stopping their HIV/AIDS medication at least once. Respondents in rural areas were slightly more likely to have sex under the influence of drugs 'most of the time'. They were also more likely to have ever traded sex for money or drugs, compared with the entire sample. Overall, when compared to the entire sample, respondents living in rural areas had lower usage, lower importance ratings, and lower satisfaction ratings.

The 2012 SCSN explored the current trends and emerging needs of rural individuals and identified the following list of issues that need to be addressed:

- Availability of HIV providers and services (may avoid local providers due to fear or stigma, and local providers don't want to be known as the "HIV Dr");
- Issues with denial and engaging in risky behavior – what happens in the big city stays in the big city;
- Issues with confidentiality, stigma, and culture;
- Community denial – "we don't have a problem here", "not in my town" mentality;
- Lack of case management services; and
- Issues with upcoming 2014 healthcare changes – treating HIV+ patient in community health centers (quality of care and training of doctors).

D. Priorities for the Allocation of Funds

i. Size and Demographics of the Population of Individuals with HIV/AIDS

The HIV Treatment and Care Planning Committee (the Committee) meets annually to make recommendations to the Ryan White Part B Program in allocating resources for the next year. When considering the allocation of funding for HIV services in Utah, the Committee refers to the most current data in the following reports and presentations:

- HIV/AIDS Epidemiological Profile;
- HIV/AIDS Treatment and Care and HIV Prevention Needs Assessment;
- Previous Comprehensive HIV Services Plans;
- Client usage data; and
- The expertise and experiences of HIV providers, community advocates, and people living with HIV/AIDS)

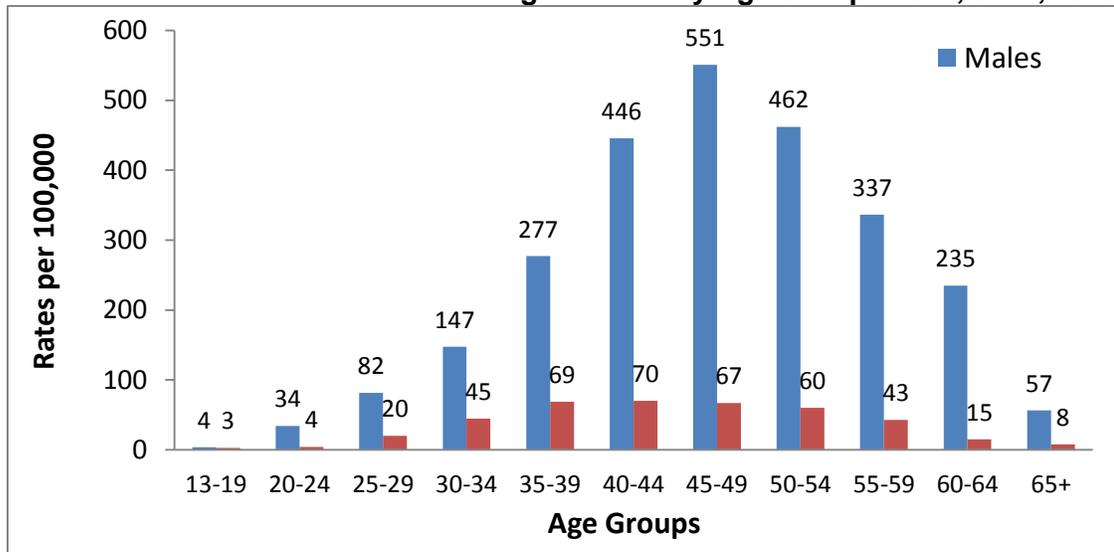
In Utah, at the end of 2010, there were a reported 1,169 individuals living with HIV and 1,382 individuals living with AIDS.

Stage 1 CD4 ≥ 500	Stage 2 CD4 200-499	Stage 3(AIDS) CD4 <200	Stage Unknown	TOTAL
203 (8.0%)	711 (27.8%)	1,382 (54.2%)	255 (10.0%)	2,551

Source: Case Data – Bureau of Epidemiology, Utah Department of Health

The following 4 tables (Table 11 through Table 14) illustrate the demographics of HIV/AIDS in Utah at the end of December 31, 2010.

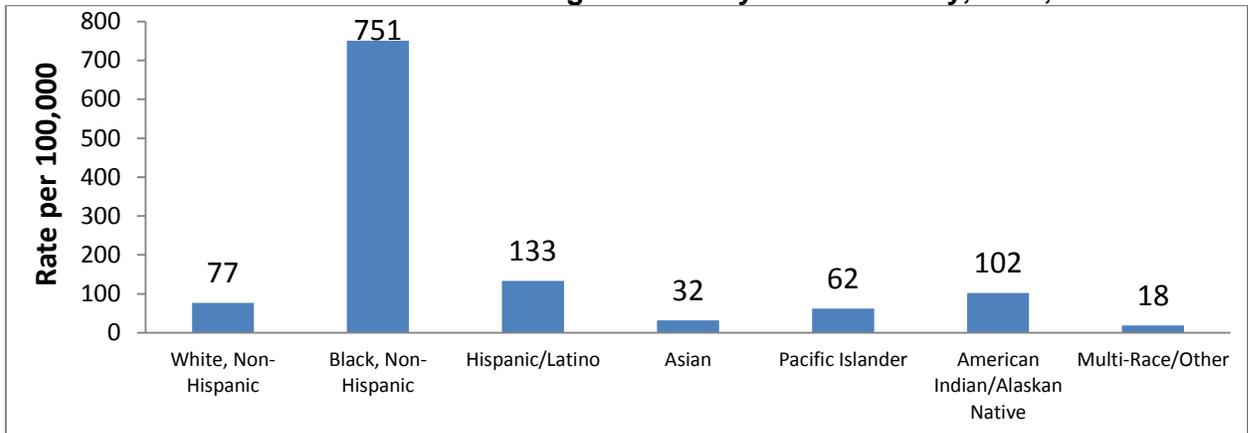
Table 11: Adolescents & Adults Living With HIV by Age Group & Sex, Utah, 2010



* By end of December 31, 2010

Source: Case Data – Bureau of Epidemiology, Utah Department of Health

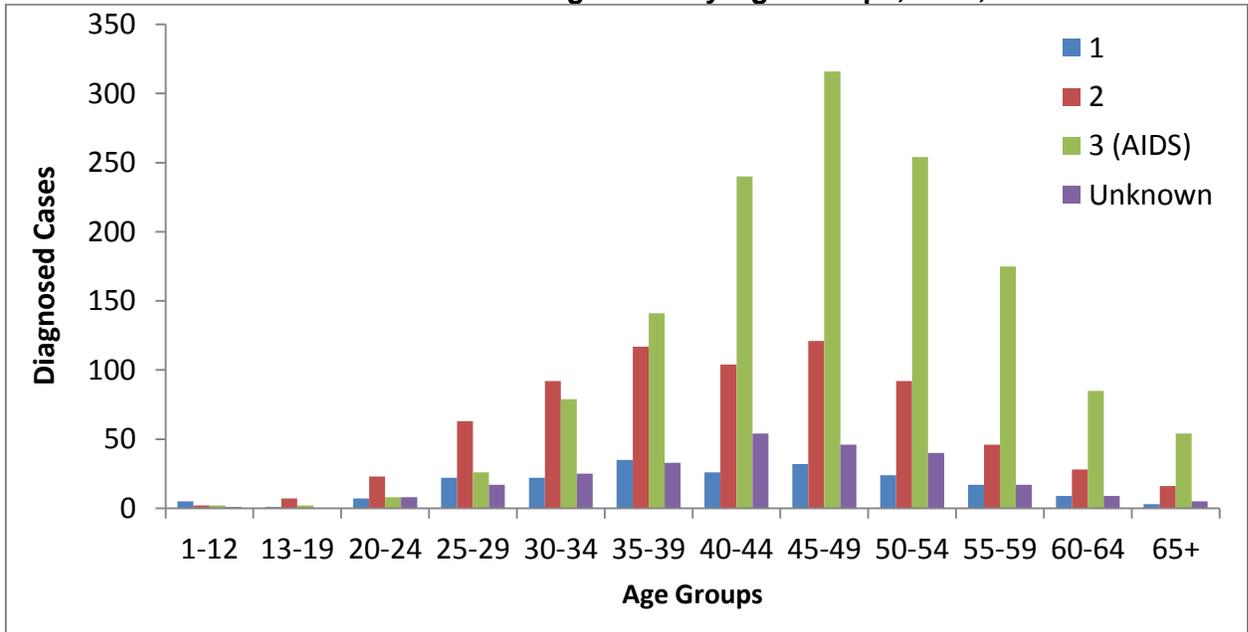
Table 12: Adults & Adolescents Living With HIV by Race/Ethnicity, Utah, 2010*



* By end of December 31, 2010

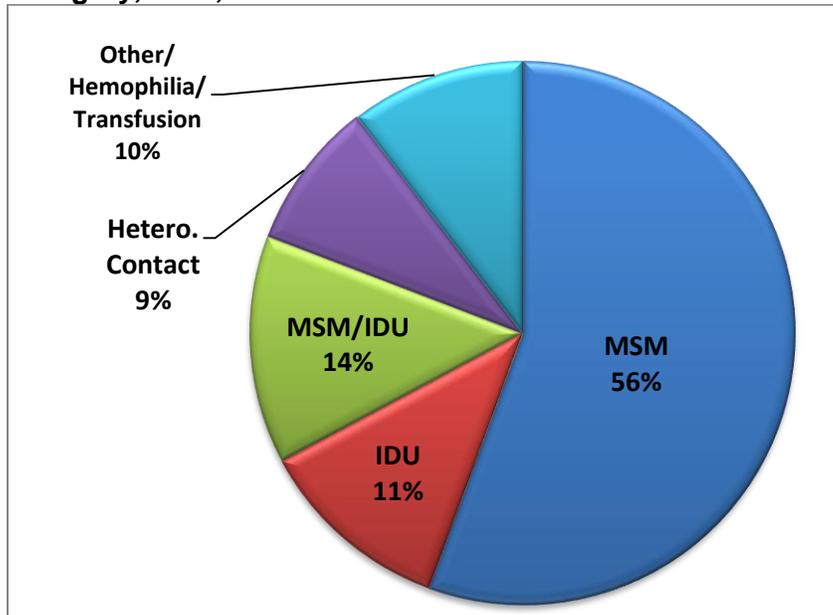
Source: Case Data – Bureau of Epidemiology, Utah Department of Health

Table 13: Adults & Adolescents Living w/ HIV by Age Groups, Utah, 2010*



* By end of December 31, 2010
 Source: Case Data – Bureau of Epidemiology, Utah Department of Health

Table 14: Percentage of Adults & Adolescents Living w/ HIV by Transmission Category, Utah, 2010*



* By end of December 31, 2010
 Source: Case Data – Bureau of Epidemiology, Utah Department of Health

Based on the above tables taken from the HIV Epidemiological Profile discussed in Section A.i. of this document, there are several populations that stand out as priority

populations with treatment and service needs. Historically these are populations have the highest degree of burden among people living with HIV/AIDS in Utah (see below).

Table 15

Highest Disease Burden Among People Living With HIV/AIDS in Utah
<ul style="list-style-type: none">• Of those living with HIV-infection (including AIDS), 86% are among males.• The highest rate* is among males 45-49 years (551.0), followed by males 50-54 years (462.2).• The rate among women (24.9) is significantly lower than among men (153.3).<ul style="list-style-type: none">• The highest rate among females is in 40-44 year olds (70.1).• White individuals account for 69% of those living with an HIV-infection, followed by Hispanics (18%), and Black/African Americans (9%).• Furthermore, when comparing rates, Black/African Americans hold the highest rate (750.7), followed by Hispanics (133.3), American Indians/Alaskan Natives (102.1), Whites (76.6), Pacific Islanders (62.0), and Asians (31.9).• Ninety-one percent of those living with HIV/AIDS have reported a risk: MSM accounts for the majority at 56%, MSM/IDU at 12%, and heterosexual contact at 9%.<ul style="list-style-type: none">• There are 9% living with an HIV-infection who identified to have an unknown risk or some other risk such as a blood transfusion or organ transplant.

*Rates per 100,000 population.

Source: Case Data – Bureau of Epidemiology, Utah Department of Health;

Population Estimates – Governor’s Office of Planning and Budget;

US Data – CDC 2011 Fact Sheets, <http://www.cdc.gov/hiv/topics/surveillance/factsheets.htm>

Men, specifically MSM and MSM/IDU make up the largest portion of the HIV/AIDS population in Utah. Additionally the highest rate among both males and females is between the ages of 45-54 years old. Although within this population there are more White individuals living with an HIV infection, it is Black/African Americans, followed by Hispanics and American Indians/Alaskan Natives that are a larger concern due to the disproportionate rate with the overall population in Utah.

These findings in people living with HIV/AIDS correlate with the HIV Prevention Epidemiological Profile indicating MSM, MSM/IDU and IDU as the three populations most at risk for HIV infection in Utah. And while African Americans have the highest rate of infection followed by Hispanics, their differences in demographics overall make Hispanics a priority in HIV prevention.

ii. Needs of Individuals with HIV/AIDS

According to the 2009 Needs Assessment the top 5 service needs of HIV positive individuals were identified as:

1. Doctor visits for HIV/AIDS;

2. CD4 count or viral load test;
3. HIV/AIDS medications;
4. Information about treating HIV/AIDS; and
5. Case management.

The ultimate goal of the Committee is to meet as many of the needs of individuals with HIV/AIDS as possible with the funding available. Careful consideration is given to the top services the individuals themselves report to be important. Additionally, services that enhance or support these top prioritized services are also considered to be an important need. For example, doctor visits for HIV/AIDS are the number one need identified by individuals with HIV/AIDS in the 2009 Needs Assessment. This service is of little use if the client is unable to get themselves to their appointment(s). Therefore, transportation for medical appointments is also considered a high need for individuals with HIV/AIDS to support the number one need.

As the Committee works through prioritizing HIV services, the input from the service providers, specifically the physicians and case managers is very important. They are in contact every day with these individuals and see and hear firsthand what the needs, barriers and gaps are.

With all of this information, the Committee works through an exercise of ranking the HIV Services Priorities. Services are divided into two categories: 1) core services and 2) supportive services. The worksheets used for this exercise can be found in Appendix E. The following table is the compilation of each committee member's ranking of the prioritized service categories for FY2012.

Table 16: Priority Setting – HIV Services 2012

CORE SERVICES	
Outpatient/Ambulatory Medical Care	1
AIDS Drug Assistance Program	2
Medical Case Management	3
Health Insurance Premium & Cost Sharing Assistance (Funded)	4
Mental Health Services	5
Oral Health Care	6
Substance Abuse Services	7
Early Intervention Services	8*

Table continued on next page.

Table 16 continued.

Medical Nutrition Therapy	8*
Home Health Care	9

*Service scores were a tie.

SUPPORT SERVICES	
Case Management (non-medical)	1
Medical Transportation Services	2
Food Bank/ Home Delivered Meals	3
Psychosocial Support Services	4
Housing Services	5
Emergency Financial Services	6
Treatment Adherence Counseling	7
Health Education/Risk Reduction	8
Outreach Services	9
Referral for Health Care / Supportive Services	10
Rehabilitation Services	11
Linguistics Services	12
Legal Services	13
Child Care Services	14
Respite Care	15

If the ranked list of services varies from the needs of individuals with HIV, committee members are allowed to change a rank by group consensus. Historically it has been important to the Committee that the ranked list closely matches the results of the needs assessment.

Next, the Committee allocates resources to this ranked list. Resources from other Ryan White Parts are considered as well as availability of individual HIV services in the community. Past funding allocations and actual expenditures are also taken into account. Final recommendations are then given to the Ryan White Part B Program.

E. Gaps in Care

The 2011 Utah HIV/AIDS Unmet Need and Service Gap Report (Unmet Needs Report) shows that of the 2,540 known PLWH/A within the state, 11.4% (289 cases) are not receiving medical care. The 2009 Needs Assessment showed that medical visits and related service were the most used of the Ryan White programs (medical visits, 97.5%; CD4 counts or viral load test, 96.7%). In Utah, there is only one medical facility who receives Ryan White HIV/AIDS Treatment Modernization Act funds and that clinic serves a majority of all Ryan White clients in the state.

One of the issues discussed at the 2012 SCSN meeting was the issue of rural areas in Utah. Rural areas are any areas that are not considered to be along the Wasatch Front. The Wasatch Front consists of four neighboring counties in Utah (Salt Lake, Weber, Davis, and Utah) that comprise the urban center, where the majority of the state's population resides. Of the 208 Utah individuals reported with HIV/AIDS in 2010, 187 (90%) live along the Wasatch Front. Sixty-five percent of these individuals live in Salt Lake County. The majority of individuals from rural areas continue to come to Salt Lake City for their medical treatment. Many PLWH/A are at or below poverty which makes it difficult to own, operate and/or maintain a vehicle. Public transportation may not be easily accessible, especially for rural clients needing to travel to Salt Lake for appointments. In recent years, public transportation has increased in cost and many PLWH/A just cannot afford it. People living in rural communities can feel isolated and reluctant to seek appropriate care. In addition, providers in those areas may not have adequate specialized training for HIV care and/or they may be reluctant to treat patients with HIV for fear of losing other clients.

Funding was also a highly discussed topic in the 2012 SCSN meeting. Reduced and level federal funding combined with lack of funding support from the state makes it difficult to keep programs open and services available. Increased utilization in recent years has further stressed this funding situation and many services were discontinued due to cost containment strategies. Dental services, mental health counseling, and substance abuse services are a few of the services no longer offered through the Ryan White Part B Supportive Services Program. The complex issues associated with mental health and substance abuse further complicate efforts with medication adherence. Additionally, HIV medications are expensive. The ADAP Program has been intermittently closed over the past 3 years due to lack of funding to sustain clients on the program. The eligibility requirements for all Part B programs, including lowering the federal poverty level from 400% to 250% to qualify for services has made it difficult for many to obtain services. Access to costly medications is a rising concern.

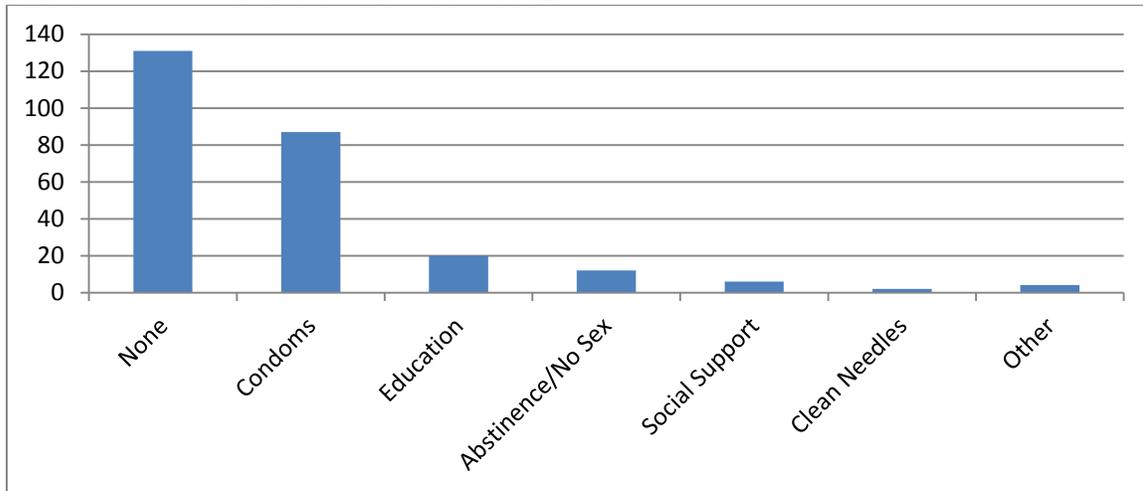
Utah historically has a very conservative mindset. The stigma associated with HIV/AIDS can make disclosing HIV status to friends and family, even medical providers difficult. Education is always a crucial need for individuals who don't know where to go to obtain services and what services are available.

F. Prevention and Service Needs

Needs of Individuals who are Aware of their HIV Status and in Care:

In the 2009 Needs Assessment Survey, survey participants were given the opportunity to identify what HIV prevention services they needed. Responses were voluntary and many respondents chose not to offer an opinion. All of the explanations were read to identify common themes in the responses. The most common theme was that respondents felt like they did not need HIV prevention services (131 respondents). The second most common theme was that they needed condoms or lube (87 respondents). Smaller groups identified education (20 respondents), social support (6 respondents), and clean needles (2 respondents) as an HIV prevention service need. One group of the respondents wrote “no sex/abstinence” (12 respondents), which we interpreted as the respondents are not sexually active and do not feel prevention services are necessary. The results are displayed in Table 17 below:

Table 17: HIV Prevention Service Needs



Needs of Individuals who are Aware of their HIV Status and Not in Care:

According to the 2011 Unmet Needs Report, it is estimated there are 289 (11.4%) HIV+/aware individuals in Utah that are not in care. This number includes 250 PLWH and 39 PLWA. The PLWH population demonstrated a higher level of unmet need ($n = 250$; 23.4%) than the PLWA population ($n = 39$; 2.6%). This means that there are more people out of care in the PLWH population than in the PLWA population. One possible explanation is that PLWH are not as likely to experience symptoms that would persuade them to seek primary medical care. As a result, PLWH have a higher level of unmet need.

The opposite is true for the PLWA population. PLWA are more likely to experience symptoms that would persuade them to seek primary medical care.

The small group discussion for this topic included several possible reasons why these individuals are not in care. Since this population is difficult to question and survey, we can only assume what the reasons why they are not in care are. Possible explanations include:

- Fear of disclosing status;
- Stigma;
- Lack of privacy and confidentiality;
- Unaware of available help;
- Questions of how do I take care of myself;
- Fear of treatment itself;
- Lack of skills to cope; and
- Cultural and/or linguistic barriers.

The Ryan White Part B Program and the Communicable Disease Prevention Program collaborate together to find people who are aware of their status but are not in medical care. Collaboration activities include joint trainings and activities, and the bi-annual needs assessment for HIV positive people in Utah. Staff from the Ryan White Part B Program are involved in outreach activities such as HIV testing in the communities along the Utah-Nevada border, which traditionally has high rates of HIV.

Needs of Individuals who are Unaware of their HIV Status:

The Ryan White Part B Program and the Communicable Disease Prevention Program collaborate together to find people who are unaware of their HIV status. As testing events and locations are planned, many factors need to be considered, including:

- Access to the event/location;
- Confidentiality if located in smaller communities;
- Fear of individual finding out test results;
- How to reach youth populations; and
- Including all populations in pre-screening (i.e. identifying as transgender, include male to female or female to male).

One advantage Utah has as a low incidence state is that there are relatively few HIV tests given each year and the number of community organizations, clinics, and hospitals and the associated staff that have to give the test and then provide the result is also relatively small compared with high incidence states. This is one of the reasons why there are so few unaware individuals who are not informed of their positive HIV test results.

Encouraging everyone to get tested and know their HIV status is essential. People have many excuses why they do not want to get tested. Some of those may include:

- Low perception of risk;
- Stigma;
- Apathy, especially with youth;
- Fear of finding out;
- Denial issues – fear of facing reality, responsibility, and/or accountability;
- Fear of losing insurance, and for young people, the fear of their parents finding out if they are on their parent's insurance;
- Disclosure issues; and
- Lack of education or awareness about HIV.

Even individuals who do decide to test for HIV may not wait for their results, missing a post-counseling opportunity, or they may not be truthful in giving personal information. It may be helpful to have one person helping them throughout the testing and counseling process to build trust, educate and ease fears.

The current referral process in place now is a relatively straight-forward system. The guidelines are:

1. Everyone who gives a positive test result in Salt Lake City and the surrounding area needs to set up an appointment at Clinic 1A, the infectious disease clinic at the University of Utah Hospital.
2. The case managers at Clinic 1A can then determine if the person can best be served at Clinic 1A or if s/he needs to go to another doctor based on the newly identified person's insurance, area of residence, or some other factor.
3. If individuals are given a positive test result outside of Salt Lake, the counselor who is providing the result will refer the individual to medical care at the closest doctor or if the counselor is unfamiliar with HIV medical care providers in the area, the

counselor will call up the Utah Department of Health and ask about nearby resources.

Individuals who test positive for HIV at private clinics or hospitals often do not go through the same set process as described above. Hopefully the health care provider is familiar with HIV medical providers in the area or has access to this information. Because this is not always the case, the essential piece is to make sure the newly diagnosed individual is contacted by a local disease investigation specialist who can ensure the individual has access to needed services including medical care. When a person is newly identified as HIV positive at a state-funded test site, a form is filled out for the new positive individual and one of the questions on the form asks if a referral into care been made. The next step to take, as taught in the HIV Prevention Counseling class and communicated to local health department nurses, is to make an appointment for every new positive at Clinic 1A, which is described in the above section. Ideally the person making the referral would then call the newly identified positive person in a week or two and see how he or she is doing and if the appointment was kept. However some people who complete the form will simply answer 'yes' if a referral was made and then turn it in to the Communicable Disease Prevention Program without waiting or checking up to see if the appointment was made. There are no other activities in place to ensure that a person made it to the medical appointment.

G. Barriers to Care

i. Routine Testing

Utah is a low HIV incidence state and many health care professionals do not see the need for routine testing. In 2008, a study to estimate the prevalence of HIV/AIDS in Utah was conducted at the University of Utah Hospital Emergency Department. Among the 1,005 individuals tested for HIV using an Oraquick Advance rapid HIV screening test, there were no HIV positive tests (not even a preliminary positive). When the study first started, the Utah Department of Health was discussing the possibility of HIV screening at other emergency departments but because of the lack of any positive tests at the University of Utah emergency department, no other hospital has been interested in committing the resources or time to a similar screening effort. Another barrier in identifying HIV positive individuals is the conservative culture in Utah. This pertains to individuals who are low to moderate risk because many health care providers do not feel

that the 'average' Utahan is at risk for HIV and consider it not worth the time or money to perform an HIV test.

As defined in previous sections, the majority of people in Utah live in Salt Lake County and the surrounding three counties, which is known as the Wasatch Front. Outside of the Wasatch front area it is difficult to find medical care providers who have clients with HIV and who are knowledgeable about HIV. For this reason, many medical care providers in rural locations may not offer HIV testing and individuals who are at risk for HIV are not as likely to discuss their risk behaviors with their providers. As described above, another challenge in identifying HIV positive individuals in rural locations is the conservative culture in Utah. Many rural locations are much more conservative than the urban cities such as Salt Lake City and in these areas it is harder to keep information from the rest of the community. This can create a barrier because people who are at high-risk for HIV can feel very uncomfortable being tested in a rural location because there is the feeling that everyone in the community will eventually learn the results and then will be highly judgmental.

The Ryan White Part B Program does not directly have any services or activities that identify individuals who are unaware of their status. Instead the Part B Program works with other programs at the Utah Department of Health (UDOH) and HIV-related organizations outside of the UDOH. The overall strategy to identify HIV positive individuals unaware of their status in the general population will be to promote the 2006 CDC recommendations of universal HIV testing in health care settings. These guidelines recommend that HIV screening be performed on a routine basis among persons 13-24 years of age at low to moderate-risk in a health care setting. Organizations promoting these CDC guidelines are the HIV prevention program and the AIDS Education Training Center (RW Part F).

The Communicable Disease Prevention Program is focused on testing for HIV in high risk populations. This includes testing events at clubs and bars and testing in locations that have a higher proportion of high-risk groups (minorities, MSM, injection drug users).

ii. Program Related Barriers

The biggest barrier to care within the Ryan White Part B Program is funding. The need for Ryan White services continues to increase, but funding levels historically do not keep pace with the rise in applicants. ADAP was closed to new clients for one year from September 2009 to August 2010 and then closed again in April 2011. The closures were due to projected shortfalls in funds resulting from an increase in the number of clients, increase in the costs of drugs, insurance premiums, and out-of-pocket expenses. The factor having the greatest impact was an increase in clients utilizing the program. There was approximately a 50% increase in client utilization over the last two years. Drug costs and insurance premiums have also been increasing over the years.

These same factors are currently stressing the Utah ADAP. On average there are 11 new clients coming onto Utah ADAP each month and only 1-2 clients coming off of ADAP due to moving to another State, receiving insurance, and/or better pay at their place of employment.

The Utah ADAP Program is able to provide medications for its current and new clients in part due to the receipt of ADAP supplemental funding, additional rebates from pharmaceutical companies in previous grant years, and ADAP Emergency Relief Funds. Continued receipt of these ADAP resources is crucial to the financial health of the Program. Without ADAP supplemental funds, rebates, and ADAP Emergency Funds the Utah ADAP will have a greater number of individuals on the wait list and additional budget restrictions would need to be implemented.

iii. Provider Related Barriers

Clinic 1A at the University of Utah staffs experienced HIV medical providers and is the main provider of HIV medical care in Utah. Approximately 60% of PLWHA in Utah receive their medical care at Clinic 1A.

At private clinics and hospitals some of the doctors have a lot of experience with HIV medical care and some are in-experienced. Doctors have experience delivering disease diagnoses to patients, but are often not familiar with HIV as a disease. Another challenge is that medical providers may be familiar with how to access HIV medical care

for their patients, but they are likely not aware of the wide variety of social services an HIV positive individual may be eligible for.

iv. Client Related Barriers

Based on the responses from the 2009 Needs Assessment Survey, the top five barriers to service were:

- 1) not having enough insurance coverage,
- 2) the cost of the service,
- 3) the person’s ability to find their way through the system,
- 4) the lack of sensitivity of the people providing the service to the respondents issues and concerns, and
- 5) the belief that the services needed do not exist.

Survey participants were asked to rate how significant each potential barrier was to accessing medical care with the scale ranging from big barrier (3 points) to no barrier at all (0 points); not applicable was also given as an option. The results are in Table 18.

Table 18: Treatment and Care Barriers to service Ratings

<u>Barrier</u>	<u>Rank</u>	<u>Applicable (%)</u>	<u>Barrier (Ave. Rating)</u>
Not having enough insurance coverage	1	86.7	1.54
The cost of the service to me	2	86.9	1.20
My ability to find my way through the system	3	87.1	1.19
The lack of sensitivity of the people providing the service to my issues and concerns	4	87.1	1.01
My concern that the services I need do not exist	5	82.2	1.01
Not having transportation	6	77.8	1.00
The amount of red tape and paperwork I had to fill out to get the service	7	86.3	0.99
The location of the organization providing services	8	87.7	0.98
The ability to get the referrals to services I need	9	84.9	0.97
Not knowing what treatment is available to me	10	85.5	0.96
Poor coordination among the organizations providing services	11	83.3	0.95
My concern that other people may see me when I go to get care or learn about my HIV infection (lack of confidentiality)	12	87.4	0.94
The organizations providing the services make me feel like a number	12	83.0	0.94
My state of mind or mental ability to deal with the services and treatments	14	88.1	0.89
The amount of time I had to wait to get an appointment or see someone	15	85.8	0.87

Table continued on next page.

Table 18 continued.

Barrier	Rank	Applicable (%)	Barrier (Ave. Rating)
My physical health	16	88.0	0.82
Not being able to get options about treatments from the people I go to for services	17	81.4	0.81
The chance of being reported to the authorities	18	74.8	0.80
Adhering or following the instructions for my medication	19	80.6	0.78
My ability to understand the instructions about services and treatment	20	85.2	0.77
My thinking that I was not being affected by the infection (denial)	21	79.5	0.70
The lack of sensitivity of the service provider to my beliefs and spiritual concerns	22	80.3	0.70
Not knowing what services I need for treating my HIV infection	23	83.6	0.69
My ability to talk and discuss my care with the service provider	24	87.1	0.68
The level of discrimination I felt from the people providing the service	25	78.9	0.66
The level of expertise of the person providing the service	26	85.8	0.64
The quality of service	27	85.5	0.59
The ability of the person providing services to speak to me in a language that I understand	28	81.4	0.42
The lack of on-site child care when I go to get services and treatments	29	38.9	0.37

Note: Information presented in this table represents the survey responses. Rank was established by ranking services by usage and then by importance. "Ave. Rating" is the average rating for a particular service category.

There were differences in the ranking and magnitude of barriers for White, non-Hispanic respondents and Hispanic respondents. Because Utah's percentage of Hispanics is the largest minority group (approximately 15% of the population), a comparison of responses from Hispanics and White, non-Hispanics was focused on. The top three barriers to medical care were the same for Hispanics and White, non-Hispanics, but the size of the barrier was greater for Hispanics. Certain barriers were more applicable to HIV positive Hispanics such as poor coordination among the organizations providing services, the concern for the lack of confidentiality, and the fear of being reported to the authorities.

H. Evaluation of 2009 Comprehensive HIV Services Plan

i. Successes

The Ryan White Part B Program annually reviewed the status of each objective within the 2009 Comprehensive HIV Services Plan to ensure that all objectives were being

achieved in a timely manner. If problems arose in the meeting of goals and objectives, the Ryan White Part B Program revised and rewrote any of the goals and objectives considered to be unsuitable/unworkable. Once approved by the HIV/AIDS Treatment and Care Planning Committee, these changes would be incorporated into the Comprehensive HIV/AIDS Plan. The HIV/AIDS Treatment and Care Planning Committee will also compare the goals and objectives to the changing trends in the epidemic and the changing needs of clients and make recommendations/revisions as needed.

Progress Report - 2009 Comprehensive HIV Services Plan Goals and Objectives:

Healthy People 2010:

Goal: Increase the proportion of HIV-infected adolescents and adults who receive testing, treatment and prophylaxis consistent with current Public Health Service treatment guidelines.

- *The Part B Program funded rapid test kits for testing for the HIV Prevention Program. All four of the programs under the Part B Program saw an increase in new client enrollment.*

AIDS Drug Assistance Program:

Goal: To ensure that medications are available to persons living with HIV disease.

Objective: On an annual basis, 487 unduplicated clients will be served through the AIDS Drug Assistance Program.

- *During the reporting period from April 1, 2009 to March 31, 2010, the AIDS Drug Assistance Program served 470 clients).*
- *During the reporting period from April 1, 2010 to March 31, 2011, the AIDS Drug Assistance Program served 496 clients).*
- *During the reporting period from April 1, 2011 to March 31, 2012, the AIDS Drug Assistance Program served 551 clients).*
- *The Ryan White Part B Program successfully applied for and received Emergency ADAP funding to remove individuals from the ADAP waiting list. A total of 106 clients have been removed from the waiting list and enrolled in the ADAP program to date (81 clients with the 2010-2011 Emergency ADAP funding and 25 clients with the 2011-2012 Emergency ADAP funding).*

Home Health Care Program:

Goal: To ensure that home and community based care services are available in order to reduce hospitalizations for persons living with HIV disease.

Objective: On an annual basis, five unduplicated clients will be served through the Home Health Care Program.

- *This goal was rewritten in 2011 to state that 3 clients would be served through the Home health Care Program. From April 1, 2009 to March 31, 2012, only 1 person has utilized these services.*

Health Insurance Continuation Program:

Goal: To ensure that Health Insurance Continuation services are available to provide health insurance coverage to persons living with HIV disease.

Objective: On an annual basis, 100 unduplicated clients will be served through the Health Insurance Continuation Program.

- *During the reporting period from April 1, 2009 to March 31, 2010, the Health Insurance Continuation Program served 119 clients. Of the 119 clients served, 59 were on the HIP program, 57 were on the COBRA program and 3 were Medicare Part D clients.*
- *During the reporting period from April 1, 2010 to March 31, 2011, the Health Insurance Continuation Program served 103 clients. Of the 103 clients served, 48 were on the HIP program, 52 were on the COBRA program and 3 were Medicare Part D clients.*
- *During the reporting period from April 1, 2011 to March 31, 2012, the Health Insurance Continuation Program served 84 clients. Of the 84 clients served, 41 were on the HIP program, 40 were on the COBRA program and 3 were Medicare Part D clients.*

Supportive Services Program:

Goal: To ensure a continuum of supportive services that link persons living with HIV disease into primary medical care.

Objective: On an annual basis, 559 unduplicated clients will be served through the Supportive Services Program.

- *During the reporting period from April 1, 2009 to March 31, 2010, the Supportive Services Program served 487 clients.*

- *During the reporting period from April 1, 2010 to March 31, 2011, the Supportive Services Program served 576 clients.*
- *During the reporting period from April 1, 2011 to March 31, 2012, the Supportive Services Program served 651 clients.*

Administration/Planning and Evaluation/Quality Management:

Goal #1: To ensure compliance with the legislative requirements of the Ryan White HIV/AIDS Treatment Modernization Act.

Objective #1: On an annual basis, the Ryan White Part B grantee will comply with all conditions of grant award.

- *The Part B Grantee (Utah Department of Health) met all conditions of the grant award for the individuals grant periods: April 1, 2009 to March 31, 2010; April 1, 2010 to March 31, 2011; and April 1, 2011 to March 31, 2012.*

Objective #2: On an annual basis, the Ryan White Part B grantee will comply with all Ryan White HIV/AIDS Treatment Modernization Act Agreements and Assurances.

- *The Part B Grantee (Utah Department of Health) met all agreements and assurances associated with the Ryan White HIV/AIDS Treatment Modernization Act.*

Objective #3: On an annual basis, the Ryan White Part B grantee will engage in a public advisory planning process including convening the HIV/AIDS Treatment and Care Planning Committee, and holding public information meetings for the purpose of developing a Comprehensive HIV Services Plan and commenting on the implementation of such plan.

- *The HIV Treatment and Care Planning Committee meetings served as the public information meeting. The work of the planning committee was completed during a day-long meeting held each September and was a large portion of the written Comprehensive HIV Services Plan. The Comprehensive HIV Services Plan Subcommittee, made up of planning committee members, reviewed and edited the Comprehensive HIV Services Plan as needed.*

Objective #4: The Ryan White Part B grantee will implement and develop the Statewide Coordinated Statement of Need (SCSN) as defined in the guidance by the Health Resources and Services Administration (HRSA). The grantee will review and update the SCSN at least every three years.

- *One SCSN Meeting has been held since the 2009 Comprehensive HIV Services Plan was originally written. This meeting, held in January of 2012 was the building blocks for the SCSN written document, submitted to HRSA on June 1, 2012.*

Objective #5: The Ryan White Part B grantee will establish a quality management program to assess the extent to which HIV health services provided to patients under this grant are consistent with the most current guidelines for treatment of HIV disease and related opportunistic infection; and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

- *The Part B grantee (Utah Department of Health) has contracted with HealthInsight to establish a Quality Management Program. A Standards of Care document has been developed for the supportive services categories. A subcommittee, made up of planning committee members, meets twice yearly to review and make recommendations to the Quality Management Plan.*

Objective #6: The Ryan White Part B grantee will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the state under Part B.

- *Please see Quality Management objective (under goal #1, objective #5).*

Objective #7: On an annual basis, the Ryan White Part B grantee will submit the Ryan White Data Report to the HRSA.

- *The Part B grantee (Utah Department of Health) has successfully transitioned to submitting the Ryan White Services Report to HRSA. This report has permanently replaced the requirement of the Ryan White Data Report. All Ryan White Services Reports have been submitted annually as required.*

Objective #8: On a quarterly basis, the Ryan White Part B grantee will submit the ADAP Quarterly Report to the HRSA.

- *The Part B grantee (Utah Department of Health) has submitted the ADAP Quarterly Report to HRSA on a quarterly basis.*

Objective #9: On a bi-annual basis, the Ryan White Part B grantee will conduct a program needs assessment.

- *The Part B grantee (Utah Department of Health) recently conducted a program needs assessment during the fall of 2011. The results are currently being analyzed into a 2011 Needs Assessment report.*

Objective #10: On an annual basis, the Ryan White Part B grantee will conduct program evaluation activities.

- *The Program Outcomes and Standards of Care are sent to all Part B service providers at the beginning of a new contract period. If any changes are made to the Standards of Care during that contract period, an amendment is processed for each contract and a new Program Outcomes and Standards of Care are sent out. Other part B providers, not under official contract, but under a provider agreement, receive the Program Outcomes and Standards of Care on an annual basis. Programs are evaluated annually with a provider audit and results are sent to individual providers.*

Objective #11: On a bi-annual basis, the Ryan White Part B grantee will conduct a customer-satisfaction survey.

- *The Part B grantee (Utah Department of Health) conducted a customer-satisfaction survey during the summer of 2009.*

Goal #2: To identify PLWH/A who are not in-care and bring them into care.

Objective: On an annual basis, outreach services will be conducted to identify PLWH/A and bring them into care.

- *Outreach Services is not currently funded under the Supportive Services Program to identify PLWH/A who are out of care. The Ryan White Part B Program collaborates with the HIV Prevention Program in their efforts to identify PLWH/A who are not in-care and bring them into care.*

Goal #3: To continue improving the efforts of the statewide HIV Planning Advisory Council, which is comprised of the HIV Prevention Community Planning Committee and the HIV/AIDS Treatment and Care Planning Committee.

Objective #1: Integrate the efforts of the HIV Prevention and the HIV/AIDS Treatment and Care Comprehensive HIV Services Plans.

- *The 2009 and the 2011 Needs Assessment was conducted in collaboration with the HIV Prevention Program and Ryan White Part C Program.*
- *A Ryan White Part B Program staff member regularly attends the HIV Prevention Program's Comprehensive HIV Services Plan Planning Committee meeting, held monthly.*

Goal #4: To further identify PLWH/A by using the HRSA's defined severe need subpopulations, with definitions of service specific to: use, need, barrier, gaps and demographic measures.

Objective: Use the findings from the 2009 Needs Assessment to develop programs to serve severe need subpopulations.

- *The 2009 Needs assessment was conducted in collaboration with the HIV Prevention Program and Ryan White Part C Program. No new programs are currently underway due to budgeting issues.*

ii. Challenges

The 2009 Comprehensive HIV Services Plan was far too narrow in scope to be “comprehensive”. Although other programs contributed to the development of the plan, it was mostly comprised of Ryan White Part B services and related information. The goals and objectives of the Plan itself only addressed part B services and requirements. And in retrospect, the goals relating to Administration/Planning and Evaluation/Quality Management should at the minimum be downsized. They made up the majority of the goals in the 2009 Comprehensive HIV Services Plan. The majority of goals should relate directly to PLWH/A and HIV related services. In future Plans, it would be beneficial to include the work and services of all the HIV services and programs available to individuals living with HIV/AIDS. As funding has become increasingly more difficult to obtain and the need for services continues to expand, it is more important than ever before to ensure the available programs are collaborating and maximizing their efforts. These should be some of the goals of this new 2012-2015 Comprehensive HIV Services Plan.

II. Where Do We Need To Go?

A. Plan to Meet 2009 Challenges Identified in the Evaluation of the 2009 Comprehensive HIV Services Plan

This new 2012-2015 Comprehensive HIV Services Plan will include goals and objective from all Ryan White funded programs and also goals to address those providers and agencies that are not Ryan White funded. This Plan will be comprehensive for the individuals living with HIV/AIDS, rather than in past plans, where the focus has been comprehensive for the Ryan White Part B Program. The Ryan White Part B Program serves the client, but is only a fraction of the resources and programs available. Some ideas on how we can accomplish this include:

- Collaboration of all programs offering HIV related services, Ryan White funded and non-Ryan White funded, is key to successful treatment and care of the individuals living with HIV/AIDS.
- Duplication of services should be identified and eliminated, maximizing all of our efforts of providing comprehensive HIV services.
- Gaps in services also need to be identified and at minimum a solution to fill these gaps needs to be explored.
- Barriers should not keep individuals living with HIV/AIDS from accessing and receiving HIV care and services. How we can remove these barriers is also an important issue to work on.

B. 2012 Proposed Care Goals

AIDS Drug Assistance Program				
Goal: To ensure that medications are available to persons living with HIV disease.				
<u>Objective(s)</u>	<u>Service Unit Definition</u>	<u>Quantity</u>		<u>Time Frame</u>
		Number of People to be Served	Total number of Service Units to be Provided	
1. To provide all drugs within the Public Health Services Guidelines for the treatment of HIV and prevention of opportunistic infections.	Uninterrupted ADAP client access to a multi-drug formulary.	500	3,360 (average of 6.72 drugs per client) 49 drugs on the formulary.	April 1, 2012 – March 31, 2013

Health Insurance Continuation Program				
Goal: To provide insurance premiums and cost-sharing assistance to persons living with HIV disease to insure continued medical coverage and to preserve ADAP monies through savings provided by private insurance.				
<u>Objective(s)</u>	<u>Service Unit Definition</u>	<u>Quantity</u>		<u>Time Frame</u>
		Number of People to be Served	Total number of Service Units to be Provided	
1. To provide insurance premium payments to persons living with HIV who are in danger of losing medical coverage.	# of persons served.	HIP:40 COBRA:40 Medicare Part D:3 TOTAL:83	996 (# of months served)	April 1, 2012 – March 31, 2013

Supportive Service Program				
Goal: To ensure individuals living with HIV/AIDS have access to ongoing health care and supportive services in order to improve their health status and quality of life.				
<ul style="list-style-type: none"> • Core Services: Primary Medical Care and Medical Case Management • Additional Services: Non-Medical Case Management, Medical Transportation, and Home Health Care Services 				
<u>Objective(s)</u>	<u>Service Unit Definition</u>	<u>Quantity</u>		<u>Time Frame</u>
		Number of People to be Served	Total number of Service Units to be Provided	
1. To provide comprehensive, accessible, and equitable <u>medical care services</u> in accordance with the Public Health Service's Treatment Guidelines for HIV positive individuals.	One office visit	600	1,200	April 1, 2012 – March 31, 2013
2. To link eligible PLWH/A with timely, coordinated and continuous access to medically-appropriate levels of health and support services through <u>case management</u> and ongoing assessment of client's needs and personal support systems.	One office/home visit	Medical: 560 Non-Medical: 100	Medical: 5,600 Non-Medical: 1,000	April 1, 2012 – March 31, 2013
3. To provide <u>transportation services</u> that facilitate access to primary medical care.	One use (to/from) for office visit	25	50	April 1, 2012 – March 31, 2013
4. To provide durable medical equipment and/or nursing visits in a home setting to PLWH/A.	One home visit	3	6	April 1, 2012 – March 31, 2013

C. Goals Regarding Individuals Aware of Their HIV Status, but Not in Care (Unmet Need)

Results of the 2010 Unmet Need report indicate that there are 289 HIV+/aware individuals in Utah that are not in care. This number includes 250 PLWH and 39 PLWA. The PLWH population demonstrated a higher level of unmet need ($n = 250$; 23.4%) than the PLWA population ($n = 39$; 2.7%). This means that there are more people out of care in the PLWH population than in the PLWA population. It is widely accepted that the need for primary medical care increases as HIV progresses. The results observed in this study support that assertion. The PLWA population, which includes people with advanced stages of HIV infection, has more people in-care than the PLWH population.

<p><u>Unmet Need</u></p> <p>Goal: Increase the number of PLWH/A in Utah who are aware of their HIV+ status into HIV outpatient/ambulatory care.</p>
<p><u>Objective(s)</u></p> <ol style="list-style-type: none"> 1. Utilize state health department staff to identify clients who are not in care and actively link them to care. 2. Establish a referral system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV. 3. Encourage PLWH/A to become active partners in their healthcare and improve the quality of their lives.

D. Goals Regarding Individuals Unaware of Their HIV Status (EIIHA)

As of December 31, 2009, it was estimated there were 2,540 living individuals diagnosed with HIV in Utah. Using 21% as the national proportion of persons undiagnosed with HIV, the estimate of HIV positive individuals unaware of their HIV status is 675 individuals [2540 * (0.21/0.79) = 675].

<p><u>Early Identification of Individuals with HIV/AIDS (EIIHA)</u></p> <p>Goal: To make individuals who are unaware of their HIV status aware of their status.</p>
<p><u>Objective(s)</u></p> <ol style="list-style-type: none"> 1. Ensure everyone who is tested for HIV is informed of their test results. 2. Expand HIV testing to include low to moderate risk populations in Utah. 3. Enhance efforts to test individuals living in rural areas of Utah. 4. Enhance efforts to test refugees entering into Utah and currently residing in Utah.

E. Proposed Solutions for Closing Gaps in Care

<u>Through our HIV Continuum of Care, we strive to eliminate gaps in care associated with:</u>	<u>Proposed Solutions:</u>
1. PLWH/A in rural areas of Utah.	<ul style="list-style-type: none"> • Traveling medical clinic • Gas cards to travel to Salt Lake City for medical care • Specialized HIV training for rural providers
2. Transportation issues in both rural and metropolitan areas.	<ul style="list-style-type: none"> • Explore option of all-day pass with public transportation • Gas cards for rural use

3. Lack of available services.	<ul style="list-style-type: none"> • Reopen dental program • Other option for mental health and substance abuse services • Supplemental grants
4. Lack of Qualified Providers.	<ul style="list-style-type: none"> • AIDS ETC specialized HIV trainings • Connection experienced HIV medical providers doctors not as familiar with HIV
5. Funding	<ul style="list-style-type: none"> • Supplemental grants • Maximize direct service dollars • Research other options services
6. Stigma	<ul style="list-style-type: none"> • AIDS ETC specialized HIV trainings for providers • Community education opportunities • Educating the media
7. Education	<ul style="list-style-type: none"> • Educating PLWH/A • RW case management training opportunities • AIDS ETC specialized HIV trainings for providers • Community education opportunities

F. Proposed Solutions for Addressing Overlaps in Care

Utah is a low incidence state, receiving a small percentage of Ryan White funding. The Ryan White Part B Program strives to maximize the funding received and avoid duplication of services.

The SCSN Committee delegated the topic overlaps in care to a smaller working group. This group discussed the issue of overlaps in care and felt that there was very little of this going on in Utah. They could not think of any examples of overlaps in care.

G. Proposed Coordinating Efforts With the Following Programs:

i. Part A Services

Utah does not receive Ryan White Part A funding.

ii. Part C Services

The Ryan White Part B Program meet quarterly with the Ryan White Part C Program and the Ryan White Part D Program to update each other on any issues or changes to their respective programs, collaborate on solving clients issues, and enhance efforts to provide PLWH/A quality care and treatment services.

iii. Part D Services

See coordinating efforts described in Part C Services above.

iv. Part F Services

The Part B Program could assist in the connection of experienced HIV medical providers from Clinic 1A with emergency department and family practice doctors who are not as familiar with the best way to deliver a HIV test and referral. The AIDS Education and Training Center could be a possible partner in this endeavor.

v. Private Providers (Non Ryan White Funded)

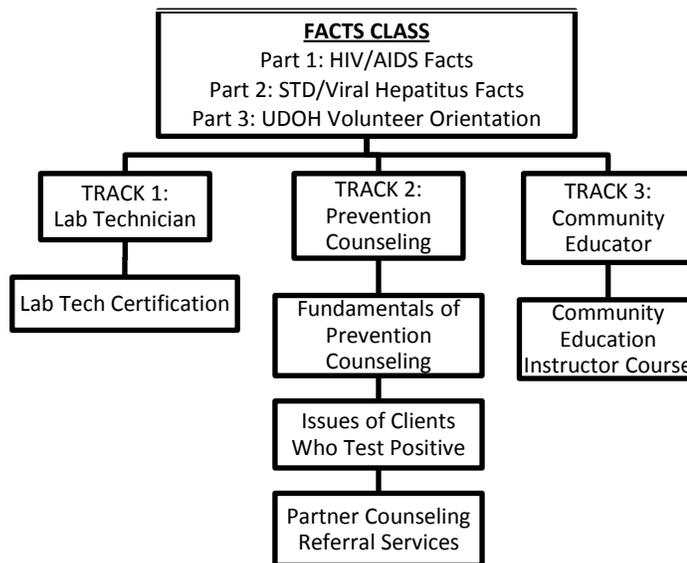
The AIDS Education Training Center (AETC) routinely offers Highly Active Antiretroviral Therapy (HAART) continuing medical education programs to practitioners who are not affiliated with Clinic 1A. The AETC provides these practitioners with case studies and chart reviews.

vi. Prevention Programs Including:

• Partner Notification Initiatives

The Utah Department of Health offers workshops to train members of the community how to do HIV prevention counseling and testing, give HIV positive test results and to gather partner information and give referrals. Two Training courses are offered, the first class is a prerequisite for the second class which includes partner counseling and referral services (see training track on next page). In order to better understand this initiative, a Ryan White Part B staff member will attend these classes sponsored by the Communicable Disease Prevention Program.

Training Track



- **Prevention with Positives Initiatives**

In 2011 the Ryan White Part B Program helped to facilitate meetings between Clinic 1A and the Communicable Disease Prevention Program, which resulted in Clinic 1A becoming a first time contractor with the Prevention Program. Clinic 1A will be implementing a “prevention for positives” intervention that includes the partners of HIV positive individuals, which is the number one priority group for the Prevention Program.

The Ryan White Part B Program would like to explore condom distribution by mail for Ryan White clients. This idea is in the preliminary stages of discussion, but is a new program likely to be implemented by the end of 2012. The Prevention Program will supply the condoms and this would be an excellent opportunity to also send educational materials directly to Ryan White clients regarding prevention for positives.

- vii. Substance Abuse Treatment Programs/Facilities**

Currently the Ryan White Part B Program does not fund any substance abuse services. The Part B Program encourages case managers to direct clients to appropriate care if needed. A list of substance abuse facilities and counseling groups are including in the HIV Resource Directory (see section B.ii.). If funding for this service were to become available in the future, the Ryan White Part B Program would work with the Salt Lake County Division of Substance Abuse, who in the past has given Ryan White Part B clients priority in placement with the guarantee of the part B Program paying the initial placement fees.

- viii. STD Programs**

The Ryan White Part B Program collaborates closely with the Communicable Disease (CD) Prevention Program, which includes the HIV Prevention Program, the STD Prevention Program, and the Hepatitis Prevention Program. Representatives from the Ryan White Part B Program regularly attend meetings and trainings organized by the CD Prevention Program. Two projects that the Ryan White Part B Program has just started collaborating with the CD Prevention Program on are the Prevention Comprehensive HIV Plan working group and the Category C Advisory Board, which is an integrated testing project for HIV, STDs, and Hep C targeting incarcerated individuals.

ix. Medicaid

PLWH/A applying for the Ryan White Program(s) are screened for Medicaid eligibility against the State Medicaid database upon initial application and semi-annual recertification to the Ryan White program(s). Pharmacy billings are checked monthly with the State Medicaid database to identify individuals who have become Medicaid eligible. Ryan White staff will begin meeting with Medicaid office as 2014 Health Care Reform approaches. The Part B Program will continue to attend webinars and other training events sponsored by HRSA regarding the changes expected with 2014 Health Care Reform.

Ryan White case managers are kept current with the services Medicaid covers and does not cover, so those benefits may be coordinated with Ryan White services. At the annual HIV Treatment and care Planning Committee, hosted by the Ryan White Part B Program, a representative from the State Medicaid office is invited to participate and often asked to present at this meeting. The next meeting will be held in September 2012 and the preliminary agenda includes a short training presentation about Medicaid and 2014 Health Care Reform.

x. Medicare

The State Medicaid database includes all eligibility for Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). PLWH/A applying for the Ryan White Program(s) are screened for Medicare eligibility against the State Medicaid database upon initial application and semi-annual recertification to the Ryan White program(s). Pharmacy billings are checked monthly with the State Medicaid database to identify individuals who have become Medicare eligible.

xi. Children's Health Insurance Program

The State Medicaid database includes all eligibility for Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). PLWH/A applying for the Ryan White Program(s) are screened for CHIP eligibility against the State Medicaid database upon initial application and semi-annual recertification to the Ryan White program(s). Pharmacy billings are checked monthly with the State Medicaid database to identify individuals who have become CHIP eligible.

xii. Community Health Centers

The Part B Program is predicting the probability of extra funding during 2012-13. If so, The Part B Program will reopen the dental services program and one of the contractors we want to work with is the Community Health Centers of Utah (CHC). With several locations to serve PLWH/A, including a center in northern Utah, the Part B Program looks forward to coordinating our efforts with CHC to provide dental services to PLWH/A later this year.

In addition, the HIV Prevention Program is exploring partnering with CHC to offer HIV testing in the future.

III. How Will We Get There?

The overall mission statement for this Comprehensive HIV Services Plan is:

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

A. Strategy, Plan, Activities, and Timeline to Close Gaps in Care

Goal: Through our HIV Continuum of Care, we strive to eliminate gaps in HIV treatment and care.

Objective 1: Eliminate gaps in treatment and care associated with PLWH/A in rural areas of Utah.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Provide access to specialized HIV care.	Provide funding for the traveling clinic staffed by members of the infectious disease clinic from the University of Utah.	1. Budget RW Part B funding to pay for traveling clinic in U of U contract.	1. RW Part B	4/1/12-3/31/13; 4/1/13-3/31/14; 4/1/14-4/31/15
		2. Collect monthly aggregate numbers of total visits and client level data.	RW Part B and Clinic 1A	Monthly from April 2012 to March 2015
		3. Collect quarterly progress reports for the number of clients served and demographics of those receiving care.	RW Part B and Clinic 1A	Quarterly from April 2012 to March 2015
		4. Analyze data to ensure this population is accessing medical care through the traveling clinic.	RW Part B	At end of each FY – 2012; 2013; 2014

Provide transportation services.	Provide funding for transportation so PLWH/A can access specialized HIV medical services.	1. Budget RW Part B funding to pay for gas cards for rural clients.	RW Part B	4/1/12-3/31/13; 4/1/13-3/31/14; 4/1/14-4/31/15
		2. Distribute gas cards to Clinic 1A to mail to clients when a medical appointment is scheduled.	RW Part B and Clinic 1A	As requested by Clinic 1A from April 2012 to March 2015
		3. Collect distribution log from Clinic 1A to monitor gas card distribution.	RW Part B	Monthly from April 2012 to March 2015
Provide specialized HIV education opportunities to rural medical and supportive services providers.	Provide specialized HIV trainings to increase knowledge and also reduce stigma.	1. Identify providers in rural areas of Utah	RW Part B AIDS ETC	7/1/2012-10/1/2012
		2. Collaborate with AIDS ETC to decide what training would be beneficial.	RW Part B AIDS ETC	Sept 2012
		3. Conduct training opportunities for rural providers.	AIDS ETC	Beginning January 2013
		4. Provide participants with post-training evaluation survey.	AIDS ETC	At training beginning January 2013
		5. Make changes to training as needed.	AIDS ETC	As needed
Objective 2: Eliminate gaps in treatment and care associated with transportation issues in both rural and metropolitan areas of Utah.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Provide transportation services to rural RW clients.	Provide funding for transportation so PLWH/A can access specialized HIV medical services.	1. Budget RW Part B funding to pay for gas cards for rural clients.	RW Part B	4/1/12-3/31/13; 4/1/13-3/31/14; 4/1/14-4/31/15
		2. Distribute gas cards to Clinic 1A to mail to clients when a medical appointment is scheduled.	RW Part B and Clinic 1A	As requested by Clinic 1A from April 2012 to March 2015
		3. Collect distribution log from Clinic 1A to monitor gas card distribution.	RW Part B	Monthly from April 2012 to March 2015
Improve public transportation option for metropolitan RW clients.	Provide funding for transportation so PLWH/A can access specialized HIV medical services.	1. Identify options for accessing public transportation.	RW Part B	July 2012
		2. Select transportation option.	RW Part B	July 2012
		3. Budget RW Part B funding to pay for UTA tokens/passes.	RW Part B	4/1/12-3/31/13; 4/1/13-3/31/14; 4/1/14-4/31/15
		4. Distribute tokens/passes to Clinic 1A to give out to clients when a medical appointment is scheduled.	RW Part B and Clinic 1A	As requested by Clinic 1A from April 2012 to March 2015
		5. Collect distribution log from Clinic 1A to monitor gas card distribution.	RW Part B	Monthly from April 2012 to March 2015

Objective 3: Eliminate gaps in treatment and care associated with lack of available services.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Reopen the RW Part B dental services program	Identify and secure funding to be used for dental services	1. Discuss options for funding the dental service program.	RW Part B, financial services coordinator	June 2012
		2. Identify funding to be used and amount available for services	RW Part B, financial services coordinator	July 2012
		3. Establish if a cap will be implemented.	RW Part B	July 2012
		4. Contact previous RW dental providers and announce program will be reopening.	RW Part B	July-Aug 2012
		5. Mail out provider agreements and service provider policy and procedure manuals.	RW Part B	Aug 2012
		6. Receive agreements back from dental providers.	RW Part B, dental providers	Aug-Sept 2012
		7. Notify RW case managers to inform the RW clients the dental program in open and they may utilize services.	RW Part B, RW case managers	Sept 2012
		8. Mail out notice of dental program reopening to all RW clients with RW recertification packet.	RW Part B	Sept 2012
Apply for grant opportunities to supplement RW funding shortfalls.	Identify opportunities to apply for additional funding.	1. Subscribe to all HRSA list-serves to be informed of any grant opportunities	RW Part B RW Part C RW Part D	Now through 3/31/2015
		2. Apply for supplemental grants as they become available.	RW Part B RW Part C RW Part D	June 2012 - 3/31/2015
Identify additional options for mental health and substance abuse services.	Improve access to mental health and substance abuse services to clients.	1. Create a list of services and costs available by region.	RW Part B	January – June 2013
		2. Identify additional financial assistance available to help clients pay for services.	RW Part B	January – June 2013
		3. Distribute information to RW case managers to help their RW clients find affordable options for mental health and substance abuse services.	RW Part B and RW case managers	June 2013

Objective 4: Eliminate gaps in treatment and care associated with lack of qualified providers.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Increase education opportunities.	Establish ways to provide specialized HIV trainings to increase knowledge and also reduce stigma.	1. Meet with AIDS ETC to discuss ways to reach all providers.	RW Part B AIDS ETC	Sept 2012
		2. Create a training timeline.	RW Part B AIDS ETC	Sept 2012
		3. Arrange for trainers and curriculum.	AIDS ETC	Sept – Nov 2012
		4. Send out information to providers.	RW Part B AIDS ETC	Dec 1 st 2012
		5. Implement training.	AIDS ETC	Beginning January 2013
		6. Provide participants with post-training evaluation survey.	AIDS ETC	At training beginning January 2013
		7. Make changes to training as needed.	AIDS ETC	As needed
Ensure availability of quality HIV care from all medical providers.	Connect experienced HIV medical providers from Clinic 1A with emergency department and family practice doctors who are not as familiar with the best way to deliver a HIV test and referral.	1. Meet with AIDS ETC to discuss a mentor-type program.	RW Part B, AIDS ETC	Sept 2012
		2. Discuss idea with Clinic 1A staff supervisor.	AIDS ETC, Clinic 1A	October 2012
		3. Gather contact info and info about program to send out.	AIDS ETC, Clinic 1A	November 2012
		4. Send connection info to outside providers.	AIDS ETC	Dec 1 st 2012
		5. Keep record of how many time providers are accessed for questions.	AIDS ETC, Clinic 1A	Dec 2012- March 2015
		6. Make changes as needed.	AIDS ETC	Dec 2012- March 2015
Objective 5: Eliminate gaps in treatment and care associated with funding.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Maximize RW funding.	Evaluate budget expenditures and identify ways to maximize RW funding.	1. Meet Monthly with financial services coordinator.	RW Part B, financial services coordinator	Monthly beginning July 2012
		2. Assess and ensure all funding is being used effectively.	RW Part B, financial services coordinator	Monthly beginning July 2012
		3. Identify any changes that could be made to budget.	RW Part B, financial svc coordinator	Monthly beginning July 2012
Obtain additional funding	Identify and apply for supplemental funding opportunities.	1. Subscribe to all HRSA list-serves to be informed of any grant opportunities	RW Part B RW Part C RW Part D	Now through 3/31/2015
		2. Apply for supplemental grants as they become available.	RW Part B RW Part C RW Part D	As become available through 3/31/2015

Identify additional resources	Research and identify other resources in the community RW clients may access for free or reduced fee services not provided by RW.	1. Create a list of services and costs available by region.	RW Part B	January – June 2013
		2. Identify additional financial assistance available to help clients pay for services.	RW Part B	January – June 2013
		3. Distribute information to RW case managers to help their RW clients find affordable options for services not covered by RW funding.	RW Part B and RW case managers	June 2013
Objective 6: Eliminate gaps in treatment and care associated with stigma.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Reduce stigma among providers.	Establish ways to provide specialized HIV trainings to increase knowledge and also reduce stigma.	1. Meet with AIDS ETC to discuss ways to reach all providers.	RW Part B AIDS ETC	Sept 2012
		2. Create a training timeline.	RW Part B AIDS ETC	Sept 2012
		3. Arrange for trainers and curriculum.	AIDS ETC	Sept – Nov 2012
		4. Send out information to providers.	RW Part B AIDS ETC	Dec 1 st 2012
		5. Implement training.	AIDS ETC	Beginning January 2013
		6. Provide participants with post-training evaluation survey.	AIDS ETC	At training beginning January 2013
		7. Make changes to training as needed.	AIDS ETC	As needed
Reduce HIV stigma in Utah.	Enhance practical knowledge to reduce fear of casual HIV transmission	1. Meet with HIV Prevention and AIDS ETC to discuss ways to reach general population.	RW Part B, AIDS ETC, HIV Prevention	Sept 2012
		2. Create a timeline to further work on ideas.	RW Part B, AIDS ETC, HIV Prevention	Sept 2012
		3. Develop ideas and meet again as necessary. May need to contact additional agencies at this point and redefine activities.	RW Part B, AIDS ETC, HIV Prevention	Sept 2012 – Mar 2013
		4. Have ideas ready to implement.	RW Part B, AIDS ETC, HIV Prevention	April 2013

Objective 7: Eliminate gaps in treatment and care associated with education.				
Strategies	Plan	Activities	Responsible Parties	Timeline
Increase HIV knowledge among providers.	Establish ways to provide specialized HIV trainings to increase knowledge and also reduce stigma.	1. Meet with AIDS ETC to discuss ways to reach all providers.	RW Part B AIDS ETC	Sept 2012
		2. Create a training timeline.	RW Part B AIDS ETC	Sept 2012
		3. Arrange for trainers and curriculum.	AIDS ETC	Sept – Nov 2012
		4. Send out information to providers.	RW Part B AIDS ETC	Dec 1 st 2012
		5. Implement training.	AIDS ETC	Beginning January 2013
		6. Provide participants with post-training evaluation survey.	AIDS ETC	At training beginning January 2013
		7. Make changes to training as needed.	AIDS ETC	As needed
Increase knowledge of available HIV services among clients.	Ensure case managers receive up to date information on where clients can obtain services and what services are available.	1. Organize a RW case manager training meeting.	RW Part B	June – Aug 2012
		2. Conduct training meeting.	RW Part B	Aug 2012
		3. Provide participants with post-training evaluation survey.	RW Part B	Aug 2012
		4. Keep in contact via email with RW case managers as changes occur and updates are needed.	RW Part B	Aug 2012 – March 2013
		5. Meet quarterly with Part C and Part D staff to discuss client issues and updates to programs.	RW Part B, RW Part C, RW Part D	Quarterly beginning July 2012
		6. Continue to hold RW case manager training meeting annually.	RW Part B	Aug 2013 and Aug 2014

B. Strategy, Plan, Activities, and Timeline to Address the Needs of Individuals Aware of Their HIV Status, But are Not in Care

Goal: Increase the number of PLWH/A in Utah who are aware of their HIV+ status into HIV outpatient/ambulatory care.

Objective 1: Identify PLWH/A who are not in care and actively link them to care.				
Strategies	Plan	Activities	Responsible Parties	Timeline
Collect and analyze prevalence data to better understand why PLWH/A are not in care.	Collect Prevalence data for PLWH and PLWA to identify the population size of each because care patterns can differ depending on the severity of disease.	1. Collect data for the HIV Unmet Needs Report	RW Part B, HIV Surveillance	Annually beginning August 2012
		2. Analyze data to determine reasons why PLWH/A are not in care.	RW Part B	Annually: Sept 2012, 2013 & 2014

Reduce unmet need and service gaps.	Develop a work plan for determining unmet need and service gaps in Utah.	1. Using data from the most recent HIV Unmet Needs Report, develop ideas to reach this population and refer them into care.	RW Part B, HIV Prevention	Annually: Oct 2012, 2013 & 2014
		2. Identify target sub populations.	RW Part B, HIV Prevention	Annually: Oct 2012, 2013 & 2014
		3. Identify and provide outreach services.	RW Part B, HIV Prevention	Beginning Spring 2013
Enhance efforts to refer PLWH/A into care.	Support RW case managers attempt to re-engage clients who are no longer in medical care and find out the reasons why the individuals dropped out of care.	1. Develop training and education materials.	RW Part B	Spring 2013, updated as needed
		2. Provide RW case managers with adherence education materials.	RW Part B, RW Part C, RW Part D	By June 2013
		3. Meet quarterly with Part C and Part D staff to discuss client issues and ways the Part B program can support their efforts.	RW Part B, RW Part C, RW Part D	Quarterly beginning July 2012
Enhance efforts to retain clients in care and treatment.	Support RW case managers attempt to retain clients in medical care and find out the reasons they might consider dropping out of care.	1. Develop training and education materials.	RW Part B	Spring 2013, updated as needed
		2. Provide clients with treatment and care. adherence education.	RW Part B, RW Part C, RW Part D	By June 2013
		3. Explore idea of peer advocates to provide outreach, education and advocacy.	RW Part B	June 2013
Objective 2: Link PLWH/A who are not in care to continuous and coordinated quality care when they are diagnosed with HIV.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Refer all newly HIV+ individuals to care when test results are delivered.	Collaborate with the HIV Prevention Program to develop and implement strategies to ensure individuals seek out care as they are diagnosed.	1. Develop training and education materials.	RW Part B	Spring 2013, updated as needed
		2. Provide HIV Counseling and Testing staff with HIV treatment and care resources and adherence education materials.	RW Part B, HIV C&T staff	By June 2013
		3. Implement a policy that individuals receiving a HIV+ diagnosis receive a follow up contact inquiring if they have sought medical care.	HIV C&T staff	By June 2013
		4. If care has not been pursued, provide individual with contact information.	HIV C&T staff	As needed

Ensure all newly released incarcerated individuals are tested for HIV and referred to care if needed.	Work with the HIV Prevention Program to support HIV testing program at correctional facilities and client's referral into medical care.	1. Attend Prevention's new Category C advisory meetings.	RW Part B, HIV Prevention	Monthly – began April 2012
		2. Provide education and adherence materials for newly diagnosed individuals (upon discharge).	RW Part B, HIV Prevention	August 2012
		3. Monitor number of positive results and refer to RW case managers for follow-up contact.	RW Part B, HIV Prevention, RW case managers	August 2012 – March 2015
Objective 3: Encourage PLWH/A to become active partners in their healthcare and improve the quality of their lives.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Educate clients to be proactive in their care of HIV.	Increase client participation in care issues.	1. Recruit PLWH/A to serve on HIV related committees, planning and advisory groups, and participate in HIV data collection surveys.	RW Part B, HIV Prevention, RW case managers	Now to March 2015 (as events are planned)
		2. Provide incentives to recruit PLWH/A.	RW Part B	At each event
		3. Work with PLWH/A on creating programs, policies and materials to maximize RW program efforts.	RW Part B	At each event
		4. Train and utilize peer advocates to take information learned back to the community.	RW Part B	Subcommittees to be formed as events occur.

C. Strategy, Plan, Activities, and Timeline to Address Needs of Individuals Unaware of Their HIV Status

Goal: To make individuals who are unaware of their HIV status aware of their status.

Objective 1: Ensure everyone who is tested for HIV is informed of their test results.

<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Increase the number of individuals who take a HIV test are informed of their test results.	Support the HIV Prevention Program to move all test sites to use the rapid HIV test. This test greatly reduces waiting time (20 minutes vs. 2 weeks) for results and increases the probability a client will wait for results.	1. As funding permits, assist the HIV Prevention program in purchasing rapid HIV test kits.	RW Part B	On-going
		2. Collaborate with the HIV Prevention Program on ways to encourage all testing sites to use the rapid HIV test.	RW Part B, HIV Prevention	Aug 2013

Refer all newly HIV+ individuals to care when test results are delivered.	Work with the HIV Prevention program to develop and distribute referral packets for individuals who test positive for HIV.	1. Develop training and education materials.	RW Part B	Spring 2013, updated as needed
		2. Provide HIV Counseling and Testing staff with HIV treatment and care resources and adherence education materials.	RW Part B, HIV C&T staff	By June 2013
Ensure that every new diagnosis of HIV is linked to medical care.	Refer all newly HIV+ individuals to care when test results are delivered.	1. Implement a policy that individuals receiving a HIV+ diagnosis receive a follow up contact inquiring if they have sought medical care.	HIV C&T staff	By June 2013
		2. If care has not been pursued, provide individual with contact information.	HIV C&T staff	As needed
		3. Review referral statistics annually.	RW Part B	Annually beginning January 2014
Objective 2: Expand HIV testing to include low to moderate risk populations in Utah.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Make rapid HIV tests available to low and moderate risk populations.	As funding permits, assist the HIV Prevention Program in purchasing rapid HIV tests to distribute in community clinics.	1. Meet Monthly with financial services coordinator.	RW Part B, financial services coordinator	Monthly beginning July 2012
		2. Assess and ensure all funding is being used effectively.	RW Part B, financial services coordinator	Monthly beginning July 2012
		3. Identify any funding that could be made available to purchase rapid HIV tests.	RW Part B, financial services coordinator	Monthly beginning July 2012
Educate medical providers of the importance of testing everyone, not just those populations at high risk.	Establish ways to provide specialized HIV trainings to increase knowledge about the importance of testing everyone.	1. Meet with AIDS ETC to discuss ways to reach all providers.	RW Part B AIDS ETC	Sept 2012
		2. Create a training timeline.	RW Part B AIDS ETC	Sept 2012
		3. Arrange for trainers and curriculum.	AIDS ETC	Sept – Nov 2012
		4. Send out information to providers.	RW Part B AIDS ETC	Dec 1 st 2012
		5. Implement training.	AIDS ETC	Beginning January 2013
		6. Provide participants with post-training evaluation survey.	AIDS ETC	At training beginning January 2013
		7. Make changes to training as needed.	AIDS ETC	As needed

Objective 3: Enhance efforts to test individuals living in rural areas of Utah.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Make rapid HIV tests available to rural populations.	Support testing events initiated by the HIV Prevention Program in rural locations.	1. Collaborate with HIV Prevention program to schedule testing events in rural Utah.	RW Part B, HIV Prevention	January 2013
		2. Develop training and education materials.	RW Part B	Spring 2013, updated as needed
		3. Provide HIV Counseling and Testing staff with HIV treatment and care resources and adherence education materials.	RW Part B, HIV Prevention	By June 2013
		4. Work with HIV Prevention to staff testing events when needed.	RW Part B, HIV Prevention	As needed
Objective 4: Enhance efforts to test refugees entering into Utah and currently residing in Utah.				
<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Responsible Parties</u>	<u>Timeline</u>
Ensure all refugees are tested for HIV when they settle in Utah.	Collaborate with the Refugee Health and HIV Prevention Programs to more actively reach out to the three Utah refugee organizations (International Rescue Committee, Catholic Community Services, and the Asian Association) to share information and find out what is being done to promote HIV testing and HIV education.	1. Meet with the three Utah resettlement agencies to discuss current policies regarding HIV testing.	RW Part B, Refugee Health Program	July 2013
		2. Identify areas that could be improved and work with the resettlement agencies to make improvements.	RW Part B, Refugee Health Program	July 2013
		3. Monitor progress and make adjustments if needed.	RW Part B, Refugee Health Program	Monthly after July 2013
Reduce language and cultural barriers.	Identify and address language and cultural barriers.	1. Meet with the three Utah resettlement agencies to discuss issues regarding language and cultural barriers.	RW Part B, Refugee Health Program	July 2013
		2. Identify possible barriers to seeking an HIV test or understanding HIV education materials.	RW Part B, Refugee Health Program	July 2013
		3. Work with Resettlement agencies to eliminate barriers and increase HIV awareness.	RW Part B, Refugee Health Program	July 2013 – March 2015

D. Strategy, Plan, Activities, & Timeline to Address the Needs of Special Populations

i. Youth

Strategies	Plan	Activities	Timeline
Decrease the rate of HIV transmission.	Collaborate with the HIV Prevention Program to increase knowledge of HIV transmission.	1. Identify ways to educate this population.	January 2013
		2. Create education materials, including resources to seek help.	Spring 2013
		3. Identify sites youth would feel comfortable obtaining education and counseling.	Spring 2013
		4. Distribute materials and condoms to youth friendly sites.	June 2013 – March 2015
Ensure all youth receiving positive test results are referred into care.	Refer all positive tests to medical care and follow-up that appointment was not missed.	1. Implement a policy that individuals receiving a HIV+ diagnosis receive a follow up contact inquiring if they have sought medical care.	By June 2013
		2. If care has not been pursued, provide individual with contact information.	As needed
		3. Review referral statistics annually.	Annually in January
Enhance efforts to retain youth in medical care.	Provide youth with treatment and care adherence education.	1. Work with Part D case manager to sustain efforts in supporting youth to remain in medical care.	Spring 2013, updated as needed
		2. Provide clients with treatment and care adherence education.	By June 2013
		3. Explore idea of peer advocates to provide outreach, education and advocacy.	June 2013

ii. Injection Drug Users

Strategies	Plan	Activities	Timeline
Improve linkages to substance abuse counseling and treatment services.	Provide clients with resources to access quality substance abuse services.	1. Create a list of services and costs available by region.	January – June 2013
		2. Identify additional financial assistance available to help clients pay for services.	January – June 2013
		3. Distribute information to RW case managers to help their RW clients find affordable options for services not covered by RW funding.	June 2013
Enhance efforts to retain IDU in medical care.	Provide IDU with treatment and care adherence education.	1. Work with RW case managers to sustain efforts in supporting IDU to remain in medical care.	Spring 2013, updated as needed
		2. Provide clients with treatment and care adherence education, including resources for basic needs, and support groups for counseling and motivation.	By June 2013
		3. Assemble working group (or subcommittee) to further explore how this special population's needs can be addressed. Invite IDUs to attend this working group.	June 2013
		4. Explore idea of peer advocates to provide outreach, education and advocacy.	June 2013

Ensure all IDU receiving positive test results are referred into care.	Refer all positive tests to medical care and follow-up that appointment was not missed.	1. Implement a policy that individuals receiving a HIV+ diagnosis receive a follow up contact inquiring if they have sought medical care.	By June 2013
		2. If care has not been pursued, provide individual with contact information.	As needed
		3. Review referral statistics annually.	Annually beginning January 2014

iii. Homeless

Strategies	Plan	Activities	Timeline
Assure housing opportunities to all individuals.	Identify options for permanent affordable housing.	1. Work with HOPWA (Housing Opportunities for People Living With HIV/AIDS) coordinators to maximize housing prospects.	Beginning July 2012
		2. Monitor movement within the HOPWA program, specifically opening as they occur.	July 2012 – March 2015
		3. Provide clients with easy to understand guidelines and paperwork to quickly transition into permanent housing.	On-going
		4. Meet bi-monthly with the HOPWA steering committee to discuss issues and collaborate with all programs.	Bi-monthly beginning July 2012
Improve linkages to mental health and substance abuse counseling and treatment services.	Provide clients with resources to access quality mental health and substance abuse services.	1. Create a list of services and costs available by region.	January – June 2013
		2. Identify additional financial assistance available to help clients pay for services.	January – June 2013
		3. Distribute information to RW case managers and to help their RW clients find affordable options for services not covered by RW funding.	June 2013
		4. Encourage HOPWA providers to refer clients to their case manager for help in accessing treatment and care.	On-going
Increase options with transportation services.	Provide funding for transportation so homeless PLWH/A can access specialized HIV medical services.	1. Budget RW Part B funding to pay for UTA all-day passes.	4/1/12-3/31/13; 4/1/13-3/31/14; 4/1/14-4/31/15
		2. Distribute passes to Clinic 1A to distribute to clients when a medical appointment is scheduled. Case managers may need to physically take the pass to the client if no mailing address is available.	As requested by Clinic 1A from April 2012 to March 2015
		3. Clients have access to all public transportation options for a full day when they attend a medical appointment that same day.	As distributed by case manager.

iv. Transgender

<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Timeline</u>
Increase understanding of the transgender population among providers and programs.	Collaborate with AIDS ETC and community organizations to provide training to increase knowledge about transgender issues.	1. Request training from the Utah Pride Center.	July 2012
		2. Collaborate with AIDS ETC to invite providers to a training meeting.	September 2012
		3. Provide participants with post-training evaluation survey.	September 2012
Provide HIV testing, prevention education, and adherence education.	Work with the HIV Prevention Program to establish ways to target this population for testing and education.	1. Meet with the HIV Prevention Program to identify opportunities to reach out to transgender individuals.	January 2013
		2. Provide education and adherence materials for newly diagnosed transgender individuals.	Spring 2013
		3. Monitor number of positive results and refer to RW case managers for follow-up contact.	January 2013 – March 2015
Improve linkages to substance abuse counseling and treatment services.	Provide clients with resources to access quality substance abuse services.	1. Create a list of services and costs available by region.	January – June 2013
		2. Identify additional financial assistance available to help clients pay for services.	January – June 2013
		3. Distribute information to RW case managers to help their RW clients find affordable options for services not covered by RW funding.	June 2013

v. Rural

<u>Strategies</u>	<u>Plan</u>	<u>Activities</u>	<u>Timeline</u>
Provide access to specialized HIV care.	Provide funding for the traveling clinic staffed by members of the infectious disease clinic from the University of Utah.	1. Budget RW Part B funding to pay for traveling clinic in U of U contract.	4/1/12-3/31/13; 4/1/13-3/31/14; 4/1/14-4/31/15
		2. Collect monthly aggregate numbers of total visits and client level data.	Monthly from April 2012 to March 2015
		3. Collect quarterly progress reports for the number of clients served and demographics of those receiving care.	Quarterly from April 2012 to March 2015
		4. Analyze data to ensure this population is accessing medical care through the traveling clinic.	At end of each FY – 2012; 2013; 2014
Provide transportation services.	Provide funding for transportation so PLWH/A can access specialized HIV medical services.	1. Budget RW Part B funding to pay for gas cards for rural clients.	4/1/12-3/31/13; 4/1/13-3/31/14; 4/1/14-4/31/15
		2. Distribute gas cards to Clinic 1A to mail to clients when a medical appointment is scheduled.	As requested by Clinic 1A from April 2012 to March 2015
		3. Collect distribution log from Clinic 1A to monitor gas card distribution.	Monthly from April 2012 to March 2015

Provide specialized HIV education opportunities to rural medical and supportive services providers.	Provide specialized HIV trainings to increase knowledge and also reduce stigma.	1. Identify providers in rural areas of Utah	7/1/2012-10/1/2012
		2. Collaborate with AIDS ETC to decide what training would be beneficial.	Sept 2012
		3. Conduct training opportunities to rural providers.	Beginning January 2013
		4. Provide participants with post-training evaluation survey.	At training beginning January 2013
		5. Make changes to training as needed.	As needed
Enhance efforts to retain rural clients in medical care.	Provide rural clients with treatment and care adherence education.	1. Work with RW case managers to sustain efforts in supporting rural clients to remain in medical care.	July 2012 – March 2015
		2. Provide clients with treatment and care adherence education.	Spring 2013
		3. Explore idea of local support groups by region or peer advocates to provide outreach, education and advocacy.	June 2013

E. Activities to Implement the proposed Coordinating Efforts with the Following Programs to Ensure Optimal Access to Care:

i. Part A Services

Utah does not receive Part A funding.

ii. Part C Services

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Updates each other on any issues or changes to program. 2. Collaborate on solving Client issues. 3. Enhance efforts to provide PLWH/A quality care and treatment services.	1. Meet quarterly with the RW Part C Program.
	2. Keep current up to date e-mail lists and phone lists of RW Part C Program staff.
	3. Invite the RW Part C Program to attend HIV planning meetings and to participate in advisory boards.

iii. Part D Services

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Updates each other on any issues or changes to program. 2. Collaborate on solving Client issues. 3. Enhance efforts to provide PLWH/A quality care and treatment services.	1. Meet quarterly with the RW Part D Program.
	2. Keep current up to date e-mail lists and phone lists of RW Part D Program staff.
	3. Invite the RW Part D Program to attend HIV planning meetings and to participate in advisory boards.

iv. Part F Services

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Connect experienced HIV doctors with other less experiences providers. 2. Help reduce stigma of HIV disease.	1. Meet with AIDS ETC to discuss ways to reach all providers.
	2. Create a training timeline.
	3. Arrange for trainers and curriculum.
	4. Send out information to providers.
	5. Implement training.
	6. Provide participants with post-training evaluation survey.
	7. Make changes to training as needed.

v. Private Providers (Non Ryan White Funded)

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Work to include private providers in HIV education programs. 2. Maintain an up-to-date list of non RW funded providers.	1. Send notification of HIV education training to all non RW funded providers.
	2. Keep list of non RW funded providers to refer clients to who do not qualify for RW programs.
	3. Offer surveys to non RW funded providers to distribute to their clients (needs assessment survey, etc.)

vi. Prevention Programs Including:

• Partner Notification Initiatives

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Collaborate with the HIV Prevention Program to better understand the partner notification initiatives.	1. RW staff will attend the HIV Facts class sponsored by the Communicable Disease Prevention Program.
	2. Upon completion of the Facts class, RW Part B staff will attend Track 2: Prevention Counseling, which included Partner Counseling Referral Services.

• Prevention with Positives Initiatives

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Facilitate meetings between Clinic 1A and HIV prevention to implement a prevention for positives initiative. 2. Condom distribution services to RW clients via postal mail.	1. Meet with Clinic 1A and HIV Prevention to discuss prevention for positives initiative.
	2. Develop the Prevention for Positives initiative.
	3. Identify ways to reach high risk groups.
	4. Meet with HIV Prevention to discuss condom distribution by postal mail.
	5. Send out information to RW clients to determine if there is interest in this program.
	6. Implement program.

vii. Substance Abuse Treatment Programs/Facilities

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Support RW case managers in referring clients to available substance abuse care.	1. Identify substance abuse facilities that are low cost or no cost to HIV clients.
	2. Work with RW case managers to refer clients to care.

viii. STD Programs

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Collaboration with HIV Prevention Program on the Prevention Comprehensive HIV Plan. 2. Serve on the Category C Advisory Board (integrated testing initiative).	1. Attend meetings and give input from a treatment and care perspective on issues to be included on the Comprehensive HIV Services Plan.
	2. Identify ways these two programs can further collaborate and work together.
	3. Advise the Category C Board of treatment and care options after an HIV+ test result. Support integration from incarceration into care.

ix. Medicaid

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Ensure RW clients are not eligible for Medicaid; 2. Keep current on changes forthcoming regarding Health Care Reform. 3. Invite Medicaid staff to attend RW committees and work groups.	1. Check pharmacy billings against the State Medicaid database monthly to ensure a client has not become Medicaid eligible.
	2. Attend webinars and other training events sponsored by HRSA regarding changes with Health Care Reform.
	3. Include Medicaid representative on invites to committees and work groups.
	4. Invite Medicaid representatives to present at and educate committees as needed.

x. Medicare

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Ensure RW clients are not eligible for Medicare.	1. Check pharmacy billings against the State Medicaid database monthly to ensure a client has not become Medicare eligible.

xi. Children’s Health Insurance Program

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Ensure RW clients are not eligible for CHIP.	1. Check pharmacy billings against the State Medicaid database monthly to ensure a client has not become CHIP eligible.

xii. Community Health Centers

<u>Proposed Coordinating Effort(s)</u>	<u>Activities</u>
1. Collaborate with CHC when dental funding becomes available. 2. HIV Prevention in exploring partnering with CHC to offer HIV testing.	1. Discuss options for funding the dental service program.
	2. Identify funding to be used and amount available for services
	3. Establish if a cap will be implemented.
	4. Contact previous RW dental providers and announce program will be reopening.
	5. Mail out provider agreements and service provider policy and procedure manuals.
	6. Receive agreements back from dental providers.
	7. Notify RW case managers to inform the RW clients the dental program in open and they may utilize services.
	8. Mail out notice of dental program reopening to all RW clients with RW recertification packet.
	9. Support HIV Prevention in exploring partnering with CHC to offer HIV testing.

F. How the Plan Address Healthy People 2020 Objectives

Diagnosis of HIV Infection and AIDS

1. *Reduce the number of new HIV diagnoses among adolescents and adults.*
2. *Reduce new (incident) HIV infections among adolescents and adults.*
3. *Reduce the rate of HIV transmission among adolescents and adults.*
4. *Reduce the number of new AIDS cases among adolescents and adults.*
5. *Reduce the number of new AIDS cases among adolescent and adult heterosexuals.*
6. *Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.*
7. *Reduce the number of new AIDS cases among adolescents and adults who inject drugs.*

8. *Reduce the number of perinatally acquired HIV and AIDS cases.*

8.1. *Number of newly perinatally acquired HIV cases.*

8.2 *Number of new cases of perinatally acquired AIDS*

- In Section IV, How Will We Get There, the strategies, plans and activities within this section propose ways to reduce HIV and AIDS prevalence in Utah. Many of the proposed strategies, plans and activities focus on prevention education and how to reach the special populations with the greatest need for HIV prevention. Education on how HIV can and cannot be transmitted is addressed.
- Collaboration with the HIV Prevention Program and the Ryan White Programs will be of vital importance in accomplishing these strategies. Populations with the highest risk factors and transmission rates are the primary focus of these proposed activities.
- Throughout the Plan, the strategy to decrease the rate of HIV transmission is addressed. However, this can only be accomplished if individuals know what their status is and can take action to prevent further transmission and infection. Therefore the strategy of expanding testing to include all populations and risk groups is proposed. We expect rates to go up as more people are tested and become aware of their status, before rates can theoretically decrease with HIV prevention measures.
- There has not been one case of mother to child transmission of HIV in Utah in the last ten years.

Death, Survival and Medical Healthcare After Diagnosis of HIV Infection and AIDS

9. *Increase the proportion of new HIV infections diagnosed before progression to AIDS.*

10. *(Developmental) Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.*

11. *Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS.*

12. *Reduce deaths from HIV infection.*

- The 2012 Proposed Care Goals (Section III.B.) in this Plan are designed to sustain quality of life, increase survival rates, and ensure access to quality medical healthcare for PLWH/A. Throughout the strategies, plans and activities proposed within this Plan, there is collaboration with the HIV Prevention Program to test and

identify new infections early on and refer newly diagnosed individuals to treatment and care.

- The overall mission of the entire Plan is to ensure collaboration and information sharing among programs in the state of Utah funded under all titles of the Ryan White CARE Act and other partners to avoid duplication of services and to assure access to quality, cost-effective services that help individuals living with HIV have an improved quality of life.

HIV Testing

13. Increase the proportion of persons living with HIV who know their serostatus.

14. Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.

14.1. Adolescents and adults.

14.2. Men who have sex with men (MSM).

14.3. Pregnant women.

14.4. Adolescents and young adults.

15. Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV.

16. Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support.

17. Increase the proportion of sexually active persons who use condoms.

17.1. Unmarried females aged 15 to 44 years.

17.2. Unmarried males aged 15 to 44 years.

18. Decrease the proportion of men who have sex with men who reported unprotected anal sex in the past 12 months.

- Through increasing the quantity of tests given and increasing testing sites to address all special populations residing in Utah, The Part B Program and the HIV Prevention program strive to increase the number of individuals in Utah who have been tested for HIV and therefore know their current status.
- Improving linkages to substance abuse counseling and treatment services is a strategy repeated over several areas within this Plan. Identifying resources other than Ryan White funding to address this need for services is a top priority for the Part B Program.

- THE Part B Program and the HIV Prevention program collaborate to find new ways to distribute condoms and encourage safe sexual behavior. In the strategies of this Plan, condom distribution via postal mail and increasing distribution sites for condoms has been planned in future activities.

G. How the Plan Reflects the Statewide Coordinated Statement Need

The Comprehensive HIV Services Plan reflects the needs identified by the SCSN including:

- Needs of individuals who are aware of their HIV-positive status but are not in care (with an emphasis on outreach, referral, and linkage to care needs),
- Needs of individuals who are unaware of their HIV-positive status (with an emphasis on outreach, counseling and testing, referral, and linkage to care needs),
- Obstacles to accessing care (including gaps and overlaps in care, as well as priorities in addressing underserved populations),
- Current/ Emerging Needs by Special Populations:
 - Homeless
 - Transgender
 - Rural
 - Injection Drug Users
 - Adolescents

The Plan is designed to address these identified needs with goals and objectives, strategies, plans and activities. It is a timeline in which the Part B Program can monitor how well we are succeeding in achieving the proposed Plan.

The SCSN also identified cross-cutting issues, shortfalls in the healthcare workforce, and anticipated trends. This information is referred to when planning activities and creating a timeline for the next three years.

H. How the Plan is Coordinated With and Adapts to Changes that Will Occur with the Implementation of the Affordable Care Act

The HIV Comprehensive HIV Services Plan will be updated annually and changes made as more information and direction becomes available with the implementation of the

Affordable Care Act. Currently, the Part B Program is attending webcasts and training associated with these changes, as acknowledged in several activities within this Plan. Additionally the Part B Program is organizing a work group with Medicaid to begin discussions and understand how the programs can best coordinate these changes.

I. How the Plan Addresses the Goals of the National HIV/AIDS Strategy (NHAS)

In July 2010, the White House released the National HIV/AIDS Strategy to provide the U.S. guidance for future HIV care and prevention activities. The NHAS identifies three primary goals:

1. Reducing HIV incidence
2. Increasing access to care and optimizing health outcomes
3. Reducing HIV-related health disparities

The Comprehensive HIV Services Plan includes strategies which focus efforts to reduce HIV incidence in Utah. Working with the HIV Prevention Program, the Ryan White Part B Program will strive to increase HIV testing over the next three years. The goals and objectives addressing the needs of individuals unaware of their HIV status (Section IV.C.) include:

Goal: To make individuals who are unaware of their HIV status aware of their status.

Objective 1: Ensure everyone who is tested for HIV is informed of their test results.

Objective 2: Expand HIV testing to include low to moderate risk populations in Utah.

Objective 3: Enhance efforts to test individuals living in rural areas of Utah.

Objective 4: Enhance efforts to test refugees entering into Utah and currently residing in Utah.

Additionally strategies throughout the Plan target HIV education to reduce risk. The Part B Program will strive to build community partners over the next three years to educate the community, providers and target populations. Suggested partnerships within this Plan include the HIV Prevention Program, AIDS ETC, Utah Pride Center, and Utah AIDS Foundation.

A large portion of this Plan is dedicated to increasing access to care and optimizing health outcomes. In Section III.B. the primary care goals focus on maximizing Ryan White funding within the Ryan White Part B Program, including funding for ADAP medications, health insurance continuation program, and the supportive services program. The supportive service program includes case management and medical transportation, which directly supports the client in accessing and adhering to medical care. Additional strategies in Section IV focus on collaborating with other Ryan White funded and non-Ryan White funded programs to ensure PLWH/A are able to access the health care they need. Associated work plans and activities concentrate on increasing client and provider adherence education, increasing medication adherence rates, and retaining individuals in medical care.

HIV testing is an important component to this Plan. Furthermore, referring all newly HIV+ individuals to care when test results are delivered is key to reducing health-related disparities. This Plan states in its various strategies multiple times the importance of ensuring that every new diagnosis of HIV is linked to medical care. Section IV.B. of this Plan addresses the needs of PLWH/A, who are not in care. The overall goal of this section is to increase the number of PLWH/A in Utah who are aware of their HIV+ status into HIV outpatient/ambulatory care.

J. Strategy to Respond to Any Additional or Unanticipated Changes in the Continuum of Care as a Result of State or Local Budget Cuts

One of the funding challenges Utah continually encounters is that the Utah State Legislature does not consider HIV/STIs a priority in the State and does not provide funding for testing or treatment of HIV/STIs. Utah does not receive any state or local funding for HIV direct services. HIV+ individuals who qualify for the State Medicaid Program receive HIV related care through this State funded program and budget cuts to the Medicaid Program has the potential to impact the Ryan White Programs. The Ryan White Part B Program monitors annual budget changes to the Medicaid Program and how it impacts PLWH/A. As funding is allocated to Part B services, these changes are reviewed and modifications are made if possible to include any unexpected shortfalls.

IV. How Will We Monitor Progress?

A. Plan to Monitor and Evaluate Progress in Achieving Proposed Goals and Identified Challenges

Ongoing monitoring, input, and adjustment are critical in continuing to ensure that available HIV/AIDS resources in Utah are maximized and the use of these resources are prioritized when changes to the system are needed. The 2012-2015 Comprehensive HIV Services Plan Goals and Objectives will be monitored by the Ryan White Part B Program staff, in collaboration with 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. Challenges will be continually monitored and additional objectives can be added as needed to achieve proposed goals.

i. How the Impact of the Early Identification of Individuals with HIV/AIDS (EIIHA) Initiative will be Addressed

The impact of EIIHA will be addressed by close monitoring of the Program's resources. The Ryan White Part B Program monitors the influx of new clients to the ADAP Program and the Ryan White Supportive Services Program on a monthly basis. The Ryan White Program staff meets monthly with the Financial Support Services Coordinator to review current Ryan White Part B budget allocations and expenditures within these programs. Budget projections for the remaining fiscal year are forecasted and a financial status of the program is assessed. These findings are presented quarterly to the ADAP Advisory Committee and recommendations are made to adjust budget allocations as needed.

ii. Timeline for Implementing the Monitoring and Evaluation Process

The 2012-2015 Comprehensive HIV Services Plan Goals and Objectives will be monitored quarterly and an evaluation will be included in an annual update to the Plan in June 2013, June 2014, and June 2015. Each annual evaluation will cover the one complete fiscal period prior to the evaluation:

- June 2013 covers 4/1/12 – 3/31/13
- June 2014 covers 4/1/13 – 3/31/14
- June 2015 covers 4/1/14 – 3/31/15

Quarterly monitoring will include:

- Confirming the activities within the strategy timeline(s) are being met;
- Monitoring the monthly budget changes and adjustments to the Ryan White Part B budget;
- Tracking the implementation of the Affordable Care Act and how it relates to the Ryan White Part B Program;
- Monitoring any unanticipated changes in the continuum of care; and
- Documenting challenges and responses that were made.

Annual evaluation includes assessing the above quarterly items monitored and the adjustments, changes and additions that need to be implementing into the Comprehensive HIV Services Plan.

iii. Process for Tracking Changes

• Improved Use of Ryan White Client Level Data

The Ryan White Part B Program and Part B contractors will generate reports from the CAREWare database to monitor consumer level utilization of core services. By complying with the Client Level Data (CLD) reporting requirement, the Ryan White Part B Program and the Part B contractors will more comprehensively enter CLD elements into CAREWare. Performance measures reports generated in CAREWare will be more accurate and useful for quality improvement activities. CLD reports as well as performance measures reports will be reviewed by the Ryan White Part B Program staff and the Quality Improvement Program to identify opportunities for quality improvement.

• Use of Data in Monitoring Service Utilization

The Ryan White Part B Program will monitor the influx of new clients to the ADAP Program and the Ryan White Supportive Services Program on a monthly basis using CLD in CAREWare. Reports generated in CAREWare will be reviewed by the Ryan White Part B Program staff and presented quarterly to the ADAP Advisory Committee so recommendations can be made to adjust budget allocations as needed. CLD reports from CAREWare will also be used by the HIV Treatment and Care Planning Committee when prioritizing supportive services for the purpose of resource allocation for the next fiscal year.

- **Measurement of Clinical Outcomes**

The Quality Improvement (QI) Program is designed to assess the performance of funded services adherence to the purpose of the Ryan White HIV/AIDS Treatment Modernization Act, as it relates to the quality, availability and appropriateness of services to all affected segments of the population. Also as applicable, the QI Program recommends strategies for improving such adherence. The QI Program specifically measures clinical outcomes for the Ryan White Programs within Utah.

The scope of the QI Program includes:

- Review of both clinical and non-clinical quality, such as access and availability and coordination and continuity of care.
- With the help of surveillance and other demographic data, review of care and services for all PLWH/A in Utah.

Ongoing activities are tracked over time and may result in a focused study if a significant opportunity for improvement is identified. Ongoing activities include:

1. Monitoring illness and trends through available surveillance and demographic data.
2. Monitoring funding patterns that may affect quality of care.
3. Monitoring advances in treatment and FDA approved medications.
4. Monitoring changes in delivery systems that may impact the health of PLWH/A, or their ability to access services.
5. Assessment of gaps in, and barriers to, service through a periodic gap analysis.
6. Evaluation of client satisfaction through client satisfaction surveys and client complaints.
7. Evaluation of service availability through provider evaluations.
8. Monitoring utilization patterns.
9. Review and tracking of rates of retention in care.
10. Evaluation of medical records standards compliance.
11. Monitoring of care quality through use of professional standards and current guidelines.

The QI Program is evaluated annually by the Ryan White Part B Program and the HIV Treatment and Care Planning Committee. The evaluation is based on the study outcomes and results of ongoing activities, and the achievement of goals as outlined in the work plan. The evaluation serves as the basis for the following year's work plan, and any revisions to the QI Plan.

**Appendix A
Ryan White Part B Budget 2012**

FY Award Information	
Part B Base Award	\$1,709,097
Part B Supplemental	TBA
Part B ADAP Earmark	\$2,109,900
Part B ADAP Supplemental	\$167,151
ADAP Emergency Relief	TBA
TOTAL (to date)	\$3,986,148*

* This total does not include the Part B Supplemental Award or the ADAP Emergency Relief Funds (to be awarded July 2012). This anticipated funding will be applied to ADAP Services.

Allocations	Amount
1. ADAP Services	\$2,320,323
2. Health Insurance	\$525,000
3. Medical Services Subtotal	\$622,288
a. Outpatient/Ambulatory Health Services	\$322,552
b. Medical Case Management	\$299,236
c. Home Health Care	\$500
4. Support Services Subtotal	\$72,090
a. Case Management (non-medical)	\$68,765
b. Medical Transportation	\$3,325
5. Clinical Quality Management	\$54,574
6. Grantee Planning and Evaluation	\$95,744
7. Grantee Administration	\$296,129
TOTAL ALLOCATIONS (to date)	\$3,986,148

Prepared by: Rachel Black
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Utah Department of Health
6/11/2012

Appendix B
Ryan White Part C Budget 2012

FY Award Information	
Part C Grant Award	\$890,955

Allocations	Amount
1. Medical Services Subtotal	\$680,493
a. Outpatient/Ambulatory Health Services	\$391,260
b. AIDS Pharmaceutical Assistance (local)	\$72,000
c. Oral Health Care	\$25,000
d. Mental Health Services	\$73,856
e. Medical Case Management (including treatment adherence)	\$118,377
2. Support Services Subtotal	\$105,118
a. Case Management (non-medical)	\$74,245
b. Medical Transportation	\$9,800
c. Referral for Health Care/Supportive Services	\$21,073
3. Clinical Quality Management	\$34,748
4. Grantee Administration	\$70,596
TOTAL ALLOCATIONS	\$890,955

Prepared by: Kris Dean
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 University of Utah
 5/7/2012

**Appendix C
Ryan White Part D Budget 2011**

FY Award Information	
Part D Grant Award	\$350,000

Allocations	Amount
1. Medical Services Subtotal	\$274,739
a. Outpatient/Ambulatory Health Services	\$215,009
b. Oral Health Care	\$6,500
c. Medical Case Management (including treatment adherence)	\$53,230
2. Support Services Subtotal	\$11,601
b. Medical Transportation	\$540
b. Outreach Services	\$500
c. Referral for Health Care/Supportive Services	\$10,561
3. Clinical Quality Management	\$34,818
4. Grantee Administration	\$28,842
TOTAL ALLOCATIONS	\$350,000

Prepared by: Kris Dean
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University of Utah
5/7/2012

Appendix D
Ryan White Part F – AIDS Education and Training Center Budget 2011-12

UT	FY 2011-2012		BASE	MAI funds	AI/AN Suppl't	Testing Suppl't	Total
			Edu	Edu	Edu	Edu	
salaries			\$54,797	\$20,123	\$2,342	\$500	\$ 77,762
fringe (36%)			\$19,727	\$ 7,244	\$843	\$180	\$ 27,994
TOTALS			\$74,524	\$27,367	\$3,185	\$680	\$ 105,756
Subcontracts (list)							
TOTALS			\$12,000	\$ 6,000			\$ 18,000
Supplies			\$1,500	\$ -			\$ 1,500
Faculty Travel			\$11,700	\$ 2,000	\$2,948	\$500	\$ 17, 148
Other Expenses							
printing			\$2,000	\$ -	\$300		\$ 2,300
IT services			-				\$ -
postage			\$1,093		\$413	\$500	\$ 2,006
copier			\$500	\$ 100		\$266	\$ 866
			\$4,000	\$ 3,000	\$750	\$219	\$ 7,969
Other			\$1,704	\$ 364	\$700	\$150	\$ 2,918
TOTALS			\$9,296	\$ 3,464	\$2,163	\$1,135	\$ 16,059
Trainee Travel Expenses							
trainee expenses			\$1,500	\$ -	\$500		\$ 2,000
TOTALS			\$1,500	\$ -	\$500		\$ 2,000
DIRECTS			\$110,521	\$38,831	\$8,796	\$2,315	\$ 160,463
IND			\$8,842	\$ 3,106	\$704	\$185	\$ 12,837
TOTAL			\$119,362	\$41,938	\$9,500	\$2,500	\$ 173, 300

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5/4/2012

Appendix E
Priority Setting Worksheets – HIV Treatment & Care Planning Committee

HIV/AIDS TREATMENT AND CARE PLANNING COMMITTEE

PART 1 -- Ranking of Core and Supportive Services

Rank the following services from 1 to 10. 10 is the highest and 1 is lowest. Consider the importance, availability, and accessibility of each service when determining rank.

RANK

CORE SERVICES -- FUNDED and UNFUNDED		
Outpatient/Ambulatory Medical Care	(Funded)	
AIDS Drug Assistance Program	(Funded)	
Medical Case Management	(Funded)	
Health Insurance Premium & Cost Sharing Assistance	(Funded)	
Mental Health Services		
Oral Health Care		
Substance Abuse Services		
Early Intervention Services		
Medical Nutrition Therapy		
Home Health Care		

Rank the following services from 1 to 15. 15 is the highest and 1 is the lowest. Consider the importance, availability, and accessibility of each service when determining rank.

RANK

SUPPORT SERVICES -- FUNDED and UNFUNDED		
Case Management (non-medical)	(Funded)	
Medical Transportation Services	(Funded)	
Food Bank/ Home Delivered Meals	(Funded)	
Psychosocial Support Services		
Housing Services		
Emergency Financial Services		
Treatment Adherence Counseling		
Health Education/Risk Reduction		
Outreach Services		
Referral for Health Care / Supportive Services		
Rehabilitation Services		
Linguistics Services		
Legal Services		
Child Care Services		
Respite Care		

HIV/AIDS TREATMENT AND CARE PLANNING COMMITTEE

PART 2 -- Ranking of Core and Supportive Services

You have 3 points available. Distribute 3 points among the services you feel deserve extra attention.

RANK

CORE SERVICES -- FUNDED and UNFUNDED		
Outpatient/Ambulatory Medical Care	(Funded)	
AIDS Drug Assistance Program	(Funded)	
Medical Case Management	(Funded)	
Health Insurance Premium & Cost Sharing Assistance	(Funded)	
Mental Health Services		
Oral Health Care		
Substance Abuse Services		
Early Intervention Services		
Medical Nutrition Therapy		
Home Health Care		

You have 3 points available. Distribute 3 points among the services you feel deserve extra attention.

RANK

SUPPORT SERVICES -- FUNDED and UNFUNDED		
Case Management (non-medical)	(Funded)	
Medical Transportation Services	(Funded)	
Food Bank/ Home Delivered Meals	(Funded)	
Psychosocial Support Services		
Housing Services		
Emergency Financial Services		
Treatment Adherence Counseling		
Health Education/Risk Reduction		
Outreach Services		
Referral for Health Care / Supportive Services		
Rehabilitation Services		
Linguistics Services		
Legal Services		
Child Care Services		
Respite Care		