

**NORFOLK, VIRGINIA
TRANSITIONAL GRANT AREA**

**RYAN WHITE PART A COMPREHENSIVE
PLAN 2012-2015**



*Greater Hampton Roads HIV Health Services Planning Council
Ryan White PART A- Norfolk, Virginia TGA*

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Acknowledgments

This document is the result of participation, input and effort by members of the HIV/AIDS community committed to improving the HIV care delivery system and advancing the treatment of those affected by this epidemic. The plan provides for the means to understand the people that constitute the epidemic, with the ability to reduce disparities in access to health care services and to prevent further transmission of HIV infection. This plan reflects the diversity of the TGA with specific details given about geographic composition, ethnic and racial background, education and income levels and the burden of HIV disease and other co-morbidities that challenge the delivery of services for those impacted by the disease in our area. We wish to thank those who volunteered their time, effort, input, and knowledge of gaps and barriers in our delivery system. We especially wish to thank all participants for their commitment to the continuous improvement of our system of care. ***In particular, we wish to acknowledge:***

Greater Hampton Roads HIV Health Services Planning Council (GHRHHSPC)

GHRHHSPC Needs Assessment and Comprehensive Planning Committee
GHRHHSPC Consumer Access Committee
GHRHHSPC Support Staff

Ryan White Part A & B:

Norfolk TGA Ryan White Part A Grantee Staff
Christine Teele, Norfolk TGA Program Manager
Eastern Virginia HIV CARE Consortium-Ryan White Part B program

Agencies/Organizations

United States Department of Defense
Virginia Department of Corrections
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Virginia State Medicaid Program
Virginia HIV Community Planning Group
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Norfolk Community Services Board
Norfolk Community Health Center
Peninsula Institute for Community Health
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AIDS Resource Center

Comprehensive Plan Consulting

Collaborative Research, LLC

EXECUTIVE SUMMARY

The inherent diversity of the Norfolk TGA poses substantial challenges for planners as they strive to create a system that provides primary medical care and supportive services for PLWHA. Males, men who have sex with men (MSM), African-Americans, adults ages 20-44, people from rural areas, and those living in poverty are disproportionately infected with HIV/AIDS in the Norfolk TGA. MSM represented 41% of AIDS prevalence and 38% of HIV (not- AIDS) prevalence in the TGA. African-Americans reported 72% of HIV (not-AIDS) and are 67% of people living with AIDS; and adults ages 20-44 represented 79% of the TGA's HIV (not-AIDS) prevalence and 76% of the AIDS prevalence. Of all high-risk groups, African-Americans, African-American females and MSM tend to be the most disproportionately impacted by HIV disease in the Norfolk TGA.

Additional factors complicating the delivery of services in the planning area include poverty, with its accompanying social ills, and rural areas that present people living with HIV/AIDS with substantial distances to travel for specialized health care without a supporting public transportation infrastructure. Understanding this diversity is critical to developing a comprehensive plan for responsive service delivery that is feasible within the context of the geographic and demographic surroundings of the diverse populations to be served.

A survey of local, regional and national responses to the HIV epidemic reveals attempts at all levels to identify unmet need in the care and prevention arenas. At the state level, the 2008 *Statewide Coordinated Statement of Need*: (SCSN) identifies major statewide unmet needs to include: 1) Care and prevention for newly diagnosed; 2) Program (care and prevention) in rural areas of Virginia; and 3) Assistance and coaching around disclosure of HIV status with sex or drug-using partners. HIV prevention needs as defined by the Community Population Group (CPG) plan developed by the Virginia Department of Health ('VDH') include: 1) PLWHA (secondary prevention); 2) African Americans; 3) Men who have sex with men (MSM); 4) High Risk Heterosexuals; 5) Transgenders; 6) Injection Drug Users; 7) Homeless; 8) Incarcerated; 9) Youth; and 10) Latino/a.

A review of TGA-specific care and treatment needs discusses the results of the Planning Council's 2011 consumer needs assessment surveys, which indicate the top Service Gaps to include: 1) *Other: Coordination of Benefits with VA/DoD), Youth-oriented services, GYN/Medical Specialty Care; 2) Housing Assistance; 3) Medical Transportation; 4) Emergency Financial Assistance; 5) Oral Health care; 6) Nutrition Assistance; 7) Financial Assistance/Health Insurance; 8) Legal Assistance; 9) Substance Abuse services; and 10) Mental Health services.

The Virginia Department of Health estimates that 55% of the TGA's people who know they are HIV positive have not made a primary medical care visit in the past year, indicating that substantial PLWH/A needs are going unmet. Almost 2,000 individuals (1,777) are estimated to be HIV positive but unaware of their HIV status using the Centers for Disease Control and Prevention back calculation.

The Norfolk TGA's continuum of care has evolved into an increasingly robust and responsive medical model of HIV care and services delivery. Primary medical care is supported by a strong HIV medication infrastructure and by a wide range of medically and socially supportive services, including substance abuse and mental health treatment services, medical and social services case management, emergency financial assistance, oral health care, transportation, outreach/case finding and other services essential to facilitating PLWH/A access and retention in HIV primary medical care.

The Planning Council has identified an ideal continuum of care for the Norfolk TGA. The core of the ideal continuum consists of both primary medical care and the supportive services that help PLWH/A to access and remain in care. This core is surrounded by services that facilitate optimal access to and full utilization of medical and supportive services. All of these services exist in the context of the five key goals of the U.S. Health Resources and Services Administration (HRSA): 1) improve access to care, 2) eliminate health disparities, 3) improve the quality of care, 4) assure cost effectiveness, and 5) improve health outcomes.

Numerous programs and the coordinated efforts by many collaborators are required to create a system of care that approaches this ideal continuum. The Planning Council and its committees have worked with numerous local planning area collaborators to identify the means by which the TGA will meet the key goals of the plan, through rigorous attainment of the following objectives:

1. Reduce Level of Unmet Need (Out of Care) in the TGA by at least 5.5% annually, with a minimum goal of 10% for three years.
2. Reduce Level of Unaware (EIIHA) in the TGA by at least 10%.
3. Decrease top ranking service gaps for all special populations as indicated in the 2011 Needs Assessment within the TGA.
4. Decrease top ranking service barriers for all special populations as indicated in the 2011 Needs Assessment within the TGA.
5. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services.
6. Increase awareness among the MSM populations through education, prevention, and risk reduction materials throughout the TGA.
7. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials throughout the TGA.
8. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization.
9. Increase linkage to HIV care specifically to our Newly Diagnosed population.
10. Address and reduce service barriers and gaps among the Out of Care population within the TGA.
11. Increase by 10% annually Part A achievement of improvements in key health outcome indicators, as evidenced by individual level client data and aggregate provider data.

The Planning Council seriously accepts its obligation to implement, monitor and evaluate the TGA's comprehensive plan, which will serve as a roadmap and touchstone for HIV/AIDS planning and service delivery for the next three years.

Section I. Where are we now?

Introduction to Section I: This Comprehensive Plan is concerned with the needs of and the access to services by people living with HIV/AIDS (PLWH/A) in the Norfolk Transitional Grant Area (TGA). In addressing the life-long needs of residents who are HIV positive, planners must first understand the factors that impact them and the environment that surrounds them. This chapter describes the Norfolk TGA with regard to the epidemiological profile of the HIV/AIDS epidemic, the disproportionate impact of HIV/AIDS in comparison to the general population, the Unmet Need estimate, and the Early Identification of Individuals with HIV/AIDS (EIIHA)/Unaware estimate. Section 1 concludes with the evaluation of the 2009 Comprehensive Plan with regard to the TGA's successes and challenges.

A. Description of the local HIV/AIDS epidemic

There are over 1.6 million people residing in the fourteen Virginia locations and one North Carolina location that comprise the Norfolk TGA. Of those, 31% are non-White/African-American. Approximately one quarter, or 450,000 residents live at or below 200% of the federal poverty level. The primary industries in the Norfolk TGA include military, technology, government and the services sector.

As of December 31, 2010, there were 6,685 PLWHA in the Norfolk TGA. Of those, 2,899 (43%) were PLWA and 3,786 were PLWH (non-AIDS) (57%). PLWH have more female representation (29% vs. 27% for PLWA); with 38% MSM and 17% heterosexual. Age group shows higher proportions of 13-19 year olds (7%). AIDS prevalence in the TGA is notable in that males represent 73% of living AIDS cases; Blacks represent 67%; MSM represent 41% and the City of Norfolk has the highest AIDS prevalence of the 15 localities. By age group, 76% of the PLWA are 20-44 year olds, and 1% is in the 13-19 age range. During the reporting period of January 1, 2008 to December 31, 2010, there were 310 new AIDS cases reported. Males represent 71% of AIDS incidence in 2010 (increased from 67% in 2009 but lower than 2008's 76%). Blacks had almost 4 times higher the number of newly reported AIDS cases than whites (N=78 vs. 20). MSM represented 36% of new AIDS cases while Heterosexuals represented 16% of new AIDS cases.

People Living With HIV (HIV Prevalence)

PLWH have more female representation (29% vs. 27% for PLWA); with 38% MSM and 17% heterosexual. Age group shows higher proportions of 13-19 year olds (7%). African Americans have the highest HIV prevalence (71.8%) in the Norfolk TGA.

People Living with AIDS (AIDS Prevalence)

AIDS prevalence in the TGA is notable in that males represent 73% of living AIDS cases; Blacks represent 67%; MSM represent 41% and the City of Norfolk has the highest AIDS prevalence of the 15 localities. By age group, 76% of the PLWA are 20-44 year olds, and 1% is in the 13-19 age range.

Number of New AIDS Cases reported within the past three years

During the reporting period of January 1, 2008 to December 31, 2010, there were 310 new AIDS cases reported. Males represent 71% of AIDS incidence in 2010 (increased from 67% in 2009 but lower than 2008's 76%). African Americans had almost 4 times higher the number of newly reported AIDS cases than whites (N=78 vs. 20). MSM represented 36% of new AIDS cases while Heterosexuals represented 16% of new AIDS cases.

TABLE 1. AIDS Incidence, HIV Incidence, AIDS Prevalence and HIV Prevalence by Demographic Group and Exposure Category for the Norfolk TGA
(Data Source: Virginia Department of Health, HIV/AIDS Surveillance through December 31, 2010)

<i>Demographic Group/ Exposure Category</i>	AIDS INCIDENCE: 01/01/08 TO 12/31/08		AIDS INCIDENCE: 01/01/09 TO 12/31/09		AIDS INCIDENCE: 01/01/10 TO 12/31/10		HIV (NOT AIDS) PREVALENCE AS OF 12/31/10		AIDS PREVALENCE AS OF 12/31/10	
<i>Race/Ethnicity</i>	#	% of Total	#	% of Total	#	% of Total	#	% of Total	#	% of Total
White, not Hispanic	17	16.3%	20	19.0%	20	18.8%	849	22.4%	759	26.2%
African-American, not Hispanic	78	76.3%	76	73.7%	78	74.0%	2,720	71.8%	1,949	67.2%
Hispanic	4	4.4%	3	3.4%	3	2.9%	129	3.4%	128	4.4%
Asian/Pacific Islander	1	1.4%	2	2.0%	1	1.0%	21	0.6%	18	0.6%
American Indian/Alaska Native						0.0%	8	0.2%	4	0.1%
Multi-race	2	1.6%	2	2.0%	3	3.3%	59	1.6%	41	1.4%
Other						0.0%	0	0.0%	0	0.0%
Total	102	100.0%	103	100.0%	105	100.0%	3,786	100.0%	2,899	100.0%
<i>Gender</i>	#	% of Total					#	% of Total	#	% of Total
Male	78	76.1%	69	67.3%	74	70.7%	2,684	70.9%	2,101	72.5%
Female	24	23.9%	34	32.7%	31	29.3%	1,102	29.1%	798	27.5%
Total	102	100.0%	103	100.0%	105	100.0%	3,786	100.0%	2,899	100.0%
<i>Age at Diagnosis (Years)</i>	#	% of Total					#	% of Total	#	% of Total
<13 years	1	0.2%			2	1.9%	42	1.1%	34	1.2%
13-19 years	9	8.8%	6	5.9%	6	5.8%	277	7.3%	33	1.1%
20- 44 years	70	68.3%	63	61.0%	59	55.8%	2987	78.9%	2203	76.0%
45 + years	22	22.5%	34	33.2%	38	36.5%	480	12.7%	629	21.7%
Total	102	100.0%	103	100.0%	105	100.0%	3,786	100.0%	2,899	100.0%

<i>Demographic Group/ Exposure Category</i>	AIDS INCIDENCE: 01/01/08 TO 12/31/08		AIDS INCIDENCE: 01/01/09 TO 12/31/09		AIDS INCIDENCE: 01/01/10 TO 12/31/10		HIV (NOT AIDS) PREVALENCE AS OF 12/31/10		AIDS PREVALENCE AS OF 12/31/10	
<i>Adult/Adolescent AIDS Exposure Category</i>	#	% of Total	#	% of Total	#	% of Total	#	% of Total	#	% of Total
Men who have sex with men	30	29.4%	34	32.7%	38	36.1%	1,425	37.6%	1,200	41.4%
Injection drug users	6	5.9%	3	3.0%	8	7.6%	305	8.1%	386	13.3%
Men who have sex with men and inject drugs	2	1.9%	1	1.3%	1	1.0%	98	2.6%	134	4.6%
Hemophilia/coagulation Disorder									8	0.3%
Heterosexuals	17	16.7%	19	18.7%	17	16.2%	645	17.0%	585	20.2%
Receipt of blood transfusion, blood components, or tissue							6	0.2%	7	41.4%
Risk not reported or identified	43	42.3%	46	44.3%	40	38.1%	1,265	33.4%	536	18.5%
<i>Pediatric AIDS Exposure Categories</i>	#	% of Total	#	% of Total	#	% of Total	#	% of Total	#	% of Total
Hemophilia/coagulation disorder							0	0.0%	2	0.1%
Mother with/at risk for HIV	2	1.9%					34	0.9%	38	1.3%
Pediatric Transplant							1	0.0%	0	0.0%
Risk not reported or identified	2	1.9%			1	1.0%	7	0.2%	3	0.1%
Total	102	100.0%	103	100.0%	105	100.0%	3,786	100.0%	2,899	100.0%

Disproportionate impact of HIV/AIDS compared to general population

Minorities. African Americans face the highest disparities and the most disproportionate impact of HIV and AIDs, comprising a significant 31% of the general population in the TGA (compared to 12% national representation) yet are 77% of new AIDS cases in 2010, and 71% of People Living with HIV/AIDS. Their disparity for AIDS incidence is 46% higher than their proportion in the general population and for HIV/AIDS prevalence is 40% higher. Latino is a small group, representing only 3% of the general population with a disparity for HIV/AIDS prevalence 1% higher than their proportion in the general population. Males are 25% higher for AIDS incidence and 23% higher for HIV/AIDS prevalence than their 49% proportion in the general population. The large age category of 20 to 44 year olds is 46% of the overall population, with higher AIDS incidence than their proportion of 32% and high HIV/AIDS prevalence of 40%.

Homeless. It is estimated that there are 872 single adults and 542 families homeless at any point in the Norfolk TGA. National estimates are that 10% of these individuals or approximately 87 single adults have HIV/AIDS, regardless if they are aware of the diagnosis or in treatment. The majority of the single adults counted in the 2011 ‘Point in Time’ study are black adult males, further portraying the disparity discussed in the minority section.

Formerly Incarcerated. It is estimated that the Norfolk TGA has 374 individuals return to the area per year that are formerly incarcerated (within the past 3 years). Of these individuals, 5-6% is HIV positive or approximately 20 PLWHA, whether aware of their diagnosis or in treatment. The Virginia Department of Corrections cites that the majority (97%) are adult black males between the ages of 18 and 45.

TABLE 2: DISPROPORTIONATE IMPACT OF HIV/AIDS IN NORFOLK TGA, 2010

% General Population v. HIV+	A	B	C	D	E
Group in Norfolk, VA TGA	General Population	New AIDS Cases	PLWHA	New Disparity	Existing Disparity
Race/Ethnic Group					
African American	31%	74%	70%	43%	39%
Asian	3%	1.0%	<1%		
Latino/a	3%	3%	4%		1%
Multi-Race	3%	3%	21%		
White	60%	19%	24%		
Gender					
Male	49%	71%	72%	22%	23%
Female	51%	29%	28%		
Age Group					
0-12	14%	2%	1%		
13-19	6%	6%	5%		
20-44	46%	56%	78%	10%	32%
45+	34%	36%	16%	2%	

Sources: Column A. US Census Bureau, 2010; Columns B & C: Virginia Department of Health (VDH)/North Carolina Division of Public Health (NCDPH); 2010

In addition to disparities in population sub-groups, primarily affecting African American males; under-representation of Ryan White Part A HIV medical care was analyzed to determine if access to care issues were present.

Table 3 shows that the following groups are under-represented compared to their proportion in the Epidemiologic Profile:

Whites. Whites have 6% less utilization than their representation in the Epi profile of PLWHA

Males. Males have a slight (2%) lower utilization.

IDU. Injection Drug Users (IDU) has a 3% lower utilization than their proportion in the EPI

MSM/IDU. MSM/ IDU have a 2% lower utilization than their EPI representation.

Explanations are different for white males who are believed to selectively access certain services in the Ryan White Part A continuum (mental and dental health) but not HIV medical care for which they use private or alternate system (Veterans Administration, Department of Defense) care providers. Studies show that IDU and MSM/IDU are not accessing other HIV medical care systems, but are first using substance abuse and mental health services to complete rehabilitation and then entering HIV medical care. Significant work has been conducted to change this perception and have IDU and MSM/IDU jointly enter primary medical care and substance abuse / mental health treatment, with limited success to date.

TABLE 3. UNDER-REPRESENTATION IN OAMC IN NORFOLK TGA: FY 2010					
Race, Gender and Risk Group	Total Prevalence 12/31/10		Part A OAMC Utilization FY11		Over/Under/Parity Utilization
	#	%	#	%	
Black	4,669	70%	734	70.8%	parity
White	1,608	24%	189	18%	under
Hispanic	257	4%	51	4.92%	parity
Asian/Pacific Islander	39	<1%	6	<1%	parity
Native American	12	<1%	2	<1%	parity
Multi-race/Other/Unknown	100	1%	54	5.2%	over
TOTAL	6,685	100%	1,036	100%	
Male	4,785	72%	707	68.2%	under
Female	1,900	28%	314	30.3%	over
Transgender/Unknown	UNK	-	15	1.5%	parity
TOTAL	6,685	100%	1036	100%	
Youth, 13-19	356	5%	99	10%	over
Adults, 20+	6,299	95%	937	90%	over
TOTAL	6,685	100%	1036	100%	
MSM	2,625	39%	438	42%	over
IDU	691	11%	88	8%	under
MSM/IDU	232	4%	19	2%	under
Heterosexual	1,230	18%	447	43%	over
Blood Recipient	13	<1%	3	<1%	parity
Perinatal	85	2%	8	<1%	under
RNR/Undetermined/Unknown	1,809	27%	33	3.2%	parity
TOTAL	6,685	100%	1036	100%	

Unmet Need Estimate

Virginia assessed unmet need based on the determination of persons “in care” as indicated by having either a viral load, CD4, evidence of antiretroviral therapy (ART) administered, or a HIV/AIDS-related health care visit during the 12-month period from 01/01/10-12/31/10 out of the total number of PLWHA in Virginia. To assess care as defined above, Virginia utilized data from multiple sources. This year, data was obtained and analyzed from eight different sources, including:

1. E-HARS - Electronic HIV/AIDS Reporting System (VDH HIV/AIDS surveillance database)
2. VACRS - Virginia Client Reporting System (Ryan White Part B database)
3. MMP - Medical Monitoring Project
4. LabCorp - Laboratory Corporation of America (CD₄ and Viral Load testing)
5. Mayo Laboratory (CD₄ and Viral Load testing)
6. ADAP - AIDS Drug Assistance Program (Part B medication dispensing database)
7. CAREWare
8. Medicaid

Evidence of care obtained from the eHARS surveillance data included all persons with a CD4 count or viral load during the calendar year (CY) 2010. Since eHARS collects information about antiretroviral therapy, but does not include treatment or medical visit dates, this information could not be used to determine who is presently in care.

To determine the number of PLWHAs, Virginia used the eHARS dataset and included all persons diagnosed with HIV (not AIDS) or AIDS who are living in Virginia with a mortality status of living as of 12/31/2010. Persons diagnosed elsewhere now living in Virginia were included, while persons diagnosed in Virginia, but living elsewhere were excluded from the count.

The eHARS database is used as the basis for determining the unmet need estimations, based on the above care-related variables. Several factors contribute to the under-representation of the number of individuals receiving care. Although excluding cases diagnosed elsewhere and now living in Virginia and including Virginia cases more datasets were included this year, it is believed that the care data used leads to an underestimation of people receiving care due to the underreporting of care from the private sector. As more data sources are explored and electronic laboratory reporting becomes the norm this estimate will be more accurate. At this point the percentage of people living with HIV (not AIDS) or AIDS who are in care is underestimated.

Provided by Health Informatics and Integrated Surveillance Systems, Virginia Department of Health - 10/05/2011

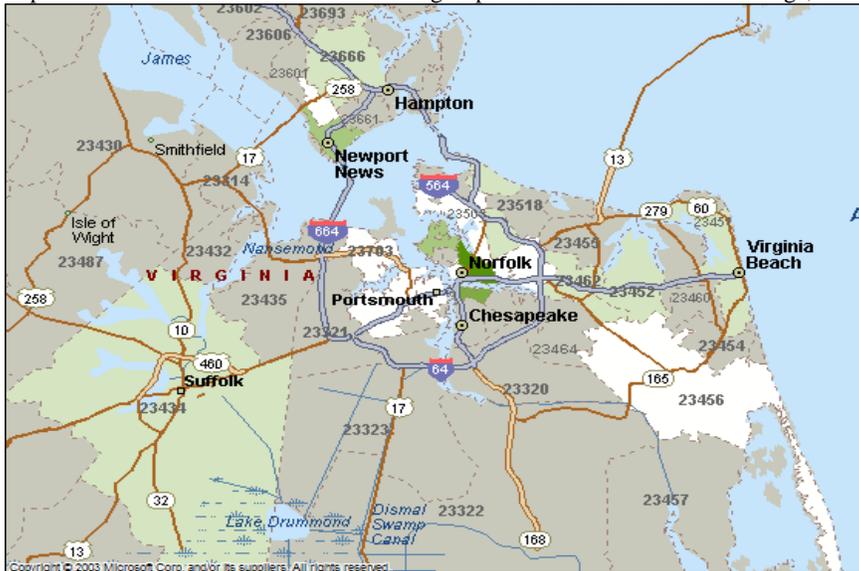
TABLE 4. HIV Positive Patients With Unmet Need in Norfolk TGA- CY2010

	HIV UNMET TOTAL			AIDS UNMET TOTAL			TOTAL		TOTAL PLWHA
	N	%	N	N	%	N	N	Percent	TOT PLWHA
Total	2270	60.0%	3,786	1413	48.7%	2,899	3683	55.1%	6,685
Age as of 12/31/2010									
0-12	4	36.4%	11	0	0.0%	2	4	30.8%	13
13-19	12	32.4%	37	5	26.3%	19	17	30.4%	56
20-29	303	47.6%	636	46	36.8%	125	349	45.9%	761
30-39	493	59.8%	824	148	40.4%	366	641	53.9%	1,190
40-54	1069	62.8%	1701	828	49.2%	1683	1897	56.1%	3,384
55+	389	67.4%	577	386	54.8%	704	775	60.5%	1,281
Sex at birth									
Female	559	50.7%	1102	341	42.7%	798	900	47.4%	1,900
Male	1711	63.7%	2684	1072	51.0%	2101	2783	58.2%	4,785
Race/Ethnicity									
Black	1578	58.0%	2720	902	46.3%	1949	2480	53.1%	4,669
White	546	64.3%	849	410	54.0%	759	956	59.5%	1,608
Hispanic (all races)	87	67.4%	129	74	57.8%	128	161	62.6%	257
Asian	17	81.0%	21	9	50.0%	18	26	66.7%	39
Amer. Indian	5	62.5%	8	3	75.0%	4	8	66.7%	12
Multi-race/Unknown	37	62.7%	59	15	36.6%	41	52	52.0%	100
Mode of transmission									
MSM	828	58.1%	1425	611	50.9%	1200	1439	54.8%	2625
IDU	199	65.2%	306	228	59.1%	386	427	61.8%	691
MSM / IDU	70	71.4%	98	73	54.5%	134	143	61.6%	232
Heterosexual contact	341	52.9%	645	256	43.8%	585	597	48.5%	1230
Pediatric	16	38.1%	42	17	39.5%	43	33	38.8%	85
Blood recipient	5	83.3%	6	8	53.3%	15	13	61.9%	21

No risk factor	811	64.1%	1265	220	41.0%	536	1031	57.2%	1801
Age at first diagnosis (years)									
0-12	14	48.3%	29	10	35.7%	28	24	42.1%	57
13-19	136	49.1%	277	44	39.3%	112	180	46.3%	389
20-29	989	65.5%	1510	468	52.3%	894	1457	60.6%	2,404
30-39	674	62.1%	1085	538	52.1%	1033	1212	57.2%	2,118
40-54	384	50.4%	762	304	41.8%	727	688	46.2%	1,489
55+	72	60.5%	119	45	47.4%	95	117	54.7%	214
Unknown	1	25.0%	4	4	40.0%	10	5	35.7%	14

Source: Virginia Department of Health, Unmet Need Data as of 09/30/2011

Sub-Groups displaying Unmet Need. The highest groups displaying Unmet Need (per VDH and Viral Load laboratory results despite reported HIV diagnosis in last 12 months) were: 1) Williamsburg – 80%; 2) Hispanic – 62%; 3) IDU – 62%; 4) MSM/IDU – 61%, 5) Male – 55%; and 6) PLWHA that are over 55 years of age – 59%. With the exception of 5) Male, these are relatively small volume groups although they stress the importance of Outreach to the isolated sub-groups in the Norfolk TGA due to age, ethnicity, or behavioral risk.



Early Identification of Individuals with HIV/AIDS (EIIHA)/Unaware Estimate

The Early Identification of Individuals with HIV/AIDS (EIIHA) initiative prompted a strategic plan within the TGA to target those individuals Unaware of their HIV status to initiate and retain them in medical care. Using the formula as indicated in the FY2011 Part A Application Guidance for EIIHA/Unaware, the TGA’s estimated number of living HIV positive individuals who were unaware of their status as of December 31, 2009 was 1,777. The Table below indicates the matrix with which the TGA will work to strategically enhance our testing and linkage to care initiatives for each sub-population and special population.

Table 5. EIIHA Matrix

<p>^{P1.} ALL Individuals in Norfolk TGA who are Unaware of their HIV Status (HIV Positive & Negative – Tested & Untested – Publically & Privately Tested)</p>						
<p>²¹(.79) * PLWHA (6,685) = <u>1,377</u></p>						
<p>^{P2.} Tested in the Past 12 Months</p>			<p>^{P3.} Not Tested in the Past 12 Months</p>			
<p>^{P4.} Individuals Not Post-Test Counseled <i>(HIV positive & HIV negative)</i></p>		<p>^{T3.} Received Preliminary HIV Positive Result Only <i>No Confirmatory Test</i></p>	<p>^{P5.} High Risk Individuals</p>		<p>^{P7.} Moderate & Low Risk Individuals</p>	
^{T1.}	^{T2.}		^{P6.}		^{T4.}	^{T5.}
Tested Confidentially	Tested Anonymously		MSM		PARTNERS	Not tested in Past 24 Months
						Not Tested in Past 48 Months
			^{T7.} MSM (Young: 13-29)	^{T8.} MSM of Color (Black)	^{T9.} MSM (Older: 45+)	^{T10.} High-Risk Heterosexual
					^{T11.} Older (45 years and over)	

B. Current Continuum of Care

The current continuum of care in the Norfolk TGA continues to evolve to meet the needs of a broad range of PLWH/A regardless of their stage of illness. The goal of the continuum of care is to promote optimal and sustained access to primary medical care services and maintenance in the care system, especially the historically underserved populations and those who know their HIV status and are not in primary care.

Ryan White Funded Care and Service Inventory

Table 6 below lists the TGA’s Ryan White funded HIV care and service providers by core and support services. Navigating through the Norfolk TGA Continuum of Care for Ryan White Part A services begins with HIV Medical Care or Outpatient/Ambulatory Medical Care (OAMC). An individual who is eligible for Ryan White services can access all services within the TGA through HIV Medical Care or Case Management services. It is preferred that all PLWH/A have a case manager, but it is not required for access to HIV Medical Care once eligibility is established.

TABLE 6. RYAN WHITE FUNDED CARE AND SERVICE INVENTORY

<i>Core Services</i>	<i>Organizations</i>
AIDS Pharmaceutical Assistance (Local)	Bayview Plaza Pharmacy, Tidewater AIDS Community Taskforce (TACT)
Early Intervention Services	ACCESS, Urban League of Hampton Roads, TACT
Medical Case Management Services	ACCESS, C3ID/Eastern Virginia Medical School (EVMS), Health & Home Support Services Inc., International Black Women’s Congress (IBWC), Norfolk Community Health Center, Peninsula Institute for Community Health, TACT, Virginia Beach Health Department
Mental Health Services	Community Psychological Resources, Norfolk Community Services Board
Oral Health Care	Peninsula Institute for Community Health, Portsmouth Community Health Center, Virginia Beach Health Department
Outpatient Ambulatory Care Services	C3ID/EVMS, Norfolk Community Health Center, Peninsula Institute for Community Health, Portsmouth Community Health Center
<i>Support Services</i>	<i>Organizations</i>
Medical Transportation Services	ACCESS, TACT
Outreach/Case Findings	ACCESS, Health & Home Support Services, Inc.
Substance Abuse Services - Outpatient	Hampton-Newport News Community Service Board, Norfolk Community Service Board

One infectious disease provider and three HIV medical providers comprise the Outpatient/Ambulatory Medical Care complement for a total of four HIV medical care locations in the TGA. C3-ID at the Eastern Virginia Medical School (EMVS), or the Center for the Comprehensive Care of Immune Deficiency, is the infectious disease provider. The three community health centers or federally qualified health centers offering HIV medical care include Norfolk Community Health Center, also located in Southside; and Portsmouth Community Health Center and the Peninsula Institute of Community Health (PICH); both located on the Peninsula.

HIV Medical Care within the Norfolk TGA has a major link to Oral Health Services and the Pharmacy Program. Medical case management is linked to core medical services and all support services. The eligible client is referred to Ryan White Part A ancillary services within the TGA through a uniform referral system established by the Grantee. The referral system in the TGA is generally facilitated by the medical case manager. Eligible clients enter the system via several points of entry (including emergency departments, homeless shelters, primary care providers, et. al) and are connected with case managers at the various agencies. This referral system attempts to eliminate barriers to care and establish an efficient continuum for the client to access. Services provided by the network range from HIV Medical Care, Oral Health Services, Substance Abuse Treatment, Mental Health Therapy, and Drug Reimbursement to all other RW Part A support services.

Medical case management providers include seven providers. These are ACCESS, Health & Human Support Services, the International Black Women’s Caucus, PICH, TACT, the Virginia Beach Department of Health and the Urban League of Hampton Roads.

Non-Ryan White Funded Care and Service Inventory

Table 7 lists organizations and services offered through the collaborative partners within the TGA that do not receive Ryan White funding.

TABLE 7. NON-RYAN WHITE FUNDED CARE AND SERVICE INVENTORY

Organizations	Testing and Prevention Services
Chesapeake Community Services Board – Chesapeake Location	HIV Prevention, Counseling, Testing
Norfolk Community Services Board- Norfolk Location	HIV Early Intervention and Prevention Program
Norfolk Health Department – Norfolk Location	STD-Sexually Transmitted Disease Clinic and HIV Testing and Counseling
Peninsula Health District – Newport News Location	HIV Testing and Counseling, Primary Medical Care
Planned Parenthood Federation of America, Inc. – Virginia Beach and Hampton Locations	HIV Testing and Counseling, Family Planning Services, STD Prevention and Treatment Services
All Care and Support Services	
AIDSinfo – Rockville Location (2)	Primary Medical Care, Case Management, Housing Assistance, Homeless and Emergency shelters (youth and adult), HIV counseling and testing, STD and family planning services, Mental Health, Substance Abuse Treatment Services, Legal Services, Employment and Job Training Assistance, Food and Transportation Services, and HIV education and referral services
American Red Cross National Headquarters – Newport News, Williamsburg/James City, and Suffolk Locations	Primary Medical Care, Case Management, Housing Assistance, Homeless and Emergency shelters (youth and adult), HIV counseling and testing, STD and family planning services, Mental Health, Substance Abuse Treatment Services, Legal Services, Employment and Job Training Assistance, Food and Transportation Services, and HIV education and referral services
American Social Health Association – Research Triangle Park Locations (2)	
Chesapeake Health Department – Chesapeake	
City of Virginia Beach – Department of Housing and Neighborhood Preservation	Housing Opportunities for People with AIDS (HOPWA)
Coram Alternative Site Health Care – Chantilly	
Faith Deliverance Christian Center – Norfolk (2 locations)	
Greenbrier Family Practice, P.C. – Chesapeake	
Greenwich Psychological Associates, P.C. – Chesapeake	
Hampton Health District – Hampton	
Hampton Roads Medical Specialists – Hampton	
Innervisions Counseling and Biofeedback – Chesapeake	
Intrepid USA Home Health Services – Williamsburg City and Virginia Beach	
Lincare Infusion Services - Chesapeake	
Maxim Health Care – Virginia Beach	
Mt. Carmel Baptist Church – Portsmouth	
Old Dominion University – Norfolk	
Peninsula Health District – Newport News	
Personal-Touch Home Care and Hospice – Norfolk and Newport News	
PharmaCare – Pittsburgh	
Portsmouth Community Health Center, Inc. – Norfolk	
Portsmouth Health District – Portsmouth (6 locations)	
Psychotherapy Center, The - Norfolk	
Psychotherapy Resources of Norfolk – Norfolk	
Rock Landing Psychological Services – Newport	

Comment [RS1]: Need all care and support services for providers below. They are not listed in the Comp Plan from 2008, rather just under the title all services.

News	
St. Paul's Episcopal Church – Newport News	
VA Medical Center - Hampton	
Victory in Jesus (Carmal Community Development Corp.) – Portsmouth	
Virginia Beach Community Services Board – 3 locations in Virginia Beach	
Western Tidewater Community Services Board – 2 locations in Suffolk, 1 location in Franklin	

Collaborations with CDC, state funded and local HIV/AIDS prevention programs, are instrumental in providing HIV prevention education services to adolescents and adults in the TGA. The Virginia Department of Health, The Virginia Commonwealth University, Public Health Departments in localities throughout the TGA and community based agencies and local school districts each serve as conduits to provide primary prevention education to youth and adults. In addition to traditional HIV education, street outreach workers target high-risk areas in the Norfolk TGA. HIV prevention education efforts stress the importance of reducing HIV transmission with consistent condom use. Mobile HIV testing, walk-in anonymous testing sites and initiatives by local health departments are instrumental in encouraging testing among PLWHA who do not know their status.

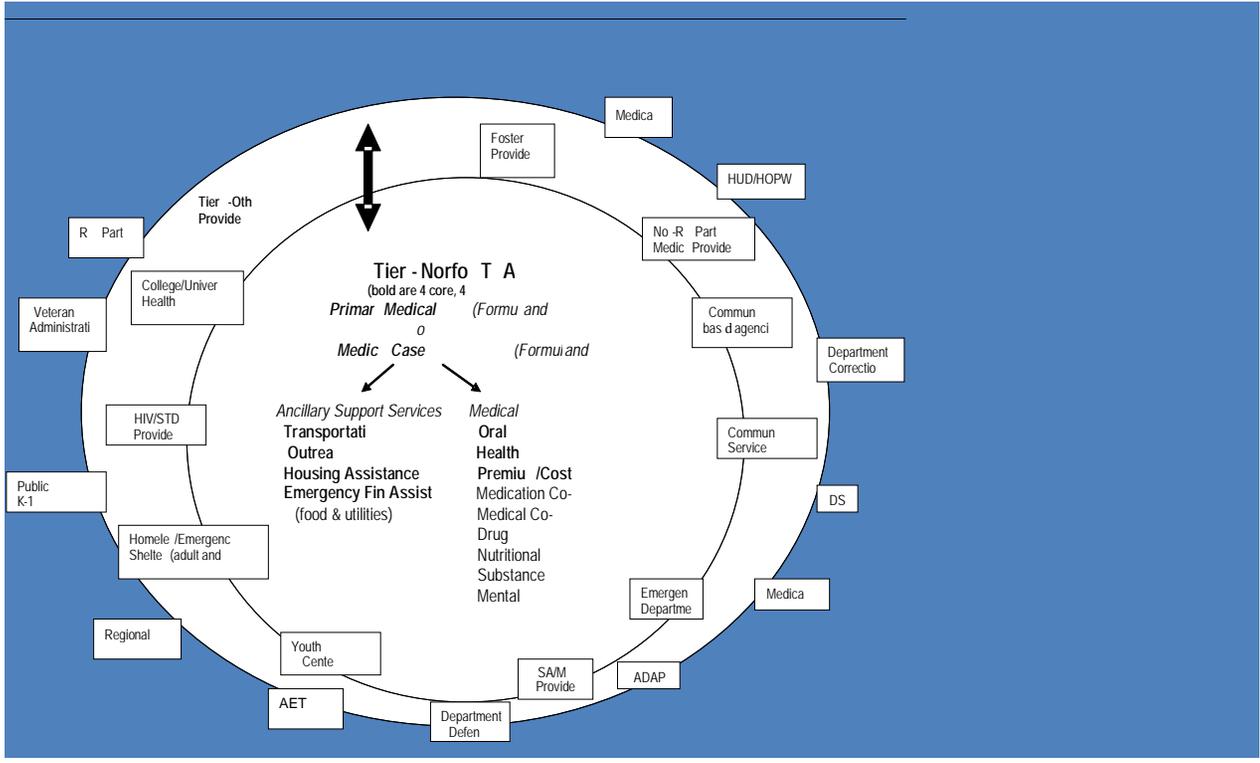
Substance Abusers (users) and/or those who inject drugs are especially difficult to reach with prevention messages. The TGA sought additional Substance Abuse providers, including the Peninsula region to increase capacity to provide services to substance users who might be at increased risk for HIV infection.

Co-infection with tuberculosis (TB) is a concern among not only the incarcerated population; but the general public, as well. To address the issue, local health departments that offer tuberculosis testing also offer HIV counseling and collaborate with providers who recommend HIV testing for high-risk individuals that test positive for tuberculosis.

The Norfolk TGA Resource Inventory reflects priority resources and service linkages in the TGA and continues to serve as a planning tool for the Planning Council and for strengthening/refining formal linkages for the Continuum of Care. Currently, there are 13 additional service agencies identified in the resource inventory. The Resource Inventory includes agencies and their satellites located throughout the TGA, with increasing service delivery to residents of the Peninsula. The range of services offered at these collaborative partner agencies provides HIV+ clients the same medical and support structure necessary to maintain their treatment adherence. Agencies work together, through case management, to avoid duplication of services within the continuum of care, yet provide a cohesive system of care for all PLWHA.

Although this current Continuum of Care seeks to address the service care needs of PLWH/A, the Planning Council concluded that significant barriers and gaps still exist. As such, the current Continuum of Care was modified to include ancillary providers and to address the needs of all special populations. Three (3) tiers of the Continuum of Care exist, from Tier 1 (Ryan White Part A services, with the top four (4) core funded services of Outpatient HIV Primary Medical Care, Medical Case Management, Oral Health Services and AIDS Pharmaceutical Assistance (Local), and the two (2) highest ranked support services—transportation to medical care and outreach. Tier 2 indicates services delivered by other providers and Tier 3 displays services funded by sources other than Ryan White Part A. *See Figure 1.*

Figure 1. Norfolk Transitional Grant Area--Continuum of Care



FY2012 Implementation Plan

The Norfolk TGA logically connected its latest 'In Care' and 'Out of Care' needs assessments conducted in 2011, the results of HRSA/HAB Unmet Need Framework, the 2009-2011 Comprehensive Plan, Service Priorities and the 2012 Implementation Plan. Information collected through the Unmet Need framework, indicated that certain populations demonstrated more unmet need in the Norfolk TGA, primarily African-Americans. The Norfolk TGA recognizes the unique needs of this population and is committed to address these disparities via targeted outreach/case finding methods, collaboration with Ryan White Part B providers, and area prevention providers to establish linkages to care for individuals newly diagnosed; and increasing collaboration with entities that serve as front-line portals to care outside of the Ryan White Part A care system (e.g. homeless shelters, substance abuse treatment centers, correctional facilities, etc.) The TGA maintains outreach and case management services specifically directed to the I/RR population. Additionally, the Greater Hampton Roads HIV Health Services Planning Council is working collaboratively with the Virginia Community Planning Group to identify those newly diagnosed via prevention agencies. The information from the Unmet Need Framework was an essential input to the Norfolk TGA resource allocation and priority setting process. This information served to guide the Planning Council's decision regarding providing services to African-Americans in general as well as sub-populations of African-Americans, including women of childbearing years, MSM-Black and the recently incarcerated. Moreover, the information served as a catalyst for increased funding for MAI Outreach/Case Finding. The Needs Assessment identified special populations (African-American, MSM-Black, and Women of Color) as having the greatest disparity. This information was utilized during the priority and allocation process resulting in increased funding for HRSA defined core services as indicated in the FY2012 Implementation Plan. The Implementation Plan indicates the barriers to care for the Norfolk TGA as transportation, poverty, substance abuse, mental illness and lack of affordable housing. The Norfolk TGA prioritized funding in transportation, emergency financial assistance and housing services, mental health and substance abuse treatment, and increased the prioritized rankings for health insurance premium/co-pay assistance and medical nutrition therapy to eliminate barriers to access and retention in care. The Grantee's Office continues its mandate for cultural competency training for all Part A funded service providers.

In 2011 the Greater Hampton Roads HIV Planning Council prioritized eight (8) out of the thirteen (13) HRSA defined core medical services; Outpatient/ Ambulatory Medical Care, AIDS Pharmaceutical Assistance (Local), Oral Health, Mental Health Services, Substance Abuse Services Outpatient, Medical Case Management, Health Insurance Premium & Cost Sharing Assistance and Early Intervention Services. The decision not to prioritize AIDS Drug Assistance Program (ADAP treatments) is a result of that service category's administration by the State of Virginia in addition to the services of Home Health Care, Home and Community-Based Health Services and Hospice Services, funded by other state and federal resources.

The 2012 Implementation Plan reflects prioritization of the four (4) medical core services; Outpatient/ Ambulatory Medical Care, Oral Health Care, Medical Case Management and AIDS pharmaceutical assistance/local drug reimbursement. The largest amounts of Part A funding are allocated in the Norfolk TGA to these four (4) core services with Outpatient/ Ambulatory Medical Care and Medical Case Management services continuing to be this TGA's highest priorities. Medical Case Management is a key access point to HIV Outpatient/ Ambulatory Medical Care and other support services. Access to medical case management services is most often synonymous with access to Outpatient/ Ambulatory Medical Care. This TGA has contracted with nine (9) medical case management agencies that provide access to services throughout the entire region. Outpatient/ Ambulatory Medical Care and Medical Case management is also coordinated with Outreach/Case Finding services in order to reach the populations who know their HIV status, but have not sought medical services or have dropped out of care. A new formalized referral protocol implemented in 2009 is successfully returning the 'erratically in care' to care and services. Oral Health is a service with chronic deficits in the TGA due to lack of adult Medicaid coverage. ADAP and local drug reimbursement assists with medications not on the state (Part B) ADAP formulary but essential to treat the multiple co-morbidities experienced by this population. Four (4) support services—Outreach and medical transportation, housing assistance and emergency financial assistance are prioritized.

The most disproportionately impacted population in the TGA continues to be African Americans. The Plan includes the goal to reduce the out of care proportion by 5% annually. As a result, the Plan has Outreach/Case Finding objectives targeting areas to locate and link hard-to-reach African American males and females who know their status and are not in care. In addition, EIS has been funded to ensure that Unaware are identified. These two services have been funded using both MAI and Formula dollars.

While Norfolk continues to experience the disproportionate impact of HIV, prevalence is also increasing in all other areas of the TGA and, in particular, Virginia Beach, Portsmouth and Newport News. To insure services where prevalence is increasing, the 2012 Plan continues to support outpatient/ ambulatory medical care providers throughout the TGA with medical case management readily available. Transportation is provided in urban and rural areas throughout the TGA to help PLWH access care. Funds were allocated for these services under formula dollars.

The six (6) special populations are African-Americans, Women of Color, MSM, IDU/Substance Abusers, Rural PLWHA and Youth ages 13-29 years. During the priority and allocation process the Planning Council listed directives for the Grantee to follow for each of the services prioritized in order to meet the needs of these populations. A continuing priority is maintaining the recently increased oral health and other services in the rural (Peninsula) area of the TGA and encouraging additional services providers, particularly transportation service providers. Targeted objectives are included in Core and Support Services to address the needs of each the TGA's severe need groups and emerging Youth populations. In particular, the Plan intends to increase the number of PLWHA who receive primary care through its outreach in non-traditional settings. The Plan supports primary care specifically targeting adolescents and other underserved populations. Mental Health and Substance Abuse funds will be used to address gaps in existing services so that clients have access to needed mental health care and substance abuse treatment, as high co-morbidity rates for each have been demonstrated in CAREWare, in recent needs assessments, and by provider experience. The Plan increased funding for transportation through van rides/drivers, bus vouchers and cabs.

The Plan focuses on *geographic parity* by assuring that HIV primary care is available in all areas, and by supporting transportation throughout the TGA to increase access to and retention in primary care and other medical services. The FY2012 Plan promotes geographical parity of HIV services through the Ryan White Part A service providers with multiple site locations throughout the region. This TGA has four (4) Outpatient/ Ambulatory Medical Care providers with multiple site locations providing services from Williamsburg to the north to Currituck County, North Carolina to the south. The quality and comprehensiveness of services is monitored through the Quality Management Program that utilize the Norfolk TGA approved Standards of Care as their guidelines. Cultural appropriateness is ensured through several objectives at the Grantee level. The competitive processes to award service contracts always require potential vendors to demonstrate the ability to provide services in a culturally appropriate manner. All Ryan White Part A service providers must adhere to the established and approved Cultural Competency Standards. The Grantee has also hosted a mandatory Cultural Competency Technical Assistance workshop each fiscal year to insure understanding and compliance of service providers.

The 2012 Plan continues to address *quality of care*. All PLWHA served with Ryan White funds are to receive primary care services that are consistent with generally accepted standards as set forth by USPHS/IDSA Guidelines, including the use of antiretroviral agents. PLWHA are to receive medical case management services that are consistent with the recently adopted Standards of Service for Medical Case Management in Virginia. Mental Health, Substance Abuse, and Oral Health Care services are to be provided in accordance with generally accepted treatment.

The major issue with HIV related services is AIDS Drug Assistance Program (ADAP). In FY 2011, the Norfolk TGA gave \$180,000 to help support HIV medications for the clients serviced in the TGA. No funds were allocated for FY 2012, but the TGA has reserved the right to support ADAP at the end of the Fiscal Year.

Presently, there are no known reductions in HIV related clinical and non-clinical services, as a result of municipal and/or state budget cuts, though Virginia is among the state's experiencing budget shortfalls of over 8% or the 2010/2011 state budget years.

C. Description of Need

In order to inform the 2012 services planning and resource allocation process, the Greater Hampton Roads HIV Health Services Planning Council commissioned three needs assessment studies in 2011:

- 1) An "In Care" PLWHA survey study to ascertain the emerging service needs, uses, barriers and gaps for the 2011 population of PLWH/A in Ryan White funded services;
- 2) A "Newly Diagnosed/New to Care" PLWH/A study of those individuals who had recently been diagnosed and entered care and services within the past year; and
- 3) An "Out of Care" survey study of those PLWH/A who have been out of care for one year or longer or who have never entered care and services, to ascertain the emerging service needs, gaps and barriers for the 2011 population of PLWH/A with unmet need.

The objective of the comprehensive 'In Care' Needs Assessment Study was to identify the extent and types of service Uses, Needs, Gaps and Barriers among PLWH/A participating in Ryan White funded services in the Norfolk TGA service area. The survey process was designed to target as high a level of participation as possible among the severe needs groups (N=227). The actual participation rate for 'In Care' survey respondents was 229 participants in the 2011 Needs Assessment process (101% of goal). Survey sources evidenced a balanced representation among Primary Medical Care and Medical Case Management providers.

The objective of the comprehensive 'Newly Diagnosed' Needs Assessment Study was to identify the demographics and characteristics of the Newly Diagnosed/New to Care PLWH/A, including their prevention and service needs and perceived barriers to testing and care, which may help the TGA to increase engagement with and retention in care while reducing the fractions of unmet need and Unaware in the service delivery area, and meet the HRSA EIIHA mandate. All AOMC clients who had entered care over the previous year were offered the opportunity to participate in the survey process. A total of 45 PLWH/A participated in the 2011 Newly Diagnosed survey process (102% of goal).

The objective of the 'Out of Care' Needs Assessment study was to better understand the evolving service Needs, Gaps and Barriers among OOC PLWH/A in the Norfolk TGA service area. A total of 42 PLWH/A with unmet need participated in the 2011 Out of Care survey process (42% of goal).

The Top 12 Ranking Service Needs of the 2011 Norfolk TGA 'In Care' survey respondent group:

- 1) Medication Assistance
- 2) Ambulatory Outpatient Medical Care
- 3) Housing Assistance
- 4) Nutrition Assistance
- 5) Mental Health/Support Groups
- 6) Medical Transportation
- 7) Other: Employment/Job Assistance
- 8) Health Insurance/Premium Assistance
- 9) Emergency Financial Assistance
- 10) Medical Case Management
- 11) Oral Health Care &
- 12) Substance Abuse Services

The Newly Diagnosed Respondents ranged in age from 18 to 50 years of age with the average age reported as 28 years. By gender, 44% of the New to Care are males; 53% females; and 3% Transgender. The vast majority are African American (87%) with 13% reporting their race/ethnicity as Caucasian. Over 1/3 report their

transmission risk mode as MSM (36%); 52% report Heterosexual sex; and 7% report IDU. The majority report a diagnosis of HIV only/not AIDS, with 14% reporting the receipt of an AIDS diagnosis.

The Top 10 Ranking Service Needs of the 2011 Norfolk TGA 'Newly Diagnosed' survey respondent group include:

- 1) OAMC
- 2) Medication Assistance
- 3) Housing Assistance
- 4) Health Education/Peer Educator
- 5) Mental Health/Support Groups tied with Nutrition Assistance
- 6) Medical Transportation tied with HIV Prevention/Condoms
- 7) Other: Employment Assistance
- 8) Health Insurance Assistance
- 9) Emergency Financial Assistance
- 10) Medical Case Management tied with Substance Abuse Services-Outpatient

The major reasons supplied by the OOC respondents to explain their absence from medical care include: "Am undetectable"; "Don't need it because I am not sick"; "I get anxious about going"; "I feel better than I did"; while less frequently reported reasons include: lack transportation, can't afford it and don't know where to go for medical care. Several of these reasons that keep PLWH/A from medical care would appear to be positively impacted through better HIV education of the benefits of regular care and treatment.

Assessment of Emerging Populations with Special Needs

1. African Americans

Unique Challenges: The largest group in terms of AIDS incidence and prevalence, this group is highly interconnected with the MSM special population. An increasingly impacted community, due to bisexual practice and failure to disclose to heterosexual partners, are African American women. MSM-Blacks represent the highest HIV-epidemic among all identified special populations in the Norfolk TGA, especially younger MSM-blacks. Qualitative needs assessment and focus group data (collected annually from 2005 through 2008) demonstrate that this population experiences a significant degree of poverty, social stigma, familial isolation, homelessness, and cultural and religious barriers. In addition, surveys from the same focus group study indicate that 57% of MSM-black participants reported having "dropped out of outpatient/ ambulatory medical care" during the duration of their disease.

As of December 31, 2010, African Americans comprise 72% of HIV prevalence, 67% of AIDS prevalence, 76% of HIV incidence and 74% of all AIDS incidence in the Norfolk TGA. In 2010, 18% of all African American PLWHA had unmet need (*2010 Unmet Need Estimate*), and comprise 70% or 1,244 of the 1,777 HIV unaware in the TGA. (*Unaware Estimate, Norfolk TGA*).

2. Men who have Sex with Men

Unique Challenges: MSM constitute the largest exposure group, with a majority presence of Black MSM. Issues with non-disclosure, presenting late to care and bisexual transmission affect this special needs group. Epidemiologically, when 'any' MSM are considered, MSM & MSM/IDU comprise 47% of AIDS prevalence; 39% of HIV prevalence; 44% of HIV incidence; and 31% of AIDS prevalence. MSM-Whites report a consistent decline in HIV-infection in the Norfolk TGA compared to MSM-African Americans. Education, income, and presence of supportive social networks are among the variables that positively affect the outcomes of this population. However, when controlled for age, substance use, homelessness and mental health, the needs of this population increase, exponentially. Data from the 2005 and 2008 Needs Assessments indicated that active substance use, mental health issues, homelessness and young age positively correlate with increased acuity within the MSM population. Not only do these conditions impact on the physical health of the individual, but they also increase the propensity to engage in high-risk behaviors. The cost of providing care to this population

is heavily contingent upon the availability of mental health and substance abuse services to meet the co-morbid conditions.

3. Women of Color

Unique Challenges. This special group of PLWHA is primarily composed of African American (non-Latino) women of childbearing years. The epidemic of HIV-disease in the Norfolk TGA evidences a disparate increase in cases among women of color. Of the 3,235 newly diagnosed HIV/AIDS cases in Virginia between 2008 and 2009, 76 percent were African American and 26 percent were women. African American women are 20 times more likely to be diagnosed with HIV/AIDS than white women in Virginia. (VDH, 2010) In 2009, women represented 32.7% of new AIDS cases; 23.9% of new HIV cases; over 27% of AIDS prevalence and over 29% of HIV (not-AIDS). Determinants identified in the TGA which significantly impact the HIV-disease epidemic among women are: 1) lack of self-efficacy with negotiating condom use; 2) unknowingly becoming infected during a marriage or long-term relationship with an infected male partner; 3) commercial sex behaviors; 4) history of injection drug use; 5) history of multiple sex partners; and, 6) lack of prevention education.

4. Substance Users/Injection Drug Users

Unique Challenges: IDU currently comprise 6% of new AIDS cases, 3% of new HIV cases, 14% of PLWA and 9% of PLWH. When the total IDU risk is considered (combining IDU and MSM/IDU), the total proportion attributable to IDU increases to over 18% among PLWA and increases to over 11% among PLWH. Even larger is the issue is non-injection substance abuse with estimates of 44% PLWHA who are actively using illicit substances (2008 TGA Needs Assessment). Unique challenges of providing services to this population are the high propensity for non-adherence to medical treatment; and the reluctance (or inability) to abstain from substance use. Survey results from IDU who participated in the OOC NA study indicated that 75% of IDU/SA had dropped out of care. When asked the “reasons for dropping out of care”, results analyzed from focus group transcripts indicated that the most common reason was active substance use. The Norfolk TGA used these findings to improve outreach-case finding and services among IDU.

5. Rural PLWHA

Unique Challenges: The total population of the rural areas is approximately 317,467 with an estimated 347 People Living With HIV/AIDS (based upon an analysis performed in 2007). This equates to a 109.3 HIV/AIDS case rate compared to the urban areas with an overall population of 1,322,845; 4,897 PLWHA and a case rate of 370.2. While it is not a surprise that the urban case rate is over three times that of rural areas, key non-metropolitan localities (i.e. Newport News, Portsmouth, and Chesapeake) exceed the Virginia and U.S. PLWHA case rates. Though improving, this is an issue of concern since transportation is such a barrier in the TGA. Outpatient/ Ambulatory Medical Care services are now offered in a branch setting located in Williamsburg, and efforts have been successful in enhancing locally-based services, inclusive of medical case management, oral health care and outreach services. The delivery of oral health services on the Peninsula is greatly equalizing geographic parity.

6. Youth

Unique Challenges: The emerging population of Youth, ages 13-29 years: Youth, ages 13-29 years comprised 49% of the emergent HIV infection reported in 2007-2008, and comprise growing numbers of PLWHA. In 2009, Youth ages 13 to 19 years comprised 6% of AIDS incidence; 9% of HIV incidence; 7% of HIV prevalence; and 4% of AIDS prevalence. Youth represented only 6.45% of all Part A clients and 7.42% of all Part A funded Outpatient/Ambulatory Medical Care services in 2008, **but in 2009 the number of Youth ages 13-24 years increased 29%, increasing access from 77 to 99.** If ‘behaviorally infected’ (the majority), the ‘adult-only’ Ryan White Part A providers now serve persons that are younger than 18; removing barriers to care for this population.

D. Description of Priorities for Allocation of Funds

Epidemiological and demographic data from VDH and the TGA were reviewed to determine trends in the epidemic, predict future needs and identify populations that are disproportionately affected. During the PSRA

workshop, the Planning Council met and reviewed four data sets to determine the TGA's 2012 Service Priorities. The data sets were:

- 1) 2011 In Care Needs Assessment
- 2) 2011 Out of Care Needs Assessment
- 3) 2011 Newly Diagnosed Needs Assessment
- 4) 2010 Service Utilization data from the Ryan White Office

Each data set was weighted based on the committee's input to the relevance of the data source.

For the TGA's 2012 Resource Allocation determination, several data sources were used including: 1) Unduplicated client count by service category for 2008, 2009 and 2010; 2) 2010 Cost per client by service category; 3) Units of service for 2010; and 4) 2010 Allocated amount by service category. The purpose of reviewing year-over-data was to provide the Planning Council with trending data to show increases or decreases in the cost of care for each service category. The average cost per client for 2010 was one component used to determine the 2012 Resource Allocation. The second criterion was the anticipated number of clients to be served by each prioritized service category based on the following four components:

1. the current number of clients in care (**Maintain**)
2. the expected increase of new clients entering the TGA's continuum of care based on the TGA's epidemiological profile and (**Anticipated Increase**)
3. the goal of bringing 5% Out of Care PLWH/A into care (**out of care into care**)
4. the goal of identifying 5% Unaware PLWHA and linking them to care (**EIIHA**)

Service utilization data, provided by the Ryan White Office is used to help determine the TGA's 2012 Service Priorities. *Needs Assessment* data is used to identify particular gaps and barriers for emerging populations in order to reduce health disparities. The *unmet need calculation* enables the Planning Council to estimate the number of persons who need to be brought into care in order to increase access to core services and reduce disparities in access. The *Unaware Estimate* enables the Planning Council to estimate the number of people to identify, inform, link and refer to appropriate medical care. Listed below are the Norfolk TGA's 2012 prioritized service categories:

SERVICE CATEGORY	FY 2012 RANKING
Outpatient/ Ambulatory Medical Care	1
Medical Case Management	2
Medical Transportation	3
Outreach	4
Housing Assistance	5
Mental Health	6
Drug Reimbursement (local AIDS Drug Assistance Program)	7
Early Intervention Services	8
Medication Co-Pay (Health Insurance Premium/ Cost Sharing Assistance)	9
Oral Health Care	10
AIDS Drug Assistance Program (ADAP)	11
Substance Abuse Services – Outpatient	12
Emergency Financial Assistance	13
<i>Medical Nutritional Therapy</i>	14
<i>Case Management (non-medical)</i>	15
<i>Health Education/ Risk Reduction</i>	16
<i>Legal Services</i>	17
<i>Psychosocial Support</i>	18
<i>Substance Abuse Services - Inpatient</i>	19

Capacity development needs

The maritime location of the Norfolk TGA and the distances included in its geographic service area make transportation a formidable challenge. Bridges, tunnels and a deficit in public transportation are significant barriers in serving a population with funds of a smaller TGA. The geography of the Norfolk TGA is a combination of peninsulas, land-bound regions and atypical land mass. The TGA's land mass is long and narrow encompassing approximately 75 miles from the northern locality (Gloucester) to the southern locality (Currituck, NC); 35 miles from the western point of the "South-Side Region" (Norfolk, Virginia Beach, Chesapeake, Suffolk, Isle of Wight) and 25 miles on the peninsula region (James City, Williamsburg, York, Newport News and Hampton) (*Norfolk Department of Planning and Community Development, 2006*). This atypical geography creates significant barriers to care and greatly impedes travel between the two regions. Currently, the primary mode of travel from one region to the next is via a system of bridges and tunnels, primarily by car. Information collected from focus group participants indicated that many PLWHA in the Norfolk TGA lack personal transportation; hence are unable to access needed HIV-related services located on the more populated South-side of the TGA. While transportation is provided in urban and rural areas throughout the TGA to help PLWH access care, more clients enter the system of care each year. Rural areas are most impacted by transportation service needs.

Oral Health is a service with chronic deficits in the TGA due to lack of adult Medicaid coverage.

Our Oral Health disparities probably mirror those of the non-HIV population.

Comment [RS2]: Add more "meat" to this capacity need

- B. **Delayed entry into HIV care and therefore delayed entry into Oral Health care. Clients often come into care late and require extensive work that may exceed the level of competency of current provider. The costs for outside referrals are exhaustive.**
- C. **Lack of education/concern about the importance of oral health prevention and maintenance. Clients may not see the connection between their HIV Health and Oral Health or it is simply not a priority until something is hurting.**
- D. **Providers have a high no-show rate for dental appointments.**
- E. **Lack of dental insurance coverage for adults. Medicaid requires prior approval and has low reimbursement rates.**
- F. **With regards to capacity development, on the individual level, more education may be needed. Provider level- continued education and updates maybe??? And lack of interest in participating in RW due to reimbursement rates and possibly stigma.**
- G. **Transportation to dental appointments should not be an issue but came up in the OOC needs assessment.**
- H. **Clients with dental coverage that are under 300% of FPL may not be able to afford co-pays.**

For those in care and employed, can't loose income for multiple appointments.

E. Description of Gaps in Care

Needs Assessment studies for In Care (n=229), Out of Care (n=42), and Newly Diagnosed (n=45) were conducted in 2011 using a consultant commissioned by the Ryan White Part A Office. Overall, when compared to the 2008 Needs Assessment findings, there is greater reported need for Employment Assistance (perhaps related to recent economic challenges) and Housing Assistance is identified by the In Care, New to Care and Out of Care as the #1 ranking service Gap.

The Top 10 Ranking *Service Gaps* of the 2011 Norfolk TGA survey respondent group include: 1) Coordination of Benefits with Veterans Administration/ Department of Defense), Youth-oriented services, GYN/Medical Specialty Care; 2) Housing Assistance; 3) Medical Transportation; 4) Emergency Financial Assistance; 5) Oral Health Care; 6) Nutrition Assistance; 7) Financial Assistance/Health Insurance; 8) Legal Assistance; 9) Substance Abuse services; and 10) Mental Health services. The top 10 ranking Service Gaps are thematic of care coordination deficiencies (involving coordination of benefits for the large military population, and coordinating access to housing, transportation and emergency financial assistance); and possible funding deficits (involving oral health services); and represent a perceived need to examine the service delivery system so that it may be more appealing to youth.

Service Gaps among Emerging Populations

The top five ranking **Service Gaps** for African American PLWHA include: 1) Housing Assistance; 2) Medical Transportation; 3) Medications; 4) Insurance Assistance; and 5) Mental Health/Support Groups.. ***African American reported reasons for these Service GAPS include:*** “Can’t afford”; “no insurance”; “funding cuts”; “hard to get people to help you”; “need more counselors”; “don’t qualify”; “income too high”; “no access”; “no car”; “no information about services”; “not sure what is available”; “pre-existing condition”; “don’t know where to go or what to do”; “services not covered by RW”; “no transportation”; “social security not yet approved so is hard to get further help”.

The top five ranking **Service Gaps** for MSM PLWHA include: 1) Housing Assistance 2) Medications; 3) Oral Health Care; 4) Insurance Assistance; and 5) Other employment assistance tied with Disability Assistance tied with Medical Transportation tied with Specialty Care. ***MSM Service GAP reasons include:*** “No income as a student to qualify for assistance”; “No housing”; “No medical insurance”; “Not enough government programs”; “I do not qualify”; “State does not have the money”; “Lack of funding”; “Income too high”; “No money”; “Lab values are good”.

Housing Assistance is cited as the #1 top ranking Service Gap by Women of Color. The next highest Service Gaps included: 2) Insurance Assistance; 3) Medications tied with Mental Health/Support Groups; 4) Other: Employment Assistance tied with Specialty Care services tied with EFA tied with Vision Care; 5) Nutrition Assistance tied with Medical Transportation; and 6) Other: Disability Assistance tied with Oral Health Care. ***Women’s Service GAP reasons include:*** “Lack of money”; “No insurance”; “Need more counselors”; “No job”; “No transportation”; “Not eligible for Medicaid”; “Not sure what is available”; “Insurance refusal”.

The top ranking **Service Gaps** for SA/IDU include: 1) Oral Health Care tied with EFA tied with Other Vision care; 2) Housing Assistance tied with Medical Transportation tied with Nutrition Assistance tied with Mental Health/Support Groups; 3) Other Disability Assistance tied with Insurance Assistance tied with Other General Medical and Specialty Services. ***SA/IDU Service GAP Reasons include:*** “Hard to get people to help you”; “I have no medical insurance”; “Lack of funds”; “No money”; “Not approved”; “No transportation”; “Services not covered by RW CARE Act”; “My SS benefits haven’t been approved, which makes it harder to obtain further assistance”.

The top ranking **Service Gaps** for Rural PLWHA (all ranked as #1) include: 1) Medications tied with Oral Health care tied with Insurance Assistance tied with Employment Assistance. ***The Rural PLWH/A Service GAP reasons include:*** “Was told I did not qualify”; “No funding”; “Ask the person who handles ADAP”.

Youth represent a newly emerging special population of significance in the Norfolk TGA, which has not previously been targeted for a comprehensive assessment of need. Strictly speaking, the local epidemiologic data supports Youth, ages 13-19 years, and Youth, ages 20-24 years as important populations in the Norfolk TGA.

The epidemiologic data and local wisdom both support the fact that older youth/young adults ages 25-39 were most likely infected at a younger age. In order to ensure the widest and most accurate representation of the relative needs, uses, gaps and barriers experienced by infected youth, the following age groups were delineated for inclusion in the 2011 comprehensive needs assessment study:

SUB-POPULATIONS OF YOUTH RESPONDENTS

Birth Range	AGE	TERM	# Study Participants
1999-2011	0-12	Child	0
1998-1992	13-19	Adolescent	3
1991-1987	20-24	Young Adult	26
			29
1986-1982	25-29	Recent Youth	17
			46

The number one ranking Service Gaps expressed by Young PLWH/A includes Medications tied with Housing Assistance; followed by: 2) Health Insurance Assistance; 3) Nutrition Assistance; 4) Oral Health Care tied with AOMC tied with Other: Disability Assistance; 5) Other: Employment Assistance tied with Vision Care. **Youth Gap reasons include:** “I don’t know, but they are hard to get”; “I have no income as a student to qualify for assistance with food in order to eat healthfully”; “I was told I don’t qualify”; “No access”; “No money”; “No insurance”; “Not accepted”; “No job”; “Not enough government programs”.

F. Description of Prevention and Service Needs

HIV prevention needs as defined by the Community Population Group (CPG) plan developed by the Virginia Department of Health (‘VDH’) include: 1) PLWHA (secondary prevention); 2) African Americans; 3) Men who have sex with men (MSM); 4) High Risk Heterosexuals; 5) Transgenders; 6) Injection Drug Users; 7) Homeless; 8) Incarcerated; 9) Youth; and 10) Latino/a. Major unmet needs include 1) Care and prevention for newly diagnosed; 2) Program (care and prevention) in rural areas of Virginia; and 3) Assistance and coaching around disclosure of HIV status with sex or drug-using partners.

The Norfolk TGA recognizes the unique needs of the special populations and is committed to address these disparities via targeted outreach/case finding methods, collaboration with Ryan White Part B providers, and area prevention providers to establish linkages to care for individuals newly diagnosed; and increasing collaboration with entities that serve as front-line portals to care outside of the Ryan White Part A care system (e.g. homeless shelters, substance abuse treatment centers, correctional facilities, etc.) The TGA maintains outreach and case management services specifically directed to the Incarcerated/Recently Released population. Additionally, the Greater Hampton Roads HIV Health Services Planning Council is working collaboratively with the Virginia Community Planning Group to identify those newly diagnosed via prevention agencies.

Specific discussion of the roles of Ryan White Part A Early Intervention Services and Outpatient/Ambulatory Medical Care providers are in progress with regard to identifying and informing individuals versus HIV testing and counseling funded agencies, especially if these are separate providers. A protocol has been developed for Partner Notification (‘VERT’) and for data recording with HIV surveillance, with increased need for surveillance and outreach services. Further protocols have been developed to link (ensure clients attend their Primary Medical Care appointments) for Ryan White Part A vs. Ryan White Part B HIV Counseling and Testing funded providers. RW Part A’s protocol with HIV prevention/disease control cedes responsibility in the

TGA to Part A to link newly diagnosed to Primary Medical Care, with roles for HIV surveillance in providing first viral load lab test and for VERT (Partner Notification) to case-find positive results.

G. Description of Barriers to Care

Coordination occurs with CTR (Counseling, Testing & Referral) services of the Virginia Department of Health for routine HIV testing. In addition, the EIS agencies collaborate with VERT (Virginia Emergency Response Team), the Partner Notification division of the Virginia Department of Health. EIS counselors refer HIV positive individuals to their VDH or CDC HIV prevention funded entities to conduct pre and post-test counseling. Referral for HIV positive to care and Linkage happens by the EIS Counselor with referral for HIV negative individual to appropriate services also enabled by the EIS Counselor.

The role of Early Intervention Services (EIS) is to provide a comprehensive HIV testing and outreach/case finding approach in collaboration with HIV prevention and testing agencies in the Norfolk TGA. Two of the three agencies contracted to provide EIS are funded by the Virginia Department of Health with CDC funds and one agency is directly contracted by CDC.

The approach regarding HIV testing is to collaborate with HIV testing entities and/or provide HIV testing through certified testers that are directly funded by CDC. Testing will occur using a mobile or roving EIS counseling team that conducts rapid HIV testing on demand at partner sites and in the community. Partnerships have been formed with clinical providers and also with the Virginia Department of Health's Partner Notification program or Virginia Emergency Response Team (VERT). Syphilis testing has been incorporated into some community screening, targeted to MSMs. Other diagnostic testing may be provided, such as cholesterol or glucose screening, with discussion of the possibility of offering other general health preventive screenings (mammograms) to both reduce the stigma of HIV testing and help reduce disparities for the other target group, black heterosexual females.

The system-level barrier representing the biggest challenge is reimbursement for the cost of rapid HIV testing kits. The TGA-specific barrier that the EIS agencies have faced is the ability to transport clients given the logistics of the TGA geography. Agencies have used a mobile van to circumvent this barrier. The mobile testing unit operates daytime, evening and weekend hours.

No specific laws exist that present legal barriers in the Norfolk TGA or Commonwealth of Virginia. The major logistical barrier is funding for the rapid HIV tests.

Client related barriers were assessed during the 2011 Needs Assessment survey. The following Service Barriers are listed by 'In Care', 'Newly Diagnosed', and 'Out of Care' respondent groups:

The Top 12 Ranking Service Barriers of the 2011 Norfolk TGA 'In Care' survey respondent group:

- 1) Housing Assistance
- 2) Medication Assistance
- 3) Medical Transportation
- 4) Health Insurance/Premium Assistance
- 5) Nutrition Assistance
- 6) Mental Health/Support Groups
- 7) Oral Health Care
- 8) Emergency Financial Assistance
- 9) AOMC
- 10) Other: Disability Assistance
- 11) Other: Help with Medical/MH Co-Pays
- 12) Other: Vision Care tied with Employment Assistance

The Top Ranking Service Barriers of the 2011 Norfolk TGA 'Newly Diagnosed' survey respondent group include:

- 1) Medication Assistance
- 2) Oral Health Care
- 3) Housing Assistance
- 4) Other: Vision Care tied with Disability Assistance
- 5) Mental Health/Support Groups tied with Medical Transportation tied with Health Insurance Assistance
- 6) Nutrition Assistance tied with Medical Case Management tied with "Knowing where to go/what to do"

When asked why PLWH/A do not get medical care for their HIV disease, the majority of the **Out of Care (OOC)** respondents reported "Worried that others will find out/fear of divulging their HIV status". The next most frequently cited reason is "Feel healthy", followed by drug use, lack of transportation, don't believe they are HIV positive, and can't afford it. Less frequently reported reasons include the lack of signs or symptoms of disease, get anxious going to doctors, don't care about getting treatment and don't want to take HIV medications. Transportation assistance, more outreach services and free medical care are the top services that this cohort of PLWH/A with unmet/under-met need for medical care report as prompts to their returning to care. Peer support, more information about the services available and how to access them, lower cost of medical care/medicines, housing assistance and assistance with financial concerns, and health insurance to pay for doctors and meds are the next most frequently reported prompters to seeking and remaining in primary medical care. The other prompters to return to care include reported by the OOC respondents include: substance abuse treatment, advice from trusted referral sources, a case manager, shorter appointment wait times, more government services, employment opportunities and better trained doctors and nurses.

H. Evaluation of 2009-2011 Comprehensive Plan

The Planning Council evaluated and monitored the progress of the 2009 Comprehensive Goals listed below utilizing various methodologies to ensure outcome driven data could provide evidence of success or offer reason for perceived challenges of each goal. Service utilization data, Needs Assessment specifically conducted for 'Newly Diagnosed', 'Out of Care', and 'In Care' clients, client level data as reported in CAREWare, review and involvement in the planning initiatives at the State level, and a review of the activities for each objective were discussed with regard to the successes and challenges presented with each goal. As challenges were presented, activities and timelines were restructured with the goal of improved access to care, improved methodologies, and enhanced care models to effectively prove success within the service delivery area.

Short-term (annual) goals and objectives for care and treatment were identified by the Greater Hampton Roads HIV Health Services Planning Council, along with 35 activities as its action plan aimed at developing the ideal continuum of care in the Norfolk TGA. Below are the short-term goals, with specific objectives, the timeframes listed, person(s) responsible, and the outcomes for the previous three year plan:

1	Goal # 1: Improve Access to Health Care Services		
Objective 1.1: Increase access to care by 5% annually for each of the special PLWHA populations in the TGA. (Baseline: 2008 New & Returning Part A Clients)	Timeframe	Responsible Person(s)	Outcomes
Activity #1.1.1. Create and widely disseminate PLWHA Resource Guide to all points of entry, including C/T, outreach & other key providers & locations. Explore feasibility of establishing an on-line resource guide/referral process	Q 1-2, Update Annually	Community Access and Care Strategy Committees	Resource Guide at all points of entry; Update needs to be addressed
Activity #1.1.2. Update, produce and distribute Part A program promotional materials	Q 1-2	Community Access and Care Strategy	Completed with Part B

		Committees	partner
<i>Activity #1.1.3. Promote availability of Outreach/HIV counseling, testing & referral in urban and rural venues serving high risk individuals, coordinating efforts with MH/SA treatment facilities, ERS, homeless shelters, etc, in collaboration with CDC funded providers</i>	Q 1, 2, 3, 4	Grantee	Continued activities to promote services
<i>Activity #1.1.4. Encourage RW Part A PMC & MH/SA providers to implement 'opt out' HIV testing as an element of routine care for all patients</i>	Quarterly/ Annually	Grantee	In progress
<i>Activity #1.1.5. Support proposals and pilot innovative alternative models for engaging clients in care</i>	Bi-Annually	Grantee	Not completed
<i>Activity #1.1.6. Increase public awareness of HIV and available Part A services & reduce stigma by participating in public awareness & education campaigns and activities</i>	Ongoing	Grantee Community Access and Care Strategy Committees	In progress
Objective #1.2: Reduce lag time from testing to care by 10% annually to speed entry into care for all newly diagnosed PLWHA populations in the TGA. (Baseline: 2008 Delays in Months from testing to Care, by special population)	Timeframe	Responsible Person(s)	Outcomes
<i>Activity #1.2.1. Confirm 'Points of Entry' & Strengthen Testing/Counseling & Referrals to Care linkages; ensure follow-up tracking strategies are used in referral confirmation</i>	Q 1-2	Planning Council; Community Access and Care Strategy Committees	Completed
<i>Activity #1.2.2. Perform a 'late to care' consumer study to determine the special needs, barriers and gaps for persons entering care with concomitant HIV/AIDS diagnoses</i>	Q1-2	Grantee Planning Council	Completed
<i>Activity #1.2.3. Devise and implement innovative strategies to impact the late to care entry phenomenon by filling gaps and reducing known barriers to care.</i>	Q 4	Grantee Planning Council	Ongoing
<i>Activity #1.2.4. Explore best practice peer advocacy/support models to facilitate earlier care entry & enhance care engagement among underserved populations</i>	Q 1-2	Planning Council	Link closely with Eastern Virginia Region AIDS Resource Center and their Peer Educator Program, which trains consumers on how to be peer advocates and educators. Consumers are trained in motivational interviewing

			, treatment adherence and HIV care and prevention.
<i>Activity #1.2.5. Explore various client-centered models of care, & best practices from other EMAs/TGAs, with emphasis on increasing 'women-', 'youth-' and 'minority-friendly' care environments.</i>	Q 1-2	Planning Council	Completed
<i>Activity #1.2.6. Strengthen coordinated linkages with non- RW providers across the life span to facilitate mutual referrals and increased cross-collaborations.</i>	Q 2-3	Grantee	Distributed list of Ryan White Part A Providers and services as well as contact information to Norfolk and Chesapeake Department of Social Services, City of Chesapeake Community Services Board and Bon Secours Affiliated Private Practice.
2 Goal # 2: Reduce Health Care Disparities			
Objective #2.1: Reduce Level of Unmet Need in the TGA by at least 2-5% Annually. (Baseline: 2008 Unmet Need)	Timeframe	Responsible Person(s)	Outcomes
<i>Activity #2.1.1. Complete an updated Out of Care Study.</i>	Q 1-2	Grantee Planning Council	Completed
<i>Activity #2.1.2. Address OOC Service Gaps & Barriers.</i>	Q 3-4	Grantee Planning Council	In progress
<i>Activity #2.1.3. Continually assess demographic profile of Part A clients to assure that disproportionately affected subpopulations and historically underserved communities are accessing services.</i>	Quarterly, Ongoing	Grantee Planning Council	Ongoing activity
Objective #2.2: Jointly Address HIV Disease and Co-Morbidity Management among New and Returning Part A clients. (Baseline: Part A Clients assessed as needing MH/SA services compared with #with confirmed referrals for same)	Timeframe	Responsible Person(s)	Outcomes
<i>Activity #2.2.1. Identify and implement best practice CM & PMC models to jointly address MH & SA co-morbidities.</i>	Q 1-2	Grantee Planning Council	Ongoing activity
<i>Activity #2.2.2. Identify and engage potential providers for the provision of expanded inpatient and outpatient mental health &</i>	Q 2-3	Grantee Planning Council	Identified VA Beach Psychiatric Center as a

substance abuse treatment services.			<i>potential partner for the expansion of inpatient mental health and substance abuse services. However, at this time partnership would not be sustainable based on funding required to maintain the program.</i>
Objective #2.3: Ensure parity of urban/rural service delivery, including assurance of access to dental care services by Peninsula residents.	Timeframe	Responsible Person(s)	Outcomes
Activity # 2.3.1 Ensure access to core medical and key support services for rural residents through increased coordination of RW and non-RW service providers; increasing satellite services; and enhanced transportation assistance.	Q 2-3	Grantee Planning Council	Completed
Objective#2.4 Increase by 10% annually the number of Part A Clients retained in Primary Medical Care (Baseline: Proportion of 2007 Part A Clients retained in care in 2008)	Timeframe	Responsible Person(s)	Outcomes
Activity#2.4.1 Assess technical assistance and training needs of Part A providers and deliver TA to increase their capacity to effectively serve and retain in care the disproportionately affected and emerging populations	Ongoing	Grantee	Ongoing
Activity 2.4.2. Evaluate and Guide Provider usage of multiple strategies to positively impact PLWH/A retention in care.	Ongoing	Grantee	Ongoing
Objective 2.5 Reduce the further spread of HIV infection through enhanced primary & secondary prevention efforts in primary care settings	Timeframe	Responsible Person(s)	Outcomes
Activity #2.5.1. Assess the TA needs of providers and ensure each has the skills and resources to integrate effective and continuous risk assessments and risk reduction counseling services for Part A PLWHA clients and their sex and drug using partners	Ongoing	Grantee	Ongoing
Activity #2.5.2. Convene a meeting at least annually among all prevention and care providers in the TGA to develop and implement mutual goals and shared strategies for reducing new HIV cases.	Annually	Grantee	Convened a series of conference calls with EIS providers to

			discuss strategies for testing, referral, linkages and education. Education under EIS consists of empowering those who do not test positive but participate in high risk behavior as well as persons that test positive.
<i>Activity#2.5.3 Ensure 'Voice of the Consumer' in Planning Council representation and inclusion in program planning and evaluation activities.</i>	Ongoing	Planning Council Committees	Ongoing
3	Goal # : Improve the Quality of Services		
Objective #3.1:Strengthen Medical Case Management Care and Systems	Timeframe	Responsible Person(s)	Outcomes
<i>Activity #3.1.1.Complete SOC performance audits of MCM provider and implement CQI TA activities as indicated to address performance improvement issues</i>	Q 1-2-3	Grantee	Completed annually
Objective #3.2:Ensure Adequate Levels of Non- Medical Case Management Services to Support Access to & Retention in Care	Timeframe	Responsible Person(s)	Outcomes
<i>Activity #3.2.1.Conduct assessment of CM provider capacity and capability and use findings to inform system changes/improvements.</i>	Q 2-3	Grantee Planning Council	NMCM not funded in the TGA; current system is a MCM model with success
Objective #3.3:Implement and Evaluate System-wide Client Level Data Reporting	Timeframe	Responsible Person(s)	Outcomes
<i>Activity #3.3.1.Implement and monitor the system-wide strategy to collect, track and report HRSA client level data</i>	Q 1-4	Grantee	Completed; all providers use CAREWare; monitored by the Grantee
<i>Activity #3.3.2.Analyze results, refine strategies and evaluate first year client level data collection and reporting efforts for ways to continue to improve the process.</i>	Q-2-4	Grantee	Completed; ongoing strategies to enhance HAB measure outcomes

4	Goal # : Ensure Cost Effectiveness of Service Delivery		
Objective #4.1: Ensure Effective Utilization of Part A Funds to fill Service Gaps and Reduce Disparities in Care	Timeframe	Responsible Person(s)	Outcomes
Activity #4.1.1. Compile and assess all services funding streams in the TGA and encourage funds diversification to maximize utilization of Part A funds and sustainability & further expansion of continuum of care.	Annually	Grantee Planning Council	Completed during PSRA process annually
Activity #4.1.2. Evaluate core and support funding splits and evaluate costs for services across providers and service categories, utilizing findings to inform cost effectiveness considerations.	Annually	Grantee Planning Council	Completed during PSRA process annually
Activity #4.1.3. Review service utilization data to ensure appropriate allocation of funds and expenditure of funds with no carry-over.	Quarterly	Grantee Planning Council	Completed
Activity #4.1.4. Perform annual priority setting/resource allocation process based on multiple programmatic and fiscal data sets.	Annually	Services Planning Committee Planning Council	Completed
5	Goal # : Improve Health Outcomes		
Objective #5.1: Increase by 10% annually Part A achievement of improvements in key health outcome indicators, as evidenced by individual level client data and aggregate provider data (Baseline: 2008 QM results)	Timeframe	Responsible Person(s)	Outcomes
Activity #5.1.1. Continue Quality Management activities and the complete integration of HRSA/HAB clinical performance measures	Quarterly Annually	Grantee	Ongoing
Activity #5.1.2. Implement key CQI projects to address low scoring performance measures	Q 1-2	Grantee	Ongoing
Activity #5.1.3. Ensure quality of existing services through QM plan driven chart review audits and client satisfaction surveys.	Q 1, 2, 3, 4	Grantee	Ongoing
Activity #5.1.4. Utilize the new CAREWare system to generate client level health outcome indicator reports, disseminate findings, and use data to inform system improvements.	Bi-annually	Grantee	Ongoing

Goal 1. Improve Access to Health Care Services

The maritime location of the Norfolk TGA and the distances included in its geographic service area make transportation a formidable challenge. Bridges, tunnels and a deficit in public transportation are significant barriers in serving a population with funds of a smaller TGA. The geography of the Norfolk TGA is a combination of peninsulas, land-bound regions and atypical land mass. The TGA’s land mass is long and narrow encompassing approximately 75 miles from the northern locality (Gloucester) to the southern locality (Currituck, NC); 35 miles from the western point of the “South-Side Region” (Norfolk, Virginia Beach, Chesapeake, Suffolk, Isle of Wight) and 25 miles on the peninsula region (James City, Williamsburg, York, Newport News and Hampton) (*Norfolk Department of Planning and Community Development, 2006*). This atypical geography creates significant barriers to care and greatly impedes travel between the two regions. Currently, the primary mode of travel from one region to the next is via a system of bridges and tunnels, primarily by car. Information collected from focus group participants indicated that many PLWHA in the Norfolk TGA lack personal transportation; hence are unable to access needed HIV-related services located on the more populated South-side of the TGA. The two major providers of transportation services report a total of

eight vans and through mutual referrals and creative scheduling work to accommodate the many transportation requests hence improved access to care.

The Ryan White Office funds three agencies for Early Intervention Services with collaboration with CDC-funded entities to conduct HIV testing and counseling. Two of the three agencies are recipients of either state or direct CDC funds for this purpose. The role of the Ryan White Part A program is to facilitate collaboration with other funders (HIV prevention, testing, intervention and STI testing) and streamline an awareness process. The specific provider role of the Ryan White Part A program is to contract with, fund and link identified individuals to the HIV treatment and care services. Memorandums of Understanding are in place with non-Ryan White funded clinical providers that provide HIV medical care, ensuring clients in all regions of the TGA have access to medical care.

Goal 2. Reduce Health Disparities

HIV testing is the first point of contact for high-risk individuals entering the HIV care system. By identifying barriers to HIV awareness and/or care entry, the EIS agencies have actually reduced disparities to care access. EIS counselors make active referrals, facilitate entry at medical and other care providers; provide transportation to initial appointments and even accompany clients to their first appointment. Medications can be picked up and delivered to clients to increase adherence. The EIS counselor functions as a transitional case manager to address medical outcomes with collaboration with their permanent medical case manager. In addition, one of the 3 agencies offers comprehensive mental health services focused on newly diagnosed to reduce common reasons for non-entry or delay into HIV medical care such as shock, stigma, depression or emotional distress.

Goal 3. Improve the Quality of Services

The 2012 Implementation Plan continues to address *quality of care*. All PLWHA served with Ryan White funds are to receive primary care services that are consistent with generally accepted standards as set forth by USPHS/IDSA Guidelines, including the use of antiretroviral agents. PLWHA are to receive medical case management services that are consistent with the recently adopted Standards of Service for Medical Case Management in Virginia. Mental Health, Substance Abuse, and Oral Health Care services are to be provided in accordance with generally accepted treatment guidelines.

To improve and ensure optimal provider sensitivity and cultural competency, the Norfolk TGA implemented Standards of Care for Cultural Competency and at the Grantee level this is assured through the contracting process. The competitive process to award service contracts always requires potential vendors to demonstrate the ability to provide services in a culturally appropriate manner. The Grantee's office requires stipulated numbers of continuing education hours, delineated by provider-type, which includes cultural competency. This training/CE requirement is reported by providers in their quarterly reports and is assessed during annual contract monitoring visits with all Part A funded service providers

Goal 4. Ensure Cost Effectiveness of Service Delivery

A Service Usage Cost patterns table was used to assist the Planning Council in allocating funding to service categories. The chart compiles cost data regarding service categories, a definition of the service unit, and the number of individuals served in the past three years, by service category. The chart also details the average unit cost for each service, along with the average expenditure per client. Planning Council members reviewed this data in order to project the future year's costs. This information was essential in determining the additional funds needed to reach the PLWHA identified in the Unmet Need and Unaware Estimates. For example, the committee can project that each additional person in the Part A system will need approximately 3 units of ambulatory/outpatient medical care for a total of \$1,870 per year; 3 units of Oral Health yearly at a cost of \$666, etc., enabling them to forecast the funding required to serve more individuals in the Part A program.

Table 8 provides an example of the cost data used by the Planning Council during their annual PSRA process to evaluate core and support funding splits, as well as evaluate costs for services across providers and service categories, utilizing findings to inform cost effectiveness considerations.

SERVICE CATEGORY	UNDUPLICATED CLIENT COUNT			UNITS OF SERVICE	UNITS/ CLIENT	UNIT COST	COST/ CLIENT
	2008	2009	2010	2010	2010	2010	2010
Medical Transportation	576	509	535	7,774	15	\$42	\$616
Outpatient/ Ambulatory Medical Care	1,011	1,036	1,208	4,070	3	\$518	\$1,746
Housing Assistance	152	88	82	87	1	\$527	\$559
Medical Case Management	1,597	1,926	1,781	90,365	51	\$12	\$615

In addition to the PSRA process annually, the fiscal staff within the Grantee's office tracks the contracts and expenditures by provider and services on a monthly basis using a Microsoft Excel spreadsheet and reconciles these totals to the City's financial system. A monthly expenditure summary is prepared and reviewed by the Planning Council to redirect funds if required.

Goal 5. Improve Health Outcomes

The information from annual site visits and the data collected from client-level data, particularly the HIV/AIDS Bureau (HAB) performance measures are used to pinpoint where quality improvement opportunities exist. Upon identification, the Quality Management Coordinator responds with individual technical assistance, TGA-wide education and/or Plan-Do-Study-Act or quality improvement efforts.

The Quality Management activities presented outcomes showing success with each activity to improve health outcomes. Table 9 below shows the TGA's outcomes for FY 2009 and FY 2010 in comparison to the National Benchmark, where applicable, for the following HAB performance measures. As evidenced, all indicators were revealed remarkable improvement over annual trending.

TABLE 9. COMPARISON OF NORFOLK TGA TO HRSA/HAB PERFORMANCE MEASURES, 09 &10

HRSA/HAB Measure	National Benchmark	FY 2009	FY 2010*	IMPROVEMENT EFFORT & Change from Baseline
Tier 1: HIV Treatment				
1.1 Medical visit q six (6) months	No national measure	90%	96%	6% improvement
1.2 CD4 test q 3 months; min q 6 months	Top 10%: 2005= 88%	98%	98%	stable
1.3 PCP prophylaxis for CD4<200	Median: 2005=94%	89%	100%	11% improvement to date, evidencing full compliance
1.4 Clients prescribed HAART	Median: 2005=95.7%	98%	100%	Strive to maintain a 100% rating—
1.5 Pregnant women on ARV	No national measure	90%	100%	Full compliance
Tier 2: Morbidity				
2.1 % women w/ pap smears q 12 months	Top 25%: 2005=87%	85%	92%	7% improvement to date
2.2 TB screening since HIV diagnosis	Top 10%: 2005=88.8%	89%	94%	5% improvement in placement & reading
2.3 Syphilis test every 12 months	Median: 2005=86.3%	62%	100%	Yearly screening, documented on flow sheet.
2.4 Hepatitis C screen initially, and then repeated among high risk annually	IHI goal=95% 2005=96.7%	78%	96%	Initial/Yearly screening; documented on flow sheet.
2.5 Adherence counseling q 6 months for pts on ARV Therapy	Median: 2005=60.8%	30%	98%	Assessments q visit with documentation & referral
2.6 Lipid screen every 12 months	Median:	87%	96%	Yearly screening

for patients on ARV Therapy	2005=85%			documented on flow sheet.
2.7 Initiated/Completed Hepatitis B vaccination series	45% in 2004 (CDC)	38%	90%	Assign staff member to monitor.
2.8 HIV Risk Reduction counseling every year	No national measure	47%	100%	Yearly & ideally q 6 months; documented on flow sheet.
2.9 Oral exam every 12 months, with annual referrals as indicated	Median: 2005=36.0%	5%	98%/58%	Joint MCM /PMC/Dental provider referral tracking

Long-Term Goals and Objectives (Over 3-year period: FY2009-2011)

Comment [RS3]: Using data elements from Part A grant app where applicable, still need feedback from NA and PC chairs.

STRATEGIES/ACTIVITIES	Timetable			Outcome
	FY '09	FY '10	FY '11	
I. INCREASE ACCESS TO CARE				
A. Increase Access to Care by 5% Annually Among Special Populations in the TGA				If looking for a number, can look at the end of the year service utilization data by race and sexual orientation for FY 08, 09 and 10. FY11 data is not available yet.
African Americans	1561	1653	1708	
MSM	822	887	958	
Women of Color			578	
Rural PLWHA			189	
Youth (13 – 24)	163	181		
Conduct community-wide services and funding Inventory & Develop/Distribute Consumer Resource Guide	■			Completed
Promote availability of outreach & HIV testing/counseling in urban/rural venues targeting high risk & aware/not in care	■	■	■	Completed under funded EIS and MAI Outreach programs. Brought over 130 clients back into care each year through Outreach

Comment [RS4]: Can we pull this data from CAREWare for Women of Color and Rural PLWHA?

STRATEGIES/ACTIVITIES	Timetable			Outcome
				from 3/09 – 2/11 and <i>located 33 newly diagnosed</i> through EIS from 3/10 to 2/12.
Encourage & support PMC & other core medical providers to implement 'opt out' HIV testing		■	■	In progress
Explore and Support Proposals/pilot innovative strategies to increase client engagement in care	■	■	■	Ongoing
B. Reduce Lag Time from Testing to Care by 10% Annually for all Newly Diagnosed in TGA				
Confirm 'points of entry' and strengthen Testing/counseling to Care linkages	■	■	■	Completed
Perform 'Late to Care' Needs Assessment Study to determine and strategically impact the special needs, gaps and barriers for persons entering care 'late' (concurrent AIDS/ diagnosis within 6 months of HIV diagnosis)	■	■		Completed
Explore best practices and pilot innovative models of care that encourage earlier entry and retention in care for youth, men, women and minorities.	■	■		Completed
Strengthen coordinated linkages with non-RW providers of services across the lifespan to increase mutual referrals and care sources	■	■	■	Completed
II. REDUCE HEALTH CARE DISPARITIES				
A. Reduce Level of Unmet Need by at least 2-5% Annually	2016	3683	2016	
<ul style="list-style-type: none"> Conduct 'Out of Care' study, analyze findings and use priority setting process to implement changes in Service Delivery System 	■	■		Completed
<ul style="list-style-type: none"> Continuously assess demographic profile of Part A clients to assure that disproportionately impacted and historically underserved are accessing services 	■	■	■	Ongoing. Slight increase in Transgender utilization, from <i>38 in FY09-10 to 44 in FY 10-11.</i>
B. Jointly Address HIV Disease and Co-Morbidity Management among new and Returning Clients				
Conduct study of best MCM/CM & PMC practices to jointly address MH and SA needs among Part A clients, and pilot test strategies	■	■		In Progress

STRATEGIES/ACTIVITIES	Timetable			Outcome
Identify and engage potential providers for the provision of expanded outpatient and inpatient MH & SA services	■	■	■	Completed
C. Ensure Parity of Urban/Rural Service Delivery, including Assurance of Oral Health services for Peninsula Residents				
Increase collaboration and coordination of RW and non-RW providers, increase satellite sites and expand transportation assistance to create more parity between urban/rural care resources	■	■	■	Completed
D. Increase by 10% Annually the number of Part A Clients Retained in Primary Medical Care	2003	2145	2335	
Refine coordination & linkage of Outreach, Case Management and Primary Medical Care	■	■	■	Completed. Worked with OR and EIS to coordinate an active handoff to MCM and PMC. Ensured that predetermined time rame for transitionin g clients was established.
Evaluate and implement numerous strategies to positively impact PLWHA retention in care	■	■	■	Completed
E. Reduce the Further Spread of HIV Disease through Enhanced primary & Secondary Prevention Linkages and Programs				
Assess and address TA needs of providers to ensure competency in performing serial risk assessments and providing risk reduction education and counseling for PLWHA and their sex and drug using partners	■	■		Completed. Providers attended training at the AIDS resource center and VDH.
Convene annual meetings of prevention and care providers to develop and implement mutual goals and shared strategies for reducing new HIV infections	■	■	■	Completed
III. Improve Quality of Services				
A. Strengthen & Refine Medical Case Management as core service				
Complete SoC performance audits of MCM providers and implement CQI TA activities to address performance improvement issues	■	■	■	Completed

Comment [RS5]: Need active clients for 2011

STRATEGIES/ACTIVITIES	Timetable			Outcome
B. Ensure Adequate levels of Non-Medical Case Managers to support Access and Retention in Care				
Conduct assessment of CM provider capacity and use findings to inform the system changes/improvements	■	■	■	Completed
C. Implement and Evaluate System-Wide Client Level Data Reporting				
Implement, evaluate and refine client level data reporting system and provide TA and guidance as indicated.	■	■	■	Completed
IV. ENSURE COST EFFECTIVE SERVICE DELIVERY				
Assess the service delivery system				
Assess all funding streams, encourage funds diversification to maximize utilization of Part A funds and expand continuum of care.	■	■	■	Completed
Review split between core and support	■	■	■	Completed
Analyze accessibility/quality/utilization of core services in service delivery system	■	■	■	Completed
Conduct priority setting/resource allocation process	■	■	■	Completed
V. IMPROVE HEALTH OUTCOMES				
A. Increase by 10% Annually in Part A Provider Improvements in Key Health Outcome Indicators, as Evidenced by Client Level and Aggregate Provider Data Sets	QM	QM	QM	
Review/Refine Standards of care for each Part A funded service category, perform chart audits, and compare findings to HRSA performance expectations	■	■	■	Completed; Review HRSA QM outcomes
Implement annual CQM monitoring and correction plan	■	■	■	Completed
Utilize new CAREWare system to generate client level health outcomes indicator data, disseminate findings, and use the data to inform system improvements	■	■	■	Completed
Ensure Planning Council is consumer-driven and reflective of epidemic in TGA	■	■	■	In progress; 21% consumer based PC and reflective of epidemic
Develop strategy to receive input from consumer-based and local and regional groups	■	■	■	Completed
Utilize multiple sources of data for evaluation and planning	■	■	■	Completed

Although the Norfolk TGA had many successes evidenced in our 2009 Comprehensive Plan goals and objectives, challenges were presented in the review. Service gaps and barriers for the special populations still

need to be addressed within the TGA to ensure clients access care. The service gaps and barriers for the out of care population, based on the 2011 Needs Assessment results, indicate a need to further address this populations' access to and retention in medical care. Education, prevention and risk reduction efforts must be enhanced within our MSM population, noting an increase in AIDS cases over the three-year trended data. Mental health and substance abuse treatment services are resource needs that the TGA continues to face challenges with specific to provider capacity. De-stigmatization efforts need to continue to be enhanced to increase testing initiatives regarding the benefits to testing and earlier diagnosis. Increased efforts to engage the military community for partner notification, disclosure, and safer sex practices must be addressed by the TGA as this population's transient nature presents barriers to the Unaware population. Lastly, with reductions in funding, the largest challenge presented to the TGA for the next triennial period is providing more services to more clients with fewer dollars.

Section II. Where do we need to go?

Introduction to Section II: The purpose of this section is to provide an opportunity to discuss the Norfolk TGA's vision for an ideal, high quality, comprehensive continuum of care and the elements that will shape this ideal system. Understanding the challenges presented in the last triennial period, we begin this section with the plan to address those challenges. The 2012 proposed care goals, along with the TGA's goals to address the Aware but not in care (Unmet Need) and the Unaware (EIIHA) are presented in this section with proposed solutions in closing the gaps in care and addressing overlaps in care. Our proposed coordinating efforts to address the proposed goals with multiple programs within the community will conclude this section.

A. Plan to meet Challenges identified in Evaluation of Comprehensive Plan (2009-2011)

With the challenge of getting PLWHA into care and ensuring that they stay in care and adhere to their medical regimens, the TGA's continuum of care model (Figure 1 above) illustrates both medical care and the supportive services that help PLWHA to engage with and remain in care are at the core (center) of the model. The care circle is surrounded by services that facilitate or assist with access to medical and supportive services to ensure delivery of these medical and support services are coordinated and consistent in manner. This core of medical, supportive, and coordination services does not exist in a vacuum; it exists in the context of goals that promote access to all those living with HIV/AIDS in the TGA, ensuring that high quality services are provided in a cost-effective manner. The entire continuum of care results in improved health outcomes.

Three (3) tiers of the Continuum of Care exist, from Tier 1 (Ryan White Part A services, with the top four (4) core funded services of Outpatient HIV Primary Medical Care, Medical Case Management, Oral Health Services and AIDS Pharmaceutical Assistance (Local), and the two (2) highest ranked support services—transportation to medical care and outreach. Tier 2 indicates services delivered by other providers and Tier 3 displays services funded by sources other than Ryan White Part A. The core of the ideal continuum of care (provide medical and support services) has primary medical care, and case management, including medications and oral health care, at its center, and shows that medical care is supported by substance abuse treatment, mental-health treatment, and other medical and supportive services such as transportation and emergency financial assistance.

Primary medical care and case management are the two points of contact within the RW service system (Tier-1). PLWH/A who enter the RW service system via primary medical care, are referred to a case manager (if needed) to determine eligibility for RW services. Eligibility is established by RW case managers. Once eligibility is accessed, consumers are either referred to appropriate non-RW sources of medical care payment (e.g. Military affiliation, private insurance); or enrolled in RW primary medical care after all other sources for HIV-medical care are exhausted.

Referrals for RW non-medical ancillary services (e.g. transportation, emergency financial assistance) are confirmed by the RW case manager. Eligible consumers need not receive RW medical care in order to access

other services, although emphasis is placed on identifying a medical home and facilitating the consumer's engagement with primary medical care. The modified continuum of care seeks to incorporate additional ancillary service providers, expand upon public and private sources and non-RW entities to improve service delivery for people living with HIV-disease in the Norfolk TGA, and ensure equitable access to all core medical and key support services for urban and rural PLWH/A, throughout the TGA. Education, prevention and risk reduction counseling is offered at every venue and point of entry for all clients, whether testing for the first time or returning to care, with emphasis on disease management and de-stigmatization.

B. 2012 Proposed Care Goals

Seamless care is achieved by coordinating among funding sources. Ideal care also provides the greatest support to those with the greatest need. To stay on target and remain relevant, the ideal care continuum requires ongoing input from consumers. While Ryan White was never intended to provide all parts of the continuum of care, the Norfolk TGA partners (council, grantee, and administrative agent) strive continuously to coordinate with other programs and funding streams to build a system that maximizes all resources to meet the needs of PLWHA.

The 2012 proposed care goals of the Norfolk TGA are:

- Reduce the number of people who become infected with HIV
- Improve access to care.
- Improve health outcomes
- Eliminate health disparities.
- Improve the quality of health care.
- Assure cost-effectiveness.

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

A. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization.

The ideal continuum of HIV care reaches beyond merely meeting the needs of those who are HIV positive to build an environment where both the risks of contracting HIV and the stigma associated with being HIV positive are minimized. It does this by educating the community at large about HIV prevention and the medical and social consequences of the disease, as well as by promoting acceptance of, and caring for, those who are HIV positive and AIDS defined. Partnering with prevention programs, along with targeted Outreach programs, allows for HIV education and risk reduction messages to be distributed to all points of entry, testing sites, and other venues where at-risk populations receive health and social services. Universal screening, to include HIV testing, within routine medical visits and community wide initiatives educating the general public of the benefits to testing with disease de-stigmatization would ensure a reduction in HIV infection among all populations. Partner notification and HIV disclosure methods with an emphasis on education of safer sex practices would reduce new infections within the TGA. The measures of efficacy of this HRSA strategy include the decreasing number/percentage of the HIV-positive prevalence (including each of the special populations) and reductions in AIDS incidence within the TGA.

Goal 2: Improve Access to Care

A. Decrease top ranking service gaps for all special populations as indicated in the 2011 Needs Assessment within the TGA;

B. Decrease top ranking service barriers for all special populations as indicated in the 2011 Needs Assessment within the TGA;

C. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services;

D. Increase linkage to HIV care specifically to our Newly Diagnosed population.

An ideal, comprehensive care system ensures that geographical, economic, social, capacity, or infrastructure obstacles preventing PLWHA from accessing that system are minimized or eliminated. A variety of local collaborative strategies, along with targeted Outreach programs are designed to overcome barriers such as

PLWHA not knowing how or where to obtain care, or not knowing what services are available through Ryan White. Well trained and organized outreach staff also serve those who are at risk by addressing their concerns about stigma and other issues that may keep them from seeking care. Outreach is strongly linked to early intervention services, with the goal of facilitating earlier access to care and shortening the interval between testing and care entry. The measures of the efficacy of this HRSA strategy include the increasing number/percentage of the HIV-positive population (including each of the special populations) who are entering care, reductions in time from testing to care, and retention in care.

Goal 3: Improve Health Outcomes

A. Increase by 10% annually Part A achievement of improvements in key health outcome indicators, as evidenced by individual level client data and aggregate provider data.

This goal sums up the overall effectiveness of both the Ryan White Part A program, and the effectiveness of all partners who serve HIV-positive consumers in the planning area. Outcomes for the specific service categories are interim measures of effectiveness for the TGA. Outcome measures selected for measurement and reporting in the upcoming fiscal year include numerous indicators of importance to the men, women and youth to be served, including the number/percent of PLWHA on ART who achieve and maintain an undetectable viral load during the project year. Another outcome measure includes the decreasing number/percent of the client population that develop an AIDS diagnosis during the project year. The ultimate health outcome measure is a reduction in death rates.

Goal 4: Eliminate Health Disparities

A. Increase awareness among the MSM populations through education, prevention and risk reduction materials throughout the TGA;

B. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials throughout the TGA;

C. Address and reduce service barriers and gaps among the Out of Care population within the TGA;

D. Reduce Level of Unmet Need (Out of Care) in the TGA by at least 5.5% annually, with a minimum goal of 10% for three years;

E. Reduce Level of Unaware (EIIHA) in the TGA by at least 10% over the triennial period.

As of December 31, 2010, African Americans/Blacks comprise 74% of all AIDS Incidence; 67% of AIDS Prevalence; 76% of HIV Incidence; and 72% of HIV Prevalence. African Americans, and AA MSM in particular, evidence a high disproportionate impact and unacceptably high level of unmet need. Women of Color living with AIDS are underrepresented in care, particularly rural WOC. The Minority AIDS Initiative (MAI) non-traditional outreach program performs targeted outreach to the African-American communities in venues outside the existing HIV provider system. The Planning Council reviews these reports and other sources of information (such as needs assessments and information from the community), and issues directives aimed at eliminating health disparities.

Co-location and high level collaboration between providers to jointly manage PLWHA's HIV disease management and other co-morbidities facilitates successful engagement and retention in care for many among the underserved populations. Implementing best practice strategies which result in more 'youth-friendly', women-friendly' and 'minority-friendly' care environments encourages entry into and retention in care. The measures of the efficacy of this HRSA strategy include the increasing number/percentage of the underserved populations who are entering into and receiving care, combined with steady reductions in the level of unmet need among the special populations.

Goal 5: Improve the Quality of Health Care

A. Increase by 10% annually Part A achievement of improvement in key health outcomes indicators.

Higher-quality core medical and support services are more effective at interrupting the progression of HIV disease and in preventing/reducing complications of the disease while contributing to quality of life. The Planning Council establishes standards of care for each service category: structures and processes that providers are expected to adhere to if they wish to receive Part A funding. These standards often incorporate professional

practice standards for specific disciplines, such as published public health standards for providing primary medical care. The Continuous Quality Improvement Program monitors provider performance against standards of care and provides technical assistance as needed.

The Planning Council reviews the quality improvement service category reports, and considers consumer needs and category performance and history as well as other funding streams available to a category when making allocation and reprogramming decisions. The measure of the efficacy of this HRSA strategy is evidenced by: 1) the presence of quality management processes and standards of care for all Part A funded services; 2) compliance with public health standards and; 3) performance improvements in key indicators annually.

Goal 6: Assure Cost Effectiveness

Services purchased must provide the maximum possible impact for each dollar expended. The Planning Council and its committees review expenditure and service delivery reports to assess trends in utilization of funds, services provided, and cost per service. The Administrative Agent provides expenditure and service reports to the Planning Council regularly throughout the year. Where funds in a service category are under-expended, the planning council reprograms the under-spent funds to other categories that have demonstrated need. The Council collaborates with other funding streams to assess any duplication of services, and strives to reduce/prevent unnecessary duplication in funding streams. The measures of cost effectiveness include: 1) A PSRA process which documents use of Part A funds to fill service area gaps; 2) demonstrated maximal use of other funding streams to support the continuum of care while achieving reductions in costs per service category uses; and 2) a system of care that continues to expand access to meet the demand, evidenced by an increasing part A client population in care.

These goals form the basis for the triennial comprehensive plan, with emphasis on the following four core themes:

- 1) Reduced numbers of people who become infected with HIV;
- 2) Increased Access to Care, especially among the emerging and special populations;
- 3) Reduced Disparities in health care access and outcomes for the emerging and historically underserved populations; and
- 4) Continuous quality improvement, including its direct relationship to client level data and provider performance data, and positive impact on health outcomes.

The implementation plan orchestrates numerous strategies and implements new and continuing initiatives, based upon the considered needs of the TGA in achieving the ideal continuum of care. All of the proposed activities include consideration of cost effectiveness and quality, so that the health outcomes of those served may continue to evidence the desired improvements.

C. Goals regarding Individuals AWARE of their Status and Not in Care (Unmet Need)

To understand the Out of Care population and comprehend the nuances and distinctions among those populating this group in the TGA, an Out of Care study was conducted in 2011. The need to address service gaps and barriers for the Out of Care population prompted the Planning Council to develop the following goals for the next triennial period:

1. Reduce the Level of Unmet Need (Out of Care) in the TGA by at least 5.5% annually;
2. Address and reduce service barriers and gaps among the Out of Care population within the TGA;
3. Decrease top ranking service gaps for all special populations as indicated in the 2011 Needs Assessment within the TGA;
4. Decrease top ranking service barriers for all special populations as indicated in the 2011 Needs Assessment within the TGA;
5. Increase awareness among the MSM populations through education, prevention, and risk reduction materials throughout the TGA; and

6. Evaluate the ability for Mental Health and Substance Abuse to co-locate within provider arenas within the TGA.

D. Goals regarding Individuals UNAWARE of their HIV Status (EIIHA)

The Early Identification of Individuals with HIV/AIDS (EIIHA) strategies developed within the TGA set the following goals:

1. Reduce Level of Unaware (EIIHA) in the TGA by at least 10%;
2. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services;
3. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials throughout the TGA;
4. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization; and
5. Increase linkage to HIV care specifically to our Newly Diagnosed population.

E. Proposed Solutions for Closing Gaps in Care

Needs Assessment studies for In Care (n=229), Out of Care (n=42), and Newly Diagnosed (n=45) were conducted in 2011 using a consultant commissioned by the Ryan White Part A Office. Information was used in the Priority Setting and Resource Allocation (PSRA) process.

The Top 10 Ranking *Service Gaps* of the 2011 Norfolk TGA survey respondent group include: 1) Coordination of Benefits with Veterans Administration (VA)/Department of Defense (DOD), Youth-oriented services, GYN/Medical Specialty Care; 2) Housing Assistance; 3) Medical Transportation; 4) Emergency Financial Assistance; 5) Oral Health Care; 6) Nutrition Assistance; 7) Financial Assistance/Health Insurance; 8) Legal Assistance; 9) Substance Abuse services; and 10) Mental Health services. The top 10 ranking Service Gaps are thematic of care coordination deficiencies (involving coordination of benefits for the large military population, and coordinating access to housing, transportation and emergency financial assistance); and possible funding deficits (involving oral health services); and represent a perceived need to examine the service delivery system so that it may be more appealing to youth.

In response to these findings, the Planning Council proposed the following solutions to close gaps in care:

1. Develop stronger linkages with Medical Case Managers and outside resources; such as the VA, DOD, Youth service organizations and specialty care clinics; to enable better coordination of benefits for clients;
2. Continue to fund Outreach services to *promote* HIV testing, education, prevention and risk reduction within the TGA while developing strategies for enhanced HIV awareness in the community;
3. Continue to fund medical transportation services and increase access to medical care for rural PLWHA;
4. Increase linkages to HIV care; and
5. Continually update and seek resources for supportive services needed within the TGA.

F. Proposed Solutions for Addressing Overlaps in Care

Access to medical case management services is most often synonymous with access to Outpatient/ Ambulatory Medical Care. This TGA has contracted with nine (9) medical case management agencies that provide access to services throughout the entire region. Outpatient/ Ambulatory Medical Care and Medical Case management is also coordinated with Outreach/Case Finding services in order to reach the populations who know their HIV status, but have not sought medical services or have dropped out of care. Overlaps in care, although not frequent, occur when the case management team within the TGA falls short in communication through the CAREWare system or case review.

The TGA's proposed solutions for addressing these overlaps in care are as follows:

1. Ensure all case management agencies require annual training of services, care planning and care coordination;
2. Continue to monitor client level data at the Grantee level to avoid duplication of services rendered;
3. Continue to assess linkages and referrals to all services for clients during care planning and reassessments.

G. Provide Description detailing the Proposed Coordinating Efforts

To ensure optimal access to care for all PLWHA, the Norfolk TGA continues to strengthen coordinated efforts with other Ryan White and Non-Ryan White funded programs that offer services to clients. There is not a Part C provider within the TGA, hence coordination efforts are critical as less resources are available to the PLWHA community.

The Early Intervention Services (EIS) providers in the TGA receiving funding from the Ryan White Part A program and the Virginia Department of Health (VDH). EIS providers link with VDH-funded testing programs to obtain referrals for those who test positive, thus connecting newly diagnosed with medical care. EIS providers also collaborate with local health departments to conduct syphilis testing in conjunction with HIV testing. The TGA proposes to continue the current EIS efforts in the community and will work closely with the local health departments and VDH funded testing programs to conduct more education programs and materials to raise HIV awareness and increase testing of those *Unaware* of their serostatus.

Injection Drug Users (IDU) currently comprise 6% of new AIDS cases, 3% of new HIV cases, 14% of PLWA and 9% of PLWH. When the total IDU risk is considered (combining IDU and MSM/IDU), the total proportion attributable to IDU increases to over 18% among PLWA and increases to over 11% among PLWH. Even larger is the issue of non-injection substance abuse with estimates of 44% PLWHA who are actively using illicit substances (*2008 TGA Needs Assessment*). In response to this need for Substance Abuse services, the Norfolk Community Service Board is currently working to expand Substance Abuse services provided to their clients to include Primary Care services. The Ryan White Part A program manager is part of the planning team to assist in this effort.

One Community Health Center (Portsmouth Community Health Center) and one Federally Qualified Healthcare Center (Peninsula Institute for Health) provide a range of pediatric and adult clinical and supportive services to PLWHA in the TGA. Ryan White funded programs continue to strengthen linkages to these entities to ensure clients have access to services that may not be funded through the TGA's Part A program.

Medical Case Managers within the Ryan White Part A program are trained to assess a client's eligibility for Medicaid assistance. Once deemed eligible, clients are referred for assistance in applying for Medicaid coverage and linked to service providers in the area. Medicaid has increasingly covered the cost of HIV and non-HIV medications and other covered services for a modestly expanding PLWHA population in the TGA.

Eligibility for Medicaid is at 74% of the Federal Poverty Level (FPL) for Supplemental Security Income (SSI) and 80% for Aged, Blind and Disabled. (*Supplemental Security Income (SSI): Kaiser Family Foundation and The Urban Institute, 2009*). **Medicaid Covered Services include:** 1) Outpatient & Inpatient Medical services; 2) Day treatment for substance abuse and mental health rehabilitation; 3) Physician services; 4) Psychologist services; 5) Prescription drug coverage; 6) Audiology services; 7) Specified medical equipment; 8) Specified prosthetics and orthotics; 9) Non-emergent outpatient diagnostic scans; and 10) Ambulance services. Virginia has added the optional Medicaid buy-in group of disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA) in a program called Medicaid Works. These beneficiaries are allowed to continue Medicaid coverage, and receive full benefits, if their income is at or below 80 percent of the FPL. No premiums are required. **Services not covered:** 1) Adult dental coverage is limited to trauma and related dental surgery; 2) Adult vision coverage is limited to refractive examinations; 3) Routine podiatric

services are not covered for preventive or routine foot care; even in diagnosed cases of neuropathy; 4) Occupational and physical therapy services are not covered; 5) Hearing aids, eyeglasses and dentures are not covered; 6) Diagnostic and screening services cover only preventive and screening services with specified coverage for mammograms; 7) For home health care, specified medical equipment and supplies are not covered; and, 8) Private duty nursing is not covered. Efforts to assist clients with the eligibility screening will continue to ensure optimal access to care.

Increased efforts to coordinate specialty referrals for medical services to private providers optimizes clients' access to care. Currently, rates are negotiated at the Medicaid rate for reimbursement with the private providers in the community. The majority of these referrals are handled by EVMS with satellite offices in all service delivery areas.

Section III. How will we get there?

Introduction to Section III: This section provides the intuitive strategies, activities and timelines proposed by the Norfolk TGA for closing gaps in care as well as addressing the needs of those *Aware* and those *Unaware*. This section includes additional strategies, plans and activities to address the needs of special populations including adolescents, injection drug users, homeless and transgender. This section provides a detailed description of the activities the TGA will implement with other programs to ensure optimal access to care. This section concludes with the plan to address Healthy People 2020 objectives, the plan's coordination with the Affordable Care Act, which specific National HIV/AIDS Strategy goals are addressed, and the TGA's strategy to respond to any additional or unanticipated changes within the continuum of care as a result of state or local budget cuts.

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

African Americans experience higher rates of individual level poverty, neighborhood level poverty (approximated by Census Tract data), lower levels of educational attainment and higher rates of mortality for the three major causes of death (heart disease, cancer, and stroke), as well as diabetes, kidney disease, septicemia, homicide, and HIV. They also experience infant mortality rates that are more than twice that of other racial and ethnic groups. In addition to the evidence of the influence of poverty on health, research also suggests that self-reported experiences of racism are associated with poorer self-rated health, higher blood pressure, usage of tobacco and alcohol, psychological distress, and depression. (*Unequal Health Across the Commonwealth-A Snapshot—Virginia Health Equity Report, 2008, VDH*)

The TGA is concerned that these service gaps and barriers create an adverse fiscal impact on the HIV care system. As such, The Greater Hampton Roads HIV Health Services Planning Council ('GHRHSPC') is committed to addressing the needs of these populations. The council has allocated significant resources in regular Part A funding and MAI funding; and developed a continuum of care that focuses on the unique service delivery needs of these populations. The Fiscal Year 2012 Implementation Plan *prioritized* four (4) core services; Outpatient/ Ambulatory Medical Care, Oral Health, Medical Case Management and local ADAP and two (2) support services—Outreach and Medical Transportation. The listing of service gaps correlates to these service needs. The following table addresses the strategies, plans and activities with the timeline proposed to close gaps in care within the TGA.

Table 10: Strategy, Plan, Activities and Timelines for Closing Gaps in Care within the Norfolk TGA

STRATEGY	GOALS & ACTIVITY	RESPONSIBLE PARTIES	TIMELINE I: 2012 NI: Multiyear
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<p>1. Decrease top ranking service gaps for all special pops within the TGA;</p> <p>2. Address service gaps among the Out of Care population.</p>	<p>1. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services</p> <p>2. Increase linkage to HIV care</p> <p>3. Increase awareness among special populations of all services available within the TGA</p> <p>4. Strengthen linkages with support and medical care providers, ensuring all clients needs are addressed</p> <p>5. Develop strong links with MCM and outside resources (VA, DOD, HOPWA, etc)</p> <p>6. Continue enhancement of medical transportation services to ensure clients have means to access services</p> <p>7. Update and seek resources continuously within the TGA.</p>	<p><i>For Strategy:</i> Roving EIS Counselors, MCMs</p> <p><i>For Provision:</i> Hospitals FQHC, CHC, SA facilities,</p> <p><i>Community:</i> Social Services and Medical providers</p> <p><i>For evaluation of success:</i> Planning Council and Grantee</p>	<p>I: 2012 NI: 2013, 2014</p>
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B. Strategy, plan, activities, responsible parties, and timeline to address the needs of individuals *Aware*, but Not in Care

To address the needs of individuals *Aware* of their HIV status, but are not in care with an emphasis on retention in care, the TGA developed the following strategies, plans, activities and timelines. *See Table 12.*

Table 11. Strategy, Plan, Activities and Timelines for Addressing Needs of *Aware* (OOC) within the Norfolk TGA

STRATEGY	GOALS & ACTIVITY	RESPONSIBLE PARTIES	TIMELINE I: 2012 NI: Multiyear
<p>1. Increase awareness among the MCM populations through education, prevention and risk reduction materials</p> <p>2. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials</p> <p>3. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services</p> <p>4. Increase linkage to HIV care</p>	<p>1. Increase HIV resources support linkage coordinators within settings where clients receive health and social services</p> <p>2. Increase linkage to HIV care</p> <p>3. Increase awareness among special populations of all services available within the TGA</p> <p>4. Strengthen linkages with support and medical care providers, ensuring all clients needs are addressed</p> <p>5. Develop strong links with MCM and outside resources (VA, DOD, HOPWA, etc)</p> <p>6. Continue enhancement of medical transportation services to ensure clients have means to access services</p> <p>7. Update and seek resources continuously within the TGA</p> <p>8. Increase community awareness of HIV and importance of testing with regard to benefits of testing, earlier diagnosis with disease destigmatization through health fairs, prevention and education materials posted in churches and</p>	<p><i>For Strategy:</i> Roving EIS Counselors, MCM, Transportation providers</p> <p><i>For Provision:</i> Hospitals FQHC, CHC, SA facilities,</p> <p><i>Community:</i> Social Services</p> <p><i>For evaluation of success:</i> Planning Council and Grantee</p>	<p>I: 2012 NI: 2013, 2014</p>

bars, website hosts with linkage to providers (facebook, twitter)		
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C. Strategy, plan, activities, responsible parties and timeline to address the needs of individuals *Unaware of their HIV status*

The Early Identification of Individuals with HIV/AIDS (EIIHA) initiative prompted a strategic plan within the TGA to target those individuals Unaware of their HIV status to initiate and retain them in medical care. Using the formula as indicated in the FY2011 Part A Application Guidance for EIIHA/Unaware, the TGA’s estimated number of living HIV positive individuals who were unaware of their status as of December 31, 2009 was **1,777**. In response to this estimate, the Norfolk TGA developed the following goals to address the needs of individuals *Unaware* of their HIV status:

- 1) To make Unaware persons infected with HIV in the Norfolk TGA aware of their status;
- 2) To inform these individuals of their status in a manner that results in them quickly receiving confirmatory diagnoses (important in Norfolk TGA given 18% currently NOT confirming);
- 3) To refer these individuals to HIV medical care;
- 4) To link these individuals (and lower the current 11% of individuals that failed to link to services) through confirmatory CD4 and Viral Load laboratory tests; and
- 5) To ensure ongoing attachment through follow-up at 3, 6, 9 and 12 months post-care entry. The estimated Return On Investment for the EIS program is: Traditional – 1%, Non-Traditional – 1 to 2%, Partner Notification – 5%, High-risk target – 7 %

To achieve these goals, the Planning Council, Grantee, and other stakeholders developed the following Early Identification of Individuals with HIV/AIDS (EIIHA) plan with methods and means to address each goal.

STRATEGIES	ACTIVITY	METHOD	MEANS
1.To decrease the number of Unaware in the Norfolk TGA	1. Universal HIV Testing 2. Testing using Mobile Van 3. Access to hard-to-reach groups	1. MOUs with Hospitals, Safety Net providers, Substance Use & Mental Health clinics 2. Identification of high-risk zip codes 3. HIV testing events at social events—bars, clubs, HBCUS	1. Two of 3 EIS agencies are funded to provide HIV testing & counseling 2. Two of 3 EIS agencies have mobile testing units
2.To inform the Unaware now Aware of their HIV Status through quick confirmatory diagnoses	1. Expedited counseling 2. MOUs with confirmatory centers 3. Transport and rapid access appointments	1. MOUs with clinical providers that conduct confirmatory tests 2. Drive target group members with no transportation	1. All 3 EIS agencies have liability coverage and historically provide transport
3.To link any HIV positive results to medical care with confirmatory CD4 and Viral Load lab tests, reducing the current 11% that failed to link to primary medical care	1. Protocols to fast-track initial appt for newly diagnosed 2. Possible accompaniment 3. Transportation to appointment 4. Medication provided to newly diagnosed 5. Linkage with VDH HIV surveillance to receive confirmation thru Viral Load test	1. MOUs with clinical providers that provide HIV medical care 2. MCMs at 3 providers 3. Protocols determined to provide both 3) HIV medication and 4) VDH Laboratory data to confirm initial appointment and VL lab value	1. Protocols and MOUs with clinical providers and VDH 2. Medical Case Managers to collaborate with, transition permanent care to upon care entry.
4.To ensure ongoing attachment post-linkage at 3, 6, 9 and 12 months linkage as evidence by 3 HIV medical visits	1. Confirmation by medical provider and MCM of appointment and treatment protocol adherence 2. Documentation of 3 medical visits/year	1. Protocols developed to jointly care manage newly diagnosed 2. Data protocol with VDH surveillance	Protocols for care entry, case management and data tracking.

The *timeline* for the above strategies begins with implementation in March of 2012 and will continue annually for the triennial period with evaluation of the progress made within the TGA. The TGA anticipates at least a

3.5% increase annually to reach the goal of reducing the level of Unaware by at least 10% during the triennial period. **Responsible parties** include: the Norfolk TGA Grantee, Planning Council, Medical Case Management agencies, Part B partner, and community stakeholders.

Further strategies were then developed with an emphasis on identifying those individuals who are Unaware, informing them of their HIV status, referring them to services, and linking them to their individual care needs. The following tables indicate (identify, inform, refer, link) the strategies, plans, activities and timelines the TGA proposes to address the needs of individuals Unaware of their HIV status. Specific subgroup activities and challenges were added to Referring and Linking of Individuals within the strategies listed with the knowledge that personal attention is necessary to engage clients into care. These specific subgroup activities and challenges are based on the knowledge of the priority needs and cultural challenges for the special populations addressed as evidenced in the 2011 Comprehensive Needs Assessment.

Identifying the Unaware population has challenges inherent with the epidemiology of the populations within the Norfolk TGA. The primary strategy to ensure consistency with the making individuals who are Unaware of their HIV status involved addressing how to identify the Unaware and the correlation to the target groups addressed in the EIIHA Matrix (*See Section 1 – EIIHA Matrix*). Table 13 lists the TGA’s goals, a description of the goal, how to identify the Unaware within each goal, and how these activities will correlate to the target groups. Table 14, 15, 16, and 17 further assess the activities, timelines, and responsible parties for the TGA’s strategies to Identify, Inform, Refer, and Link the Unaware populations with HIV medical care and treatment.

GOAL	DESCRIPTION	IDENTIFICATON OF UNAWARE	CORRELATION TO TARGET GROUP
Goal 1	To decrease the number of Unaware in the Norfolk TGA	1. Partner with agencies serving high risk groups 2. Conduct outreach at areas that related to Target Groups: Substance use, STI and Safety Net clinics using Universal HIV testing; EDs and Hospital Ambulatory Care Clinics; Homeless Shelters & HBCUS.	Black MSM, Young MSM, Older MSM correlate to higher substance use, possible homelessness. Youth correlate to Historically Black Colleges & Universities (HCBUS). Heterosexual (male & female with focus on female) are identified through GYN, STI and Safety Net clinics.
Goal 2	To inform the Unaware now Aware of their HIV Status through quick confirmatory diagnoses	1. Use Partner Notification as identification strategy 2. Use roving EIS counseling team on mobile unit to reach those without transportation	Partner notification has proven to be the highest seropositivity result for MSM. Roving EIS teams reach heterosexuals and Young MSM lacking transport
Goal 3	To link any HIV positive results to medical care with confirmatory CD4 and Viral Load lab tests, reducing the current 11% that failed to link to primary medical care	1. EIS counselors facilitate enrollment into HIV medical care (fast-track appts, transport, possible accompaniment) 2. Function as transitional case managers	Facilitated enrollment ensures that MSM and Heterosexuals enter HIV medical Care. Both responded that they had delayed care entry upon suspecting or initial rapid test positive for HIV in the 2011 Needs Assessment,
Goal 4	To ensure ongoing attachment post-linkage at 3, 6, 9 and 12 months linkage as evidence by 3 HIV medical visits	1. Use HIV surveillance to confirm initial Viral Load 2. Secure linkage agreements with key Points of Entry 3. Provide testing on evenings and weekends and upon request or need.	The Viral Load confirms care attendance with Points of Entry geared to rapidly care for these Target Group members. Ongoing or post-attachment following referral & linkage is critical for these transient groups

Table 14. Identifying the Unaware Populations within the TGA

STRATEGY	GOALS & ACTIVITY	RESPONSIBLE	TIMELINE
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		PARTIES	I: 2012 NI: Multiyear
<p><i>HIV Testing through</i></p> <p><i>1) Expansion of traditional (Health Dept, STI Clinic) to non-traditional healthcare provider and community locations.</i></p> <p><i>2) Roving EIS counselors at provider agencies and community locations, emergency rooms and counseling/testing sites</i></p> <p><i>3) Outreach/ Health Literacy: Computer Kiosk with Health Risk Appraisals including HIV Risk</i></p> <p><i>4) Use of GIS /zip code mapping to identify areas with high viral load; target testing initiatives within those areas</i></p>	<p>1) Increase Universal HIV Testing in healthcare provider locations</p> <p>2) Use computer kiosks to conduct Health Risk Appraisals (Health Literacy/ Education)</p> <p>3) Enhance ‘roving EIS counselors’ program and ensure EIS counselors target areas and venues where at-risk populations receive social and health services</p> <p>4) Using geo-mapping, target testing sites within high viral load areas</p>	<p><i>For Strategy:</i> Roving EIS Counselors</p> <p><i>For Testing:</i> VA HIV Counseling & Testing Services</p> <p><i>For Provision:</i> Hospitals FQHC, CHC, SA facilities,</p> <p><i>Community:</i> Social Services, Medical providers, testing sites</p> <p><i>For evaluation of success:</i> Grantee and PC</p>	<p>I: 2012 NI: 2013, 2014</p>

Table 15. Informing the Unaware Populations within the TGA

STRATEGY	GOALS & ACTIVITY	RESPONSIBLE PARTIES	TIMELINE I: 2012 NI: Multiyear
<p><i>Confirmatory Testing rapid results through</i></p> <p><i>1) Expedited counseling</i></p> <p><i>2) MOUs with confirmatory centers</i></p> <p><i>3) Transport and rapid access appointments</i></p>	<p>1) EIS providers to engage individuals during pre and post test counseling; protocol developed for Partner Notification (“VERT”)</p> <p>2) Develop MOUs with healthcare provider locations that conduct confirmatory testing</p> <p>3) Drive target group members with no transportation</p>	<p><i>For Strategy:</i> Roving EIS Counselors; Medical Transportation</p> <p><i>For Confirmatory Testing:</i> VA HIV Confirmatory Testing Centers;</p> <p><i>For Provision:</i> Hospitals, FQHC, CHC, SA facilities</p> <p><i>Community:</i> Social Services; Outpatient/Ambulatory Medical Services</p> <p><i>For evaluation of success:</i> Planning Council and Grantee</p>	<p>I: 2012 NI: 2013, 2014</p>

Priority needs and cultural challenges have been identified for the TGA’s special populations based on Needs Assessment data. Strategies to eliminate barriers to testing due to these priority needs and cultural challenges individuals face have been developed specific to each special population. In addition, Table 16 and 17 show the specific challenges each special population faces with regard to entering into care. Activities are developed and designed to ensure cultural challenges do not create barriers to care, as well as addressing the priority needs of each population.

Table 16. Referring the Unaware Populations within the TGA

STRATEGY	GOALS/ ACTIVITY	RESPONSIBLE PARTIES	TIMELINE*	SUBGROUP/ CUSTOMIZED ACTIVITIES/ CHALLENGES
<p><i>Health Literacy/ Education</i></p> <p><i>Seasoned HIV Counseling & Testing Staff deployed to Agencies</i></p>	<p>Use seasoned HIV Counseling & Testing Staff located at provider agencies to ensure respectful, time-intensive counseling to HIV negative (risk reduction education) and HIV positive (gently conveying preliminary positive result, possibly conducting confirmatory test, and stressing importance of quick entry to HIV medical care)</p>	<p><i>For Strategy:</i> Roving EIS Counselors</p> <p><i>For Provision:</i> Hospitals FQHC, CHC</p> <p><i>For evaluation of success:</i> Planning Council and Grantee</p>	<p>I: 2012 NI: 2013, 2014</p>	<p>Black Males: <i>Activity:</i> Sensitive delivering result, if positive. If negative, converting risks into referrals for reduction <i>Challenge:</i> Low health care use, Low conversions from preliminary positive to confirmatory result (lowest of any sub-group, per VDH @ 21% vs. 18% for All).</p> <p>Black Females: <i>Activity:</i> Sensitive delivery of result with inclusion of sexual partner contact (PCRS) if HIV positive; If HIV negative, discussion of risk behaviors and means to communicate, determine these with partner(s) <i>Challenge:</i> Delicate issues surrounding culture, lifestyle</p> <p>MSM: <i>Activity:</i> Sensitive delivery of results with inclusion of partner contact (PCRS) if HIV Positive; If HIV negative, discussion of risks, means to minimize <i>Challenge:</i> Message fatigue, Conversion to confirmatory test; Significant concerns/education about need for PCRS</p> <p>Heterosexual: <i>Activity:</i> Sensitive delivery of results with inclusion of partner contact (PCRS) if HIV Positive; If HIV negative, discussion of risks, means to minimize <i>Challenge:</i> Delicate issues surrounding culture, lifestyle</p> <p>Age 13-19 (Youth): <i>Activity:</i> Sensitive delivery of results with inclusion of partner contact (PCRS) if HIV Positive; If HIV negative, discussion of risks, means to minimize <i>Challenge:</i> Perception that they are 'bullet proof'; belief that HIV Meds can 'cure' disease</p> <p>Age 20-44: <i>Activity:</i> Sensitive delivery of results with inclusion of partner contact (PCRS) if HIV Positive; If HIV negative, discussion of risks, means to minimize <i>Challenge:</i> Delicate issues surrounding culture, lifestyle</p>

Table 17. Linking the Unaware Populations within the TGA

STRATEGY	GOALS/ ACTIVITY	RESPONSIBLE PARTIES	TIMELINE*	SUBGROUP/ CUSTOMIZED ACTIVITIES/ CHALLENGES
<i>Expeditious entry into HIV medical care</i>	<p>(1) HIV Positive: Using seasoned HCT counselors to make immediate entry into HIV medical care.</p> <p>1) Further refining current 'fast-track' appointments for newly diagnosed 2) Possible creation of peer counselors to accompany newly diagnosed to initial appointments.</p> <p>(2) HIV Negative: Referring individuals to services (i.e. Mental Health, Substance Abuse treatment) that reduce their risk for HIV acquisition.</p>	<p><i>For Strategy:</i> Roving EIS Counselors</p> <p><i>For Provision:</i> Hospitals FQHC, CHC</p> <p><i>For evaluation of success:</i> Planning Council and Grantee</p>	I: 2012 NI: 2013, 2014	<p>Black Males: <i>Activity:</i> Providing support of EIS counselor and possible accompaniment of peer to attend first HIV medical appointment <i>Challenge:</i> Low health care use, Suspicion</p> <p>Black Females: <i>Activity:</i> Providing support of EIS counselor and possible accompaniment of peer to attend first HIV medical appointment <i>Challenge:</i> Ensuring supportive services to access care (i.e. transportation, child care)</p> <p>MSM: <i>Activity:</i> Providing support of EIS counselor and possible accompaniment of peer to attend first HIV medical appointment <i>Challenge:</i> Reticence to engage</p> <p>Heterosexual: <i>Activity:</i> Providing support of EIS counselor and possible accompaniment of peer to attend first HIV medical appointment <i>Challenge:</i> Fear, Issues with partner accompaniment</p> <p>Age 13-19 (Youth): <i>Activity:</i> Providing support of EIS counselor and possible accompaniment of peer to attend first HIV medical appointment <i>Challenge:</i> Parental involvement (or not), Legal issues</p> <p>Age 20-44: <i>Activity:</i> Providing support of EIS counselor and possible accompaniment of peer to attend first HIV medical appointment <i>Challenge:</i> Variable circumstances of divergent group, Issues with fear, financial concerns, health care use</p>

D. Strategy, plan, activities, responsible parties and timeline addressing the needs of special populations

The emerging population of Youth, ages 13-29 years: Youth, ages 13-29 years comprised 49% of the emergent HIV infection reported in 2007-2008, and comprise growing numbers of PLWHA. In 2009, Youth ages 13 to 19 years comprised 6% of AIDS incidence; 9% of HIV incidence; 7% of HIV prevalence; and 4% of AIDS prevalence.

Injection Drug Users (IDU) currently comprise 6% of new AIDS cases, 3% of new HIV cases, 14% of PLWA and 9% of PLWH. When the total IDU risk is considered (combining IDU and MSM/IDU), the total proportion attributable to IDU increases to over 18% among PLWA and increases to over 11% among PLWH. Even larger is the issue is non-injection substance abuse with estimates of 44% PLWHA who are actively using illicit substances (*2008 TGA Needs Assessment*). Unique challenges of providing services to this population are the high propensity for non-adherence to medical treatment; and the reluctance (or inability) to abstain from substance use.

Homeless. It is estimated that there are 872 single adults and 542 families homeless at any point in the Norfolk TGA. National estimates are that 10% of these individuals or approximately 87 single adults have HIV/AIDS, regardless if they are aware of the diagnosis or in treatment. The majority of the single adults counted in the 2011 'Point in Time' study are black adult males, further portraying the disparity as evidenced in Section I.

Transgender.

In response to addressing the needs of these special populations, the TGA developed the following strategies, plans, activities and timelines:

TABLE 18. TARGET GROUPS/ACTIVITIES TO ADDRESS PRIORITY NEEDS OF SPECIAL POPULATIONS IN				
TARGET GROUP	PRIORITY NEEDS	ACTIVITIES	TIMELINE	RESP. PARTIES
YOUTH (13-29 years)	1) Confidential testing sites 2) Sites with younger CTR staff 3) STI linkages 4) High rates of homelessness 5) High rates of substance use	1) Conduct confidential testing at youth-friendly venues combined with other preventive health screens including STI testing 2) Work with local housing providers to ensure youth access to housing	I: FY 2012 NI: FY 2013 and 2014	Ryan White Office EIS Staff
INJECTION DRUG USERS	1) Substance use/abuse treatment needs 2) Experience with homelessness 3) STI linkages 4) Adherence issues 5) Mental health needs 6) Medical Transportation needs 7) Co-morbidities such as Hep C treatment needs	1) Link with SA providers 2) Incorporate testing venues with general medical including STI screens 3) Provide linkages to housing services 4) Provide medical transportation for retention in care 5) Link with EIS and outreach providers for	I: FY 2012 NI: FY 2013 and 2014	Ryan White Office EIS Staff
HOMELESS	1) Stable housing 2) Substance use/abuse treatment needs 3) Mental health needs 4) Financial assistance 5) Medical Transportation needs 6) Co-morbidities such as TB, Hep A, Hep B treatment needs	1) Link with Housing providers 2) Link with mental health and SA providers 3) Provide awareness of low or no cost services for HIV treatment 4) Provide testing at homeless shelters 5) Provide medical transportation for	I: FY 2012 NI: FY 2013 and 2014	Ryan White Office EIS Staff
TRANSGENDER	1) Confidential testing sites 2) Peer mentors within provider locations 3) Stable housing 4) Substance use/abuse treatment needs 5) STI linkages 6) Mental Health needs 7) Adherence counseling	1) Provide testing and HIV education at venues and neighborhoods with high concentration of transgender 2) Provide awareness of low or no cost services for HIV treatment 3) Link with mental and emotional health (including EIS with outreach mental health) to counsel 4) Link with SA providers 5)	I: FY 2012 NI: FY 2013 and 2014	Ryan White Office EIS Staff

E. Provide description detailing activities to implement proposed coordinated efforts

Part B Services, including ADAP: ADAP will be used to identify newly diagnosed individuals requesting HIV medication. This will help identify individuals that have health insurance that might not be eligible for Ryan White but are eligible for HIV medication assistance. The Norfolk TGA has been proactive, in the midst of federal and state budget cuts, of allocating \$500,000 for HIV medications given the Norfolk TGA's epidemiologic role of being almost one-third (28%) of HIV/AIDS cases. This will help reduce any wait lists for newly diagnosed in the Norfolk TGA.

Part C Services: There is not a Ryan White Part C funded entity in the Norfolk, Virginia TGA.

Part D Services:

Part F Services:

Private Providers (Non-RW funded):

Prevention Programs including partner notification & prevention w/positive initiatives:

Substance Abuse Treatment Programs/Facilities:

STD Programs:

Medicare:

Medicaid:

Children's Health Insurance Program:

Community Health Centers: Peninsula Institute for Community Health (PICH) and the Norfolk Community Health Center (NCHC) are two of three Community Health Centers that offer Ryan White funded services to PLWHA in the TGA. PICH and NCHC are in the process of implementing Universal HIV testing to coordinate their efforts with the TGA's goal of increasing testing at primary care facilities.

F. How the plan addresses Healthy People 2020 objectives

The primary goal in Healthy People 2020 relates to reduction of new HIV infections, with specific reduction among adolescents and MSM. The services outlined in the FY 2012 Implementation Plan address these goals, with focus on OAMC, MCM, local drug reimbursement and transportation to access HIV medical care. Outreach has also been prioritized to return PLWHA to care. Table 19 below shows the relation of the Norfolk TGA 2012-2015 proposed care goals with the respective Healthy People 2020 objectives.

HEALTHY PEOPLE 2020 OBJECTIVE	NORFOLK TGA 2012-2015 GOAL
13-1 Reduce AIDS among adolescents & adults	a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Increase by 10% annually Part A achievement of improvements in key health outcome indicators c. Reduce level of Unmet Need by 5.5% annually d. Reduce level of Unaware by 10% e. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services f. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials

13-2 Reduce number of new AIDS cases among adolescent and adult MSM	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Reduce level of Unaware by 10% c. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services d. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials e. Increase awareness among the MSM populations through education, prevention and risk reduction materials
13-3 Reduce number of new AIDS cases among females and among males who inject drugs.	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Reduce level of Unaware by 10% c. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services d. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials e. Address and reduce service barriers and gaps among the Out of Care population
13-4 Reduce number of new AIDS cases among adolescent and adult MSM/IDU	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Reduce level of Unaware by 10% c. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services d. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials e. Increase awareness among the MSM populations through education, prevention and risk reduction
13-5 Reduce number of HIV cases among adolescents & adults	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Reduce level of Unaware by 10% c. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services d. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials
13-6 Increase proportion of sexually active persons who use condoms	<ul style="list-style-type: none"> a. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials
13-7 Increase number of HIV positive persons who know their serostatus	<ul style="list-style-type: none"> a. Reduce the number of Unaware PLWHA by 10% within the TGA b. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization
13-8 Increase proportion of substance abuse treatment facilities offering HIV/AIDS education & counseling	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services

13-9 Increase number of State prison systems that provide comprehensive HIV/AIDS, STD and TB education	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services
13-10 Increase proportion of inmates in State prison systems who receive voluntary HIV counseling & testing during incarceration	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services
13-11 Increase proportion of adults with TB tested for HIV	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services
13-12 Increase proportion of adults in publicly funded HIV Counseling & Testing sites screened for STDs and immunized against Hepatitis B	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services c. Increase by 10% annually Part A achievement improvements in key health outcomes
13-13 Increase proportion of HIV-infected adolescents and adults who receive testing, treatment, and prophylaxis consistent with PHS guidelines	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services c. Increase by 10% annually Part A achievement improvements in key health outcomes
13-14 Reduce deaths from HIV infection	<ul style="list-style-type: none"> a. Increase by 10% annually Part A achievement improvements in key health outcomes b. Decrease top ranking service gaps for all special populations c. Decrease top ranking service barriers for all special populations d. Address and reduce service barriers and gaps among the Out of Care population
13-15 Increase proportion of new HIV infections and diagnosis before progression to AIDS.	<ul style="list-style-type: none"> a. Increase by 10% annually Part A achievement improvements in key health outcomes b. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization c. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services d. Decrease top ranking service gaps for all special populations e. Decrease top ranking service barriers for all special populations f. Increase linkage to HIV care specifically to our Newly Diagnosed population

13-16 Increase proportion of HIV-infected persons surviving more than 3 years after a diagnosis of AIDS	<ul style="list-style-type: none"> a. Increase by 10% annually Part A achievement improvements in key health outcomes b. Reduce level of Unmet Need by at least 5.5% c. Decrease top ranking service gaps for all special populations d. Decrease top ranking service barriers for all special populations e. Address and reduce service barriers and gaps among the Out of Care population
13-17 Reduce number of perinatally acquired HIV/AIDS diagnosed each year.	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services c. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials
13-18 Reduce number of new HIV/AIDS cases in adolescent and young adult females aged 13-24 associated with heterosexual conduct.	<ul style="list-style-type: none"> a. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization b. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services c. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials

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

This plan was developed in concert with the Virginia Statewide Coordinated Statement of Need, with input from the Norfolk TGA as one of three Ryan White Part A entities and with collaboration in development of their document. The recommendations of the SCSN are to:

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

The Norfolk TGA already contracts with numerous Federally Qualified Health Centers as HIV Medical providers in addition to other clinical services. The Affordable Care Act (ACA) should not have an appreciable impact on the skill base or comfort with medical care, but could impact the volume of individuals eligible for services through Medicaid. The TGA and its Planning Council are staying current on developments as the ACA moves to full implementation in 2014-2018, and is actively involved in influencing the expanded benefit design for PLWH.

I. Describe how Comprehensive Plan addresses the goals of the National HIV/AIDS Strategy, as well as which specific NHAS goals are addressed

The National HIV/AIDS Strategy goals are focused on the overarching principles of reducing new HIV infections, increasing access to care and improving health outcomes for PLWH, and reducing HIV-related health disparities. Table 20 shows the Norfolk 2012-2015 proposed care goals in relation to the specific indicators with the NHAS goals.

TABLE 20. NATIONAL HIV/AIDS GOALS AND RELATION TO 2012-2015 PLAN

NATIONAL HIV/AIDS STRATEGY GOAL	NORFOLK TGA 2012-2015 GOALS
Increase the proportion of Ryan White HIV/AIDS program clients who are in continuous care	a. Reduce Unmet Need by 5.5% annually within the TGA b. Decrease top ranking service gaps for all special populations c. Decrease top ranking service barriers for all special populations d. Address and reduce service barriers and gaps among the Out of Care population
Increase the percentage of people living with HIV who know their serostatus	a. Reduce the number of Unaware PLWHA by 10% within the TGA b. Increase testing throughout primary care settings/community wide initiatives
Increase the proportion of Newly Diagnosed patients linked to clinical care within 3 months of their HIV diagnosis	a. Increase linkage to HIV care specifically to our Newly Diagnosed population
Increase the proportion of HIV diagnosed gay and bisexual men with undetectable Viral Loads	a. Increase awareness among the MSM populations through education, prevention and risk reduction materials b. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials c. Increase by 10% annually Part A achievement of improvement in key health outcome indicators
Increase the proportion of HIV diagnosed Blacks with undetectable Viral Loads	a. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials b. Increase by 10% annually Part A achievement of improvement in key health outcome indicators

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

Presently, there are no known reductions in HIV related clinical and non-clinical services, as a result of municipal and/or state budget cuts, though Virginia is among the state’s experiencing budget shortfalls of over 8% or the 2010/2011 state budget years. The TGA monitors changes within the State ADAP system in order to proactively respond to any affects our local pharmaceutical assistance programs may have with any changes made at the State level. Currently, the TGA covers ADAP drugs for three to five days until the client is deemed eligible and is receiving ADAP assistance. Medications not provided by ADAP, but are on the Ryan White formulary, are covered under the Ryan White local assistance program.

Section IV. How will we monitor progress?

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

The plan to monitor and evaluate progress of the six (6) strategic goals and twelve (12) objectives involves a coordinated review during each Fiscal Year of assigning implementation and oversight activities to the Care Strategy Committee of the Greater Hampton Roads HIV Health Services Planning Council in conjunction with Grantee operations through quality improvement, electronic database operations and fiscal oversight. The Ryan White Part A contracted provider base of thirteen (13) organizations provides the mandated Continuum of Care of six funded core services and 3 funded support services.

In the Monitoring and Evaluation Calendar outlined in Section C below, responsibilities are outlined by committee, Planning Council (PC), Grantee, and contracted providers.

The identified challenges from the 2009-2011 fiscal year continues to concern the Norfolk TGA. Service gaps and barriers for the special populations, as well as the Out of Care population, must continue to be addressed to ensure optimal access to care. Education, prevention and risk reduction efforts must be enhanced within our MSM population where the TGA noted a significant increase in AIDS cases over the three-year trended data. Provider capacity with regard to services such as Mental Health and Substance Abuse treatment facilities continue to taunt the TGA's efforts to ensuring clients needing these services are able to readily attain care. With reductions in funding, the largest challenge presented to the TGA this triennial period is providing more services to more clients with fewer dollars.

B. Plan will describe how the EIIHA Initiative will be addressed

C. Timeline for implementing monitoring and evaluation process should be clearly stated

Annual review of the six (6) strategic goals and twelve (12) objectives occurs by the Executive Committee of the Planning Council with ongoing review by the Care Strategy Committee assigned responsibility for implementation and oversight in conjunction with the Grantee or Ryan White Office.

STRATEGIES/ACTIVITIES	Timetable			Responsible Party
	2013	2014	2015	
1) REDUCE THE NUMBER OF PEOPLE WHO BECOME INFECTED WITH HIV				
<i>A. Increase testing throughout primary care settings/community wide initiatives with regard to the benefits of testing and earlier diagnosis with disease de-stigmatization</i>	■	■	■	
• Increase Universal HIV testing in healthcare provider locations	■	■	■	Grantee, Providers, PC
• Use computer kiosks to conduct Health Risk Appraisals (Health Literacy/Education)	■	■	■	Grantee, Providers
• Enhance "roving EIS counselors" program and ensure EIS counselors target areas and venues where at-risk populations receive social and health services	■	■	■	Grantee, Providers
• Use geo-mapping to identify areas with high viral loads; target testing initiatives within these areas	■	■	■	Grantee, PC
• Develop strategies for enhancing HIV awareness in the community; specific to benefits of testing, early diagnosis, and disease de-stigmatization	■	■	■	Grantee, PC
2) IMPROVE ACCESS TO CARE				
<i>A. Decrease top ranking service gaps for all special populations</i>	■	■	■	
• Develop stronger linkages with Medical Case Managers and outside resources, such as the VA, DOD, Youth organizations	■	■	■	Grantee, Providers, PC
• Continue funding medical transportation services thus increasing access to medical care for rural PLWHA	■	■	■	Grantee, PC
• Increase linkages to HIV care, both RW and non-RW funded providers	■	■	■	Grantee, PC
• Update and seek new resources for supportive services needed within the TGA	■	■	■	Grantee, PC
• Increase coordinating efforts with MH/SA treatment facilities for special populations	■	■	■	Grantee, PC

<i>B. Decrease top ranking service barriers for all special populations</i>	■	■	■	
• Continue to fund Outreach services to promote HIV testing, education, prevention and risk reduction with the TGA	■	■	■	Grantee, PC
• Develop MOUs with healthcare provider locations that conduct confirmatory testing to expedite test results for rapid access appointments	■	■	■	Grantee
• Develop strategies for enhancing HIV awareness in the community; specific to benefits of testing, early diagnosis, and disease de-stigmatization	■	■	■	PC, Community Access and Care Strategy Committees
<i>C. Increase HIV resources support linkage coordinators within settings where at-risk populations receive health and social services</i>	■	■	■	
• Use seasoned HIV Counseling & Testing staff located at agencies to ensure respectful and time-intensive counseling to HIV negative (risk reduction) and HIV positive (gently approach to engage in medical care)	■	■	■	Providers
• Create peer counselor program to accompany newly diagnosed to initial appointments	■	■	■	Grantee, Providers, PC
• Strengthen linkages with support and medical care providers	■	■	■	Grantee, PC
<i>D. Increase linkage to HIV care specifically to our Newly Diagnosed population</i>	■	■	■	
• Develop protocols to fast-track initial appointments for newly diagnosed	■	■	■	PC, Providers
• Linkage with VDH HIV surveillance to receive confirmation through Viral Load test to EIS program	■	■	■	Grantee, Providers
• Develop peer counselor program to accompany newly diagnosed to initial appointments	■	■	■	Grantee, PC
• Secure linkage agreements with key Points of Entry	■	■	■	Grantee, Providers
3) IMPROVE HEALTH OUTCOMES				
<i>A. Increase by 10% annually Part A achievement of improvements in key health outcome indicators, as evidenced by individual client level data and aggregate provider data.</i>	■	■	■	
• Complete SoC performance audits of MCM providers and implement CQI TA activities to address performance improvement issues	■	■	■	Grantee
• Review/Refine Standard of Care for each Part A funded service category, perform chart audits, and compare findings to HRSA performance expectations	■	■	■	Planning Council, Grantee, QI
• Implement annual CQM monitoring and correction plan	■	■	■	Grantee
4) ELIMINATE HEALTH DISPARITIES				
<i>A. Increase awareness among the MSM population through education, prevention and risk reduction materials throughout the TGA</i>	■	■	■	
• Increase community awareness of HIV and importance of testing, with regard to benefits of testing, earlier diagnosis with disease de-stigmatization (HIV negative=risk reduction; HIV positive=counseling for engagement in medical care)	■	■	■	Community Access and Care Strategy Committees

<ul style="list-style-type: none"> Partner with prevention programs for education and awareness materials to be distributed using geo-mapping for high risk areas 	■	■	■	Grantee, PC
<i>B. Improve HIV disclosure and safer sex practices through education, prevention and risk reduction materials throughout the TGA</i>	■	■	■	
<ul style="list-style-type: none"> Develop strategies for enhancing HIV awareness; benefits to testing, earlier diagnosis with emphasis on disease de-stigmatization 	■	■	■	PC, Community Access and Care Strategy Committees
<ul style="list-style-type: none"> Continuously assess protocol and success of partner notification program 	■	■	■	Grantee, PC
<i>C. Address and reduce service barriers and gaps among the Out of Care population within the TGA</i>	■	■	■	
<ul style="list-style-type: none"> Update and seek new resources for supportive services needed within the TGA 	■	■	■	PC, Grantee
<ul style="list-style-type: none"> Develop best practice models of care that encourage retention in care for special populations within the TGA that are Out of Care 	■	■	■	PC, Providers
<i>D. Reduce level of Unmet Need (Out of Care) in the TGA by at least 5.5% annually, with a minimum goal of 10% for three years</i>	■	■	■	
<ul style="list-style-type: none"> Continuously assess demographic profile of Part A clients to assure that disproportionately impacted and historically underserved are accessing services 	■	■	■	Grantee, PC
<ul style="list-style-type: none"> Conduct 'Out of Care' study, specific to special populations such as MSM/IDU, Transgender, Youth; analysis of findings to ensure priority setting process implements changes to Service Delivery System where applicable 	■	■	■	Grantee, PC
<i>E. Reduce Level of Unaware (EIIHA) in the TGA by at least 10% over the triennial period</i>	■	■	■	
<ul style="list-style-type: none"> Continue to convene annual meetings of prevention and care providers to assess success/challenges of strategies used for reducing Unaware 	■	■	■	Grantee
<ul style="list-style-type: none"> Promote Universal HIV Testing with Hospitals, Safety Net providers, Substance Use & Mental Health clinics 	■	■	■	PC, Providers, Grantee
<ul style="list-style-type: none"> Conduct HIV testing events at social events – bars, clubs, health fairs emphasizing HIV awareness prevention and risk reduction with disease de-stigmatization 	■	■	■	Providers
5) IMPROVE THE QUALITY OF HEALTH CARE				
<i>A. Increase by 10% annually Part A achievement of improvement in key health outcome indicators</i>	■	■	■	
<ul style="list-style-type: none"> Continue TA for providers with regard to cultural competency annual trainings 	■	■	■	Grantee
<ul style="list-style-type: none"> Conduct satisfaction surveys at all agencies, with outcomes presented during Quality Management meetings to address issues presented 	■	■	■	Grantee, PC
<ul style="list-style-type: none"> Ensure Planning Council is consumer-driven and reflective of epidemic in TGA 	■	■	■	Grantee, PC Staff
<ul style="list-style-type: none"> Evaluate input data from consumer-based and local and regional groups for use in planning 	■	■	■	Grantee, PC
<ul style="list-style-type: none"> Utilize multiple sources of data for evaluation and planning 	■	■	■	Grantee, PC
6) ASSURE COST EFFECTIVENESS				

<ul style="list-style-type: none"> Assess all funding streams, encourage funds diversification to maximize utilization of Part A funds and expand continuum of care 	■	■	■	Grantee, PC
<ul style="list-style-type: none"> Review split between core and support 	■	■	■	Grantee, PC
<ul style="list-style-type: none"> Analyze accessibility/quality/utilization of core services in service delivery system 	■	■	■	Grantee, PC
<ul style="list-style-type: none"> Conduct priority setting/resource allocation process 	■	■	■	Grantee, PC, Service Planning Committee

D. Monitoring and evaluation plan should describe process for tracking changes

Improved use of Ryan white client level data

Use of data in monitoring service utilization

Currently, the Norfolk TGA utilizes HRSA’s supported data collection system, CAREWare for both client level data reporting by provider and for data operations of the Part A program. The CAREWare system is accessed by 100% of Ryan White Part A funded providers to report client therefore 100% of Part A providers have the ability to produce client level data.

The Norfolk TGA distinguishes which clients are served by each individual funding stream with the data collection system CAREWare. Providers with multiple Parts are set up in the system using Contracts with either Part A or Part B and input the information only in those parts. When a report is needed for Part A only Part A information is gathered. The Norfolk TGA has only Part A and Part B funding; all other parts are not available in this TGA.

For any newly identified HIV positive individual referred into a Ryan White funded program, EIS Counselors can confirm HIV medical appointment attendance and care regimen adherence within one month of referral. In addition to confirming a client’s attendance, EIS Counselors are able to confirm with HIV medical providers, Medical Case Managers, and/or through the use of CAREWare that 3 visits to an HIV medical care provider occurred within the first full year. This system of monitoring service utilization allows EIS Counselors the opportunity to ensure clients are engaging in and maintaining their medical treatment regimens, thus preventing clients being ‘lost to care’.

Measurement of clinical outcomes

The Clinical Quality Management Program (CQM) in the Norfolk TGA has been active in promoting quality improvement. Consistent with the overall mission of HRSA, the CQM Program is committed to improving health by assuring equitable access to comprehensive quality health care. We place emphasis on assessing the extent to which HIV health services are consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV disease. The Norfolk CQM Program envisions that all persons living with HIV/AIDS in the Norfolk TGA will have access to comprehensive, culturally competent, quality medical care and support services. Therefore, the **mission** of the Ryan White Part A CQM Program is to *ensure the highest quality of medical care and supportive services for people living with HIV/AIDS in the Norfolk Transitional Grant Area*. The **goals** of the CQM program are to prioritize services that reduce or eliminate barriers to accessing care so that PLWHA enter and maintain outpatient medical care; to reflect the continuum of care through standards that define expected delivery of services; and to build capacity among providers within identified services. Through these goals, the structure of the CQM program is based on Standards of Care (SoC) for each funded category to guide providers in improving client-level health outcomes.

Three main entities comprise the CQM Program infrastructure:

1. **Ryan White Office:** The grantee retains the lead role in QM, with responsibility to monitor the standards of care, or definition of the manner in which services are to be delivered by contracted providers, and the outcome measures, or expected result of funded interventions. The Program Manager of the Grantee Office oversees the CQM Program. The ongoing development and implementation of day-to-day quality management efforts are coordinated by the CQM Analyst.
2. **Care Strategy Committee:** The Care Strategy Committee is responsible for the development of the SoC and outcome measures for service categories, in cooperation with the grantee. The Committee evaluates the effectiveness of service strategies, and develops and assesses the Continuum of Care in the Norfolk TGA. Linkages and inter-relationships among Ryan White Part A and other funded services are also the province of the Care Strategy Committee in coordinating provision of services. The Care Strategy Committee is structured with stakeholders, the Quality Assurance Coordinator, Contract Monitoring Specialist, Fiscal Officer, Data Analyst, service providers and clients.
3. **GHRHHSPC:** The Planning Council ensures the effective and efficient delivery of quality medical and support services to persons affected and infected by HIV/AIDS in the Norfolk TGA, and is composed of 30-33 individuals representing the membership categories outlined in the Ryan White Treatment Modernization Act of 2006.

Through coordinated effort, SoC in 12 service categories were developed, refined and adopted by the Greater Hampton Roads HIV/AIDS Planning Council during the past two years to aid sites in delivering ideal services. The SoC meet HHS Public Health Service mandates, and state and professional society regulations and guidelines. The State (Virginia Department of Health) collaborated with Ryan White Part A entities to create a unified Medical Case Management Standard of Care. In FY2009, all core medical and support Service Use Definitions were reviewed and updated, and specific outcomes and quantifiable indicators were developed for each service category. Additionally, following an in-depth chart review and analysis, the Outreach standards of care were revised to incorporate specific protocols and referral mechanisms to address the 'erratic in care' PLWHA. *Specific indicators that are being monitored for outpatient medical care and medical case management and how these indicators are measured are depicted in the chart below.*

TABLE 21. SPECIFIC QUALITY INDICATORS FOR OAMC AND MCM IN NORFOLK TGA, 2010			
INDICATOR	NUMERATOR	DENOMINATOR	MEASURE
OUTPATIENT AMBULATORY MEDICAL CARE			
1) OP medical care provided by certified practitioner	# OP medical providers with HIV Specialist certification, 20 hours of HIV CME, and prescription of ART	Total # of OP Medical Providers	Licensure, certification & # of CME hours through training
2) Compliance with PHS guidelines	<i>Six (6) indicators</i>		
2.1 CD4 test every 6 months	# clients with 2+ CD4 tests at least 3 month apart	# clients with medical visit	Client chart
<i>INDICATOR</i>	<i>NUMERATOR</i>	<i>DENOMINATOR</i>	<i>MEASURE</i>
2.2 Clients prescribed ART that have AIDS	# clients with AIDS prescribed ART in year	# clients with AIDS in year	Client chart
2.3 Medical visit every 6 months	# clients with medical visit 2+ times, 3 months apart	# clients with medical visit	Client chart
2.4 Clients with CD4 < 200 prescribed PCP prophylaxis	# clients with CD4 < 200 on PCP prophylaxis	# clients with CD4 < 200	Client chart
2.5 Pregnant clients that are prescribed ART	# pregnant clients prescribed ART in 2nd or 3rd trimester	# pregnant clients	Client chart
2.6 Clients w/improved clinical status (biological markers)	# clients w/ improved status (higher CD4, lower VL) seen by medical provider twice, 3 months apart	# clients with 2 medical visits	Client chart
3) Appropriate referrals to community support services and linkage to care	Three (3) indicators		

3.1 Refer to Services			Client Chart
3.2 Document psychosocial history			Client chart
3.3 Document MCM provider and agency			Client chart
4) Treatment Adherence Assessment & Counseling	Six (6) indicators		
4.1 Assess treatment adherence	# clients assessed for treatment adherence each quarter	# of total clients in quarter	Treatment adherence referral log
4.2 Assess educational needs	# clients assessed for education needs	# of clients	Client chart
4.3 Measure medication adherence	# of clients with quantitative measurement of med adherence	# of clients	Client chart
4.4 If adherence issue, document follow-up	# clients assessed for treatment adherence with follow-up	# of clients assessed for treatment adherence	Treatment adherence logs
4.5 Decrease # of missed appointments	# missed appointments by client in year	# missed appointments/prior year	Client charts in TGA (aggregate)
4.6 Increase biological markers for clients with treatment adherence issues	# clients reporting decreased CD4 or increased VL with medical visit in last year	Total # of clients	Client charts in TGA (aggregate)
5. Screen new clients for substance abuse	# new clients screened for substance abuse issues	Total # new clients	Client chart
6. Screen new clients for mental Health	# new clients screened for mental health issues	Total # new clients	Client chart
Medical Case Management			
1. Confidentiality	1.1 # agencies with locked records that are password protected 1.2 # records with signed client confidentiality statement	Total # agencies Total # client records	Agency audit Client record
2. Intake	2.1 # clients with intake containing all needed information to link to RW and retain in care	Total # clients	Client record
3. Care Plan	3.1 # records w/ client assessment 3.2 # client records with Care Plan	Total # new client records	Client record
4. Reassessment	4.1 # client records with Completed Service Plan Review	Total # new client records	Client record
5. Referral/Linkage	5.1 # clients with documentation of referrals to service	Total # client records	Client record
6. Case Conference	6.1 # case managers attending monthly case conference with OP medical care providers	Total # case managers	Training Log
7. Training	7.1 # medical case managers receiving mandated training	Total # medical case managers	Training Log

This quality performance data is used to update the Quality Management Plan, further refine the Standards of Care and assess the ability of providers in the Norfolk TGA to quantitatively measure the variance between desired practice and current operations. This evolution of the Standards of Care resulted in a gradient of performance stratifying providers within a Service Category. This stratification permits more sophisticated progress of top-notch providers, and converts Standards of Care to daily practice versus use as guidelines not regularly referenced for daily operations. On a quarterly basis, health outcome information is forwarded to the Ryan White Office by each of the funded Part A providers. On an annual basis, sampled chart abstraction occurs to validate compliance with the internally developed SoC for all Ryan White Part A funded services.

Evaluation: The CQM Program is evaluated annually to assess quality infrastructure and activities to ensure that the quality program is in line with its overall purpose. Based on those findings, the key personnel and Care

Strategy Committee will refine strategies for the following year. Chart audit results, provider and consumer input, effectiveness of CQM activities, and program goals will be used to evaluate the program.

Capacity Building: Contracted providers are assessed quarterly, semi-annually, and on an annual basis. Given findings about compliance with Standards of Care by Service Category, Technical Assistance may be needed. Issues that impact all providers of a Service Category or training specific to an updated or revised Standard of Care will be addressed in workshops or mandatory training sessions.

Communication: Monthly Care Strategy Committee and Planning Council Meetings are conducted with minutes recorded. Stakeholder input is gathered at public meetings – Planning Council, committees, and local consortia. Annual site evaluation visits are conducted with providers, with feedback reports given face-to-face and in print. Reports are provided to the following: 1) Ryan White Office (data analysis for grant application and contract monitoring); 2) Provider administration and service (data analysis for quality improvement); 3) Care Strategy Committee (data analysis of SoC); 4) Priorities and Reallocations Committee (data analysis for Priority Setting, Resource Allocation, Comprehensive Plan); 5) Finance/Membership Committee (data analysis for Resource Allocation and Planning Council membership reflectiveness).

Process to Update Clinical Quality Management Plan: The Clinical Quality Management Plan is reviewed and updated annually by the Care Strategy Committee.

Two methods of data collection exist for quality improvement measures: (1) monthly submission of quality indicators that contribute to performance measures and (2) annual site visits with chart audits that objectively quantify compliance with Standards of Care by Service Category (in addition to fiscal, program and planning metrics).

The information from annual site visits and the data collected from client-level data, particularly the HIV/AIDS Bureau (HAB) performance measures are used to pinpoint where quality improvement opportunities exist. Upon identification, the Quality Management Coordinator responds with individual technical assistance, TGA-wide education and/or Plan-Do-Study-Act or quality improvement efforts. The past two years of quality monitoring outcomes are trended in the chart below.

HRSA/HAB Measure	National Benchmark	FY 2009	FY 2010*	IMPROVEMENT EFFORT & Change from Baseline
Tier 1: HIV Treatment				
1.1 Medical visit q six (6) months	No national measure	90%	96%	6% improvement
1.2 CD4 test q 3 months; min q 6 months	Top 10% 2005= 88%	98%	98%	stable
1.3 PCP prophylaxis for CD4<200	Median 2005=94%	89%	100%	11% improvement to date, evidencing full compliance
1.4 Clients prescribed HAART	Median: 2005=95.7%	98%	100%	Strive to maintain a 100% rating—
1.5 Pregnant women on ARV	No national measure	90%	100%	Full compliance
Tier 2: Morbidity				
2.1 % women w/ pap smears q 12 months	Top 25%: 2005=87%	85%	92%	7% improvement to date
2.2 TB screening since HIV diagnosis	Top 10%: 2005=88.8%	89%	94%	5% improvement in placement & reading
2.3 Syphilis test every 12 months	Median: 2005=86.3%	62%	100%	Yearly screening, documented on flow sheet.
2.4 Hepatitis C screen initially, and then repeated among high risk annually	IHI goal=95% 2005=96.7%	78%	96%	Initial/Yearly screening; documented on flow sheet.
2.5 Adherence counseling q 6 months for pts on ARV Therapy	Median: 2005=60.8%	30%	98%	Assessments q visit with documentation & referral
2.6 Lipid screen every 12 months for patients on ARV Therapy	Median: 2005=85%	87%	96%	Yearly screening documented on flow sheet.

2.7 Initiated/Completed Hepatitis B vaccination series	45% in 2004 (CDC)	38%	90%	Assign staff member to monitor.
2.8 HIV Risk Reduction counseling every year	No national measure	47%	100%	Yearly & ideally q 6 months; documented on flow sheet.
2.9 Oral exam every 12 months, with annual referrals as indicated	Median: 2005=36.0%	5%	98%/58%	Joint MCM /PMC/Dental provider referral tracking

The information from annual site visits and the data collected from client-level data, particularly the HIV/AIDS Bureau (HAB) performance measures are used to pinpoint where quality improvement opportunities exist. Upon identification, the Quality Management Coordinator responds with individual technical assistance, TGA-wide education and/or Plan-Do-Study-Act or quality improvement efforts.

