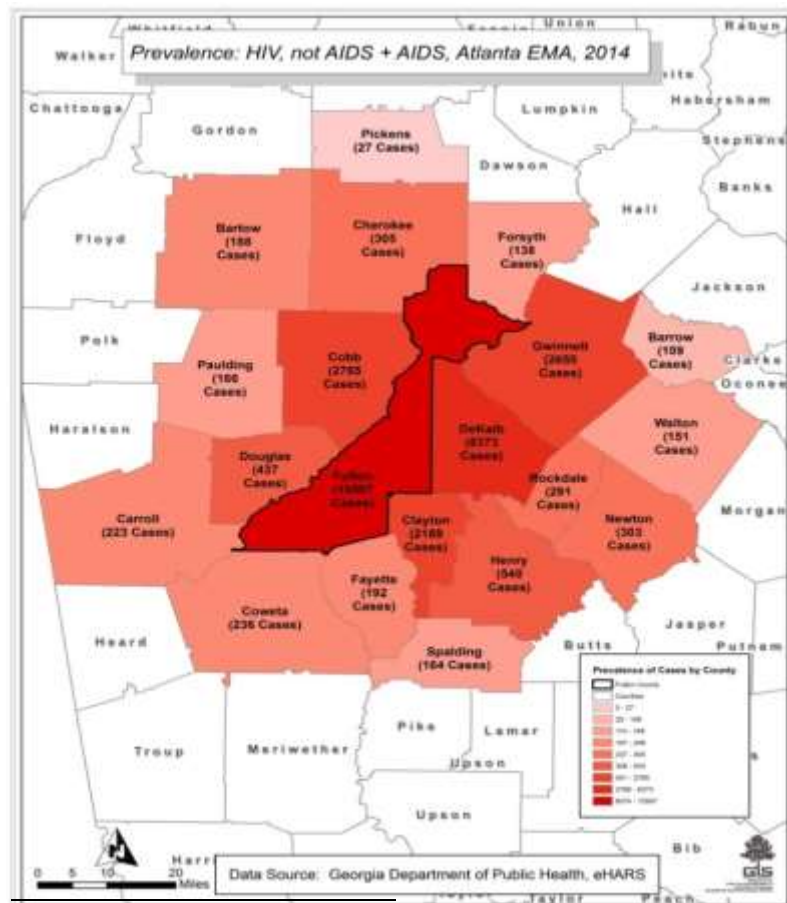


ii. Project Narrative
INTRODUCTION

The purpose of the Atlanta Eligible Metropolitan Area (EMA) Ryan White Part A program is to improve the availability and quality of care for low-income, uninsured, and underinsured individuals and families affected by HIV in the 20-County Atlanta EMA. Funds support clients as they progress through the HIV care continuum and include core medical and support services. The program serves a large number of people living with HIV¹ (PLWH) living in poverty, afflicted with other medical conditions, and lacking health insurance. This includes a sizable population of PLWH who are not eligible for insurance under the Affordable Care Act (ACA), or most publicly-funded programs. Ryan White Part A funds will be used to address service needs and gaps as the implementation of the ACA continues. Funds are also used to support the Quality Management (QM) program and Metropolitan Atlanta HIV Health Services Planning Council (Planning Council), the planning body that undertakes comprehensive planning activities, establishes service priorities and allocates funds in the EMA. Minority AIDS Initiative (MAI) funds are allocated to Outpatient/Ambulatory Health Services (OAHS) to improve health outcomes of people of color.

A. Epidemiologic Overview²

1) Describe/map the region with regard to communities affected by HIV infection.



The EMA is comprised of the following Counties: Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding, and Walton. The HIV epidemic in metro Atlanta is concentrated primarily in one downtown section of Fulton and DeKalb Counties. The prevalence rate of HIV within the cluster is 1.34 percent and is compatible with what the World Health Organization would describe as a “generalized epidemic”. (In comparison, outside the cluster the HIV prevalence is 0.32%.) In 2014, 90% of the EMA's prevalent cases were located in the urban core of the EMA with Fulton at 44.53% (15,597), DeKalb at 23.90% (8,373), Cobb 7.89% (2,765), Gwinnett 7.58% (2,655),

¹ PLWA refers to Persons Living with AIDS/Stage 3. PLWH-Non AIDS refers to Persons Living with HIV that has not progressed to AIDS/Stage 3. PLWH refers to Persons Living with HIV Non-AIDS + Persons Living with AIDS/Stage 3.

² The “Georgia Integrated HIV Prevention & Care Plan” was jointly developed to cover the entire State and does not have the level of specificity for the EMA to cover all sections requested in this application; therefore, EMA-specific information has been added. The Integrated Plan used 2014 data since this was the year that all data sources had in common. 2015 data are used in other sections of the application as appropriate.

and Clayton 6.19% (2,169). Henry 1.54% (540), and Douglas with 1.25% (437) were the only remaining counties with a prevalence >1% with the others ranging from Pickens with 0.08% (27 cases) to Cherokee at 0.87% (305).

2) Describe the socio-demographic characteristics.

a) Demographic data.

In 2014, there were 1,738 new diagnoses and 36,923 PLWH. Fulton and DeKalb Counties accounted for 63% of new diagnoses and 68% of PLWH in the EMA, and 42% of new diagnoses and 45% of PLWH in Georgia. As shown in Tables 1 and 2, overall, 81% of new diagnoses were among males, and approximately two-thirds were among Blacks/African Americans (Black/AA). Among men, the majority of new diagnoses were attributed to male-male sex; among women the great majority of new diagnoses were attributed to heterosexual contact. A higher percentage of new diagnoses among White women was attributed to injection drug use (IDU) than among Black/AA or Hispanic women. Almost two-thirds of new diagnoses were among persons < 40 years of age; almost two-thirds of PLWH were 40 years of age and older (Tables 1 and 2). Marked differences in age at diagnosis were observed among men who have sex with men (MSM) by race/ethnicity. Almost 60% of Black/AA MSM were <30 years of age at diagnosis, compared with 25-35% of Hispanic and White men. In 2014, nine transgender persons were diagnosed with HIV, and 148 were living with HIV (these figures may be low as they rely on providers indicating transgender status on the HIV case report form). HIV/AIDS is taking a substantial toll on the transgender community. Although there is no systematic surveillance data for the transgender population, it has been estimated in recent studies that between 41% to 63% of Black/AA transgender women, 14% to 50% of Latina transgender women, and 4% to 13% of Asian-Pacific Islander transgender women are HIV-positive. Initial studies of transgender male youth have also estimated the HIV prevalence to be between 19% and 22%. Other studies of the overall prevalence of HIV among transgender men estimate that 2% to 3% of transgender men are HIV-positive.³ CAREWare, which is the HRSA provided client-level database, is used to collect client level data on transgender clients served in the Ryan White system. Persons at highest risk for HIV infection include Black/AA MSM, Young Black MSM (YBMSM), and Black/AA heterosexual women.

Table 1. New Diagnoses by Selected Characteristics, 2014	New Diagnoses (1,738)		PLWH (36,923)	
	N	%	N	%
Male	1,410	81	29,266	79
Female	322	19	7,588	21
Transgender	10	<1	132	<1
White	216	12	7,036	19
Black/AA	1,119	64	24,470	66
Hispanic	107	6	2,238	6
Asian	11	<1	171	<1
AI/AN	<5	--	17	<1
API	29	2	16	<1
Unknown	253	15	1,301	4

Table 2. New Diagnoses, Transmission Category by Race/Ethnicity and Sex, 2014	New Diagnoses (1,738)		PLWH (36,923)	
	N	%	N	%
White Male	175	92	5,686	88
MSM	<5	--	142	2
IDU	8	4	482	8
MSM/IDU	<5	--	88	1
Heterosexual	175	92	5,686	88
Black/AA Male				
MSM	783	87	15,111	82
IDU	26	3	1,121	6
MSM/IDU	17	2	1,036	6
Heterosexual	75	8	1,107	6

³ “Trans Lives Matter: All Lives Matter, but Not all Lives are Treated Equally”, Fulton County Department of Health and Wellness, HIV High Impact Prevention Program, 2015.

Table 1. New Diagnoses by Selected Characteristics, 2014	New Diagnoses		PLWH	
	(1,738)		(36,923)	
	N	%	N	%
MSM	1,070	62	1,674	5
IDU	51	3	23,331	63
MSM/IDU	29	2	2,337	6
Heterosexual	329	19	1,734	5
13-19	64	4	7,439	20
20-29	637	37	100	<1
30-39	439	25	2,094	13
40-49	310	18	2,971	18
50-59	215	12	4,429	27
60+	66	4	4,624	28

Table 2. New Diagnoses, Transmission Category by Race/Ethnicity and Sex, 2014	New Diagnoses		PLWH	
	(1,738)		(36,923)	
	N	%	N	%
Hispanic Male				
MSM	78	83	1,503	83
IDU	<5	--	70	4
MSM/IDU	<5	--	110	6
Heterosexual	10	11	121	7
White Female				
IDU	5	17	152	25
Heterosexual	21	82	433	72
Black/AA Female				
IDU	11	5	709	12
Heterosexual	200	93	5,045	85
Hispanic Female				
IDU	<5	--	53	13
Heterosexual	11	85	355	85

Overall, 22% of persons diagnosed in 2014 were diagnosed with Stage 3 disease (AIDS) within 3 months of their HIV diagnosis. A higher proportion of Hispanics (34%) than Whites (20%) or Black/AA (22%) were diagnosed late; late diagnoses were more common among persons 40 years of age and older (30%), and among IDU (27%).

In the past 5 years, the number of prenatally-infected infants born each year has been 4 in 2010, 12 in 2011, 8 in 2012, 3 in 2013 and 5 in 2014. Approximately two-thirds are born in the Atlanta metro area.

b) Socioeconomic data.

Uninsured and poverty are discussed in greater detail in Section A. Impact of Funding 2) a). Table 3 provides socioeconomic data for the EMA as a whole. Data specific to newly diagnosed, PLWH, and persons at higher risk for HIV infection follows.

Table 3. Socioeconomic data for the Atlanta EMA, 2014 ⁴			
Category	Average	High	Low
Primary Care Physician Ratio	1,543:1	7,975:1	906:1
Dentist Ratio	1,992:1	7,240:1	1,097:1
Mental Health Provider Ratio	1,239:1	11,695:1	589:1
Uninsured Adults	25%	32%	15%
Uninsured Children	10%	12%	8%
Average Health Care Costs	\$9,614	\$11,097	\$8,424
High School Graduation Rate	70%	86%	51%
Some Post-Secondary Education	67%	77%	45%
Unemployment Rate	8.8%	11.3%	6.8%
Severe Housing Problems	15%	23%	12%
Children Living in Poverty	22%	37%	8%

⁴ County Health Rankings & Roadmaps, <http://www.countyhealthrankings.org/reports>

3) Burden of HIV in the EMA.

Table 4. New HIV diagnoses and HIV prevalence by sex and race/ethnicity per 100,000 population, Atlanta EMA, 2014			
	Population Size	New diagnoses	Prevalence
Black/AA	1,826,271	61.3	1,339.9
Hispanic	565,229	18.9	395.9
White	3,010,508	7.2	233.7
Asian	314,996	3.5	54.3
American Indian	43,140	Number too low to report	39.4

New diagnoses: Among Black/AA men, the number of new diagnoses among men < 30 years of age outnumbered those among men 30 and older starting in 2010. New diagnoses have declined in men 30 and older (Figure 1). Among White men, the number of new diagnoses declined in men 30 and older and remained stable in men under 30 (Figure 2). Among Hispanic men new diagnoses were fairly stable in men under and over 30 (Figure 3).

Figure 1. New HIV Diagnoses among Black/AA Men by age at Diagnosis, Atlanta EMA, 2006-2014

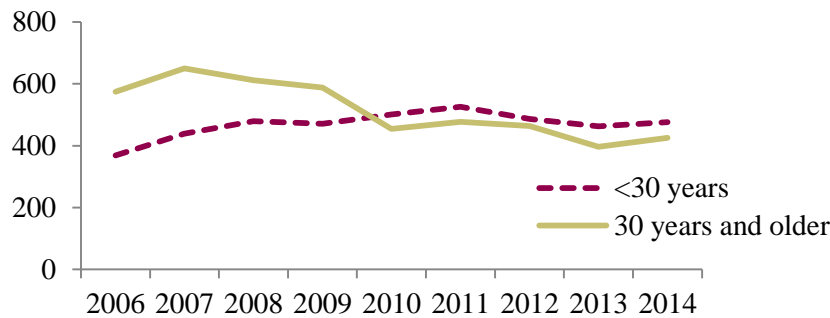


Figure 2. New HIV Diagnoses among White Men by Age at Diagnosis, Atlanta EMA, 2010-2014

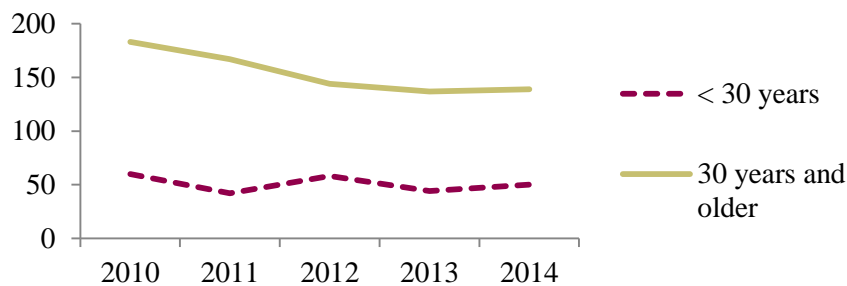
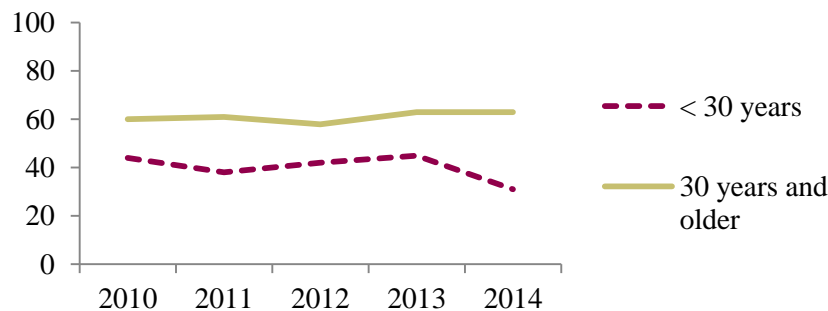
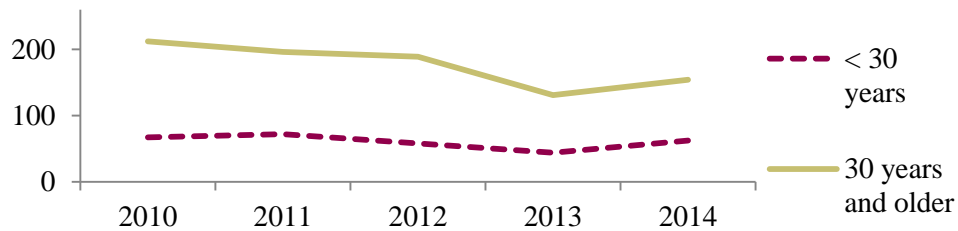


Figure 3. New HIV Diagnoses among Hispanic Men by Age at Diagnosis, Atlanta EMA, 2010-2014



Among Black/AA women, new diagnoses declined both for women over and under 30 years of age (Figure 4). For White and Hispanic women trends are difficult to interpret due to small numbers.

Figure 4. New HIV Diagnoses among Black/AA Women by Age at Diagnosis, Atlanta EMA, 2010-2014



HIV prevalence: HIV prevalence has increased in all groups as a result of declines in mortality.

4) Indicators of risk for HIV.

a) Behavioral surveillance data.

Georgia National HIV Behavioral Surveillance (NHBS) data are used to describe socio-economic status and risk behaviors of populations at high risk of HIV: MSM, IDU, and high risk heterosexuals (HRH). Georgia data are collected entirely in metropolitan Atlanta. The interviews are conducted every fall, with a different population targeted each time in rotation over a three-year cycle. Different participants are interviewed during each data collection period. The NHBS recruit MSM from venues frequented by MSM, and offers them an incentive to complete the interview and be tested for HIV. An effort was made to recruit Young Black/African American MSM (YBMSM), accounting for the higher proportion of 18-29 in the Black/AA MSM sample. Respondent-driven sampling is used to recruit IDU and high risk heterosexuals, and they too are offered an incentive.

MSM: Overall, among those self-reporting negative HIV status, 21% reported condomless anal sex, 39% reported sex with a partner of unknown status, and 40% reported 5 or more sexual partners in the last 12 months. There were no major differences in risk behaviors between Black/AA and White MSM with the exception that a higher proportion of White men reported 5 or more partners (54% versus 32%). Thirty-three percent of Black/AA MSM and 23% of White MSM responded very likely or somewhat likely to “*what is your gut feeling about how likely you are to get infected with HIV?*” Among men less than 30 years old, there was no difference between Blacks/AA and Whites (33% and 36% respectively), while there was a marked difference among Black/AA and White men 30 and older (33% and 17%, respectively). Awareness of PrEP was substantially lower among Black/AA MSM than White MSM (43% and 66%, respectively). Overall 66% of MSM had an HIV test in the last 12 months; 9% of Black/AA MSM and 3% of White MSM reported never having had an HIV test.

Persons Who Inject Drugs (PWID): Heroin was the most commonly reported often used drug (60%), followed by speedball (heroin and cocaine) (29%) and cocaine (9%). Twenty-nine percent reported using needles someone had already injected with, and 10% reported using needles someone else had already injected with half of the time or more. Forty-eight percent reported being tested for HIV in the last 12 months, and 8% reported having never been tested. PWID were interviewed in fall 2015, with an emphasis on reaching young PWID. Compared with persons older than 35 years of age, a higher proportion of persons under 30 was White, and a higher proportion was previously addicted to prescription painkillers. Among PWID 18 to 35 years of age, 27% reported being Hepatitis C Virus (HCV) positive and 23% had never been tested for HCV; 23% reported using a needle after someone else half of the time or more in the past 12 months and 35% reported sharing other injection equipment (spoon, cotton, water).

High Risk Heterosexuals: Seventy-one percent of males and 81% of females reported no condom at last sex encounter and over half reported not knowing last sex partner's HIV status. Eighty-five percent of respondents reported yes to having been tested for HIV with 40% tested in the last 12 months.

Demographic characteristics and risk behaviors among PLWH in care: One data source utilized to provide information on the demographic characteristics among PLWH in care is the Medical Monitoring Project (MMP). The MMP is a surveillance system through which behavioral and clinical information is collected via interviews and chart abstractions for a representative sample of PLWH receiving HIV care in Georgia. The MMP is designed to be representative of Georgia as a whole and it is not intended to be analyzed at the sub-state level; nonetheless, similar patterns within EMA and outside EMA provide a reasonable approximation.

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

Thirty-six percent reported no sexual activity in the last 12 months (22% of MSM, 56% of men who have sex with women [MSW] and 45% of women who have sex with men [WSM]). Among MSM, 12% reported unprotected anal sex with a partner of unknown or negative status in the last 12 months. Among MSW, 3% reported unprotected vaginal sex with women of unknown or negative status, and 15% of WSM reported unprotected vaginal sex with men of unknown or negative status. Only 9 of 795 reported injection drug use in the last 12 months; 22% reported non injection drug use (the vast majority marijuana). PLWH in care have lower rates of risky behaviors than PLWH who are not in care. Furthermore, a substantial proportion of PLWH in care is virally suppressed and therefore at very low risk of HIV transmission. Data from the MMP do not provide information about transmission risk from HIV infected persons who are not in care.

b) HIV surveillance data.

HIV Testing Data (Table 5): efforts are aligned with the need to target those populations that are at greatest risk of HIV infection consistent with prevalence and new diagnoses trends noted from HIV Surveillance data. Positivity rates are highest among Black/AA, Hispanics, males, MSM, and transgender. Provisions of HIV testing in non-healthcare settings see high impact in the identification and diagnoses of young persons and MSM unaware of their positive status with positivity rates 2.9% for Fulton/DeKalb⁵ respectively. HIV testing in healthcare settings for Fulton/DeKalb saw positivity rates greater than 20% for MSM and MSM/IDU.

Table 5. Assessment of Public Health Supported, Test-Level HIV Testing Data in Healthcare and Non-Healthcare Settings, in Fulton and DeKalb Counties, Georgia, CY 2014												
Characteristics	Test Events				Confirmed Positive				Newly Confirmed			
	Healthcare		Non		Healthcare		Non		Healthcare		Non	
	#	%	#	%	#	+ Rate	#	+ Rate	#	+ Rate	#	+ Rate
Total Test-Level Testing Events	24,265	100	11,260	100	637	2.6	72	0.6	208	.09	82	0.6
Age												
Less than 13	649	2.7	10	0.1	<5	--	<5	--	<5	--	<5	--
13 – 19	1,964	8.1	826	7.3	6	0.3	<5	--	<5	--	<5	--
20 – 29	10,199	42	3,930	34.9	257	2.5	38	1	100	1.0	34	0.9
30 – 39	5,677	23.4	2,369	21.2	159	2.8	15	0.8	53	0.9	12	0.5
40 – 49	3,143	13	1,811	16.1	107	3.4	13	0.7	28	0.9	12	0.7
50 - 59	1,895	7.8	1,552	13.8	83	4.4	<5	--	21	1.1	<5	--
60+	719	3	665	5.9	24	3.3	<5	--	<5	--	<5	--

⁵ Fulton and DeKalb County are directly funded by CDC for prevention activities and are the two jurisdictions with the highest HIV rates in the EMA. The State of Georgia provides prevention services for the remainder of the state. In the interest of brevity, Fulton and DeKalb numbers are presented.

Race/Ethnicity												
American Indian/ Alaska Native	12	0.0	18	0.2	<5	--	<5	--	<5	--	<5	--
Asian	1,739	7.2	196	1.7	<5	--	<5	--	<5	--	<5	--
Black/ African American	19,543	80.5	9,000	79.9	568	2.9	57	0.6	191	1	49	0.5
Hispanic	1,143	4.7	628	5.6	24	2.1	5	0.8	8	0.7	5	0.8
More than one race	93	0.4	105	0.9	<5	--	5	4.8	<5	--	<5	--
White	1,619	6.7	1,202	10.7	38	2.3	<5	--	5	0.3	<5	--
Gender												
Female	13,322	54.9	5,160	45.8	110	0.8	9	0.2	30	0.2	9	0.2
Male	10,820	44.6	6,015	53.4	512	4.7	63	1	171	1.6	53	0.9
Transgender F to M	39	0.2	31	0.3	<5	--	<5	--	<5	--	<5	--
Transgender M to F	50	0.2	43	0.4	15	30	<5	--	7	14	<5	--
HIV Risk Factor												
Heterosexual Contact	18,970	78.2	8,133	72.2	223	1.2	23	0.3	73	0.4	18	0.2
Injection Drug User (IDU)	125	0.5	202	1.8	5	4	<5	--	<5	--	<5	--
MSM	1,673	6.9	1,569	13.9	348	20.8	45	2.9	116	6.9	40	2.5
MSM/IDU	27	0.1	28	0.2	9	33.3	<5	--	<5	--	<5	--

c) Ryan White HIV/AIDS Program (RWHP):

Table 6. Demographics of Populations Served by Part A, CY 2014		
SEX	Male	10,675
	Female	3,464
	Transgender	140
	Unknown/Unreported	2
RACE	Black/African American	11,119
	White	2,074
	Asian	102
	More than one race	187
	Other	18
	Unknown/Unreported	6
ETHNICITY	Hispanic	793
	Non-Hispanic	14,281
PERCENT OF FEDERAL POVERTY LEVEL⁶	≤138%	10,160
	≤300%	12,664
	≤400%	13,261
	>400%	211
	Unknown/Unreported	809
HIV TRANSMISSION RISK CATEGORY	MSM	8,034
	IDU	586
	MSM/IDU	232
	Heterosexual	6,283

⁶ While the FPL is the official measure of poverty used to determine income eligibility for most public benefits programs, the measure is an outdated one, developed in the 1960s and based solely on the cost of the basic food budget needed to meet minimum nutritional requirements. The FPL does not take into account costs for housing, transportation, health care, and other necessary living expenses. Thus, estimates of poverty based on the FPL more likely reflect a picture of people living in extreme poverty.

d) Other relevant demographic data including Hepatitis, STD, TB and Substance use:

STDs: Incidence of STDs is a proxy measure for sexual behaviors which may increase exposure to HIV. Syphilis, Gonorrhea, and Chlamydia rates in metropolitan Atlanta are among the highest in the U.S. The great majority of primary and secondary (P&S) syphilis occur among males (MSM), among Blacks/AA, and among persons 20-29 years of age. Women account for approximately half of gonorrhea diagnoses, and for approximately three quarters of chlamydia diagnoses. Blacks/ AA and persons 15-25 years of age account for the majority of both. Based on a match between STD data and HIV Surveillance: Among the 1,311 P&S syphilis diagnoses in 2014, 893 (68%) had also been diagnosed with HIV. **Syphilis:** The overall rate of reported P&S syphilis cases in the 50 most populous metropolitan statistical areas (MSAs) was 8.7⁷ in 2014, which represents a 13.0% increase since 2013 (7.7). In metropolitan Atlanta the rate was 18.0 (46% increase from the 2010 rate of 12.3) ranking Atlanta 1st among all MSAs. The rate among males in the MSAs was 16.4; the rate in Atlanta was 35 (a 48% increase from the 2010 rate of 23.6) ranking Atlanta 1st among all MSAs.⁸ **Chlamydia:** In 2014, the rate of reported cases of chlamydia in the 50 most populous MSAs increased 3.6% from the rate in 2013 (458.3 and 474.6 respectively). In the Atlanta MSA the rate was 466.1 which was an 11% increase over the 2010 rate of 420. Among the MSAs, the rate among men increased 8.1% (283.8 to 306.8; in Atlanta the rate among men was 297.5 (an increase of 18% over the 2010 rate of 252). **Gonorrhea:** The overall rate of reported gonorrhea cases in the 50 most populous MSAs was 122.8 in 2014, representing a 5.0% increase compared with 2013 (117.0). In the Atlanta MSA the rate was 131.4 (a 17% decrease from the 2010 rate of 155.7). Among the MSAs the rate among men was 144.1; the Atlanta rate was 155.7 (a 7% decrease from 167.5 in 2010). While improving, Atlanta rates exceed the average.

Tuberculosis (TB): TB patients need to be tested for HIV for the optimal treatment of TB. Active TB often accelerates the natural progression of HIV infection, and treatment may change if patient is using antiretroviral therapy (ART) for HIV infection. In 2014, HIV status was reported for 93% of TB cases overall and 98% of persons 25-44 years of age. Among 311 TB cases with known HIV status in 2014, 37 (12%) were HIV positive. **In 2014, a TB outbreak occurred in Fulton County, with 43 TB cases reported among homeless persons; of these 16 (37%) were HIV infected.** In 2013, only 3 homeless TB cases were reported in Fulton County, none were HIV infected. The background rate of HIV infection among TB cases in Fulton County in 2014 was 28%, indicating that persons with HIV infection were particularly vulnerable to the outbreak in 2014.

Hepatitis C Virus (HCV): Diagnoses of HCV have been steadily increasing in the EMA over the last five years, most likely as a result of improved surveillance and increased testing efforts. Because of the chronic nature of HCV infection, diagnoses provide limited information about incidence. There was an increase of 246% in reported cases from 2010-2014 and an increase of 270% in confirmed cases. Diagnoses in persons 30 and under are a better indicator of recent infection and have also been increasing over the last five years. Georgia has observed a 230% increase in reported HCV infections since 2010. Less than half of the reported HCV infections in this young adult population were confirmed with HCV PCR testing. A high proportion of HCV cases for which risk information is obtained in the young adult population are found to have a current or past history of injection drug use. Among the IDU interviewed as part of the NHBS almost half of those 35 years of age and older reported testing positive for HCV and one-third of those 35 years of age and younger.

e) Qualitative data: Not included in Integrated Plan

⁷ Expressed as cases per 100,000 population

⁸ www.cdc.gov/std/stats14

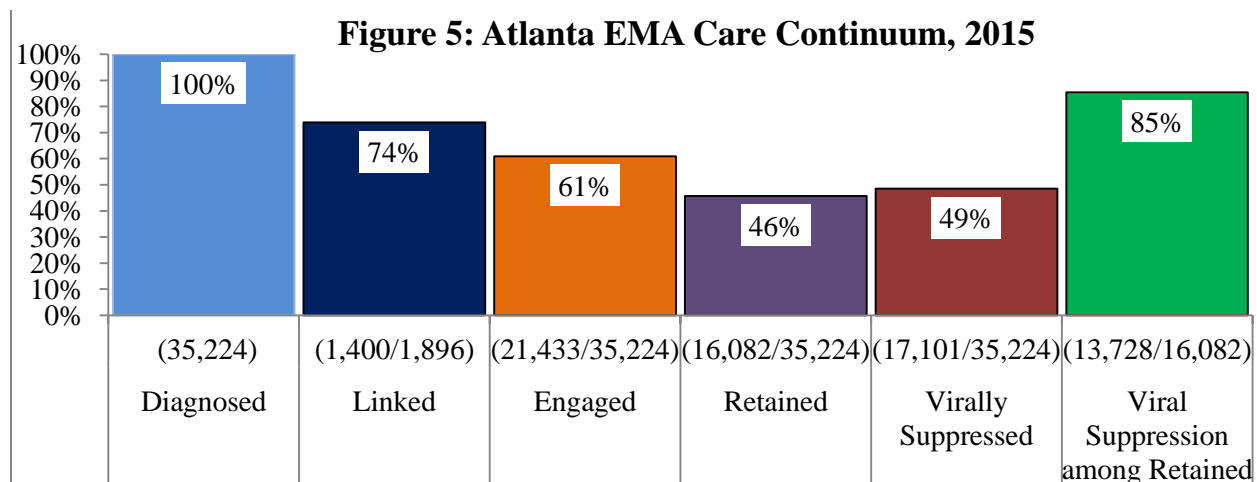
f) Vital statistics data: In 2012-2014, there were 1.1 to 1.5 HIV-related deaths per 100,000 population among Whites, 9.6-10.1 HIV-related deaths per 100,000 population among Black/AA, and 0.7-1.0 HIV-related deaths per 100,000 population among Hispanics.

g) Other relevant program data including Community Health Center data:

Georgia’s health care delivery system, including its safety net providers, will continue to play an important role in delivering health care to the state’s vulnerable populations. Georgia’s community health centers and hospitals provide access to needed primary, preventive, and acute care services for low-income and underserved residents. Georgia is home to 29 federally qualified health centers (FQHCs), together operating 161 clinic sites throughout the state. In 2012, the state’s FQHCs saw over 320,000 patients and had nearly 1 million patient visits. Over half (53%) of patients were uninsured, while 26% had Medicaid or CHIP. Nearly all (96%) were low-income, including about three-quarters (73%) who had income below poverty. In 2014, Georgia’s FQHCs saw 3,530 patients with HIV. Demographic data were not available for inclusion in this document.

B. FY17 HIV Care Continuum

1) Figure 5 illustrates the Atlanta EMA HIV Care Continuum using 2015 data (the most currently available dataset). The number and percent of PLWH in the EMA prescribed antiretroviral therapy are unavailable.



The following definitions were used to calculate the Atlanta EMA Care Continuum:

a) **HIV-Diagnosed:** These are persons with a diagnosis of HIV infection (regardless of stage of disease at diagnosis) as of September 30, 2015 and living through December 31, 2015 = 35,224 (*eHARS: hiv_aids_dx_dt<2015*)⁹. Note: This number differs from the figures in Attachment 3 which cover the entire 12-month year.

b) **Linkage to Care (L):** The number of people diagnosed with HIV in 2014 (*eHARS: hiv_aids_dx_dt=2014*)⁹) with one or more documented medical visits, viral load or CD4 tests within 3 months of diagnosis (numerator) = 1,400. Data submitted to the Georgia Department of Public Health (DPH) are limited to lab reports and do not include medical visits. The total number of people diagnosed with HIV in 2014 (denominator) = 1,896.¹⁰ 1,400/1,896= **74%**.

⁹ Enhanced HIV/AIDS Reporting System (eHars) and HIV/AIDS Epidemiology Unit, Georgia Department of Public Health, September 2016. Numbers for persons living with HIV infection are based on data entered as of June 27, 2016 and are not adjusted for reporting delays.

¹⁰ HIV/AIDS Epidemiology Unit, Georgia Department of Public Health, September 2016.

Engaged in Care (E): The number of diagnosed individuals who had one documented medical visit, viral load or CD4 test performed in the measurement year (numerator) = 21,433.¹⁰ Data submitted to DPH are limited to lab reports and do not include medical visits. The percentage was calculated by dividing the numerator of 21,433 by the denominator, HIV-Diagnosed of 35,224 resulting in **61%**. This number is useful for planning purposes because it includes those individuals who are in care, are virally suppressed, and have less frequent medical visits as a result of their good health. This figure also allows us to consider individuals entering care who were diagnosed previously and were never in care or dropped out of care.

c) **Retained in Care (R):** The number of diagnosed individuals who had two or more documented medical visits, viral load or CD4 tests performed at least three months apart in the measurement year (numerator) = 16,082.¹⁰ Data submitted to DPH are limited to lab reports and do not include medical visits. The percentage was calculated by dividing the numerator of 16,082, by the denominator, HIV-Diagnosed of 35,224 resulting in **46%**.

d) **Antiretroviral Use (A):** The number of people receiving medical care and who have a documented ARV prescription in their medical record. These data are not available to DPH.

e) **Viral Suppression (VS):** The number of individuals whose most recent HIV viral load within Calendar Year (CY) 2015 was less than 200 copies/mL was obtained from DPH to which all labs in the state are reported. There were 17,101 performed in the year.¹⁰ The percentage of HIV-Diagnosed who had documented viral suppression was 17,101 which divided by 35,224 results in **49%** (up from 41% in 2014 which represents an increase of 20%).

Viral Load Suppression among Retained (VSR): The number of individuals retained in care whose most recent HIV viral load within CY15 was less than 200 copies/mL was obtained from DPH to which all labs in the state are reported. There were 13,728 performed in the year.¹⁰ The percentage of retained individuals who had documented viral suppression was 13,728 which divided by 16,082 (the number retained in care) results in **85%**. A low percent virally suppressed may reflect differences in receipt of any HIV care, retention in care, treatment with and adherence to ART, or missing data. When no viral load for 2014 was reported to DPH, the individual was assumed to be not virally suppressed. It is helpful to examine the proportion virally suppressed among persons retained in care. Overall in the EMA there was a small difference in viral suppression among those retained in care by sex (males 86%, females 84%). There were, however, greater differences by race (White 93%, Black/AA 82%).¹¹ This analysis of persons retained in care demonstrates that disparities in viral suppression are not always simply a function of access to and retention in care.

Approximately half of persons living with HIV in Georgia in most demographic categories examined had no viral load reported in 2014, and are considered not suppressed in this analysis. Missing viral load measurements may lead to an underestimate of VS and VSR.

2) **There are disparities related to sex, race, sexual orientation and age.**

When analyzing the characteristics of PLWH in each stage of the Atlanta EMA's HIV Care Continuum, 46% were found to be retained in care (up from 39% last year), or put another way, 54% were identified as **not** being retained in care. The ultimate goal is the suppression of the HIV virus. Analyzing VS and VSR reveal a number of disparities:

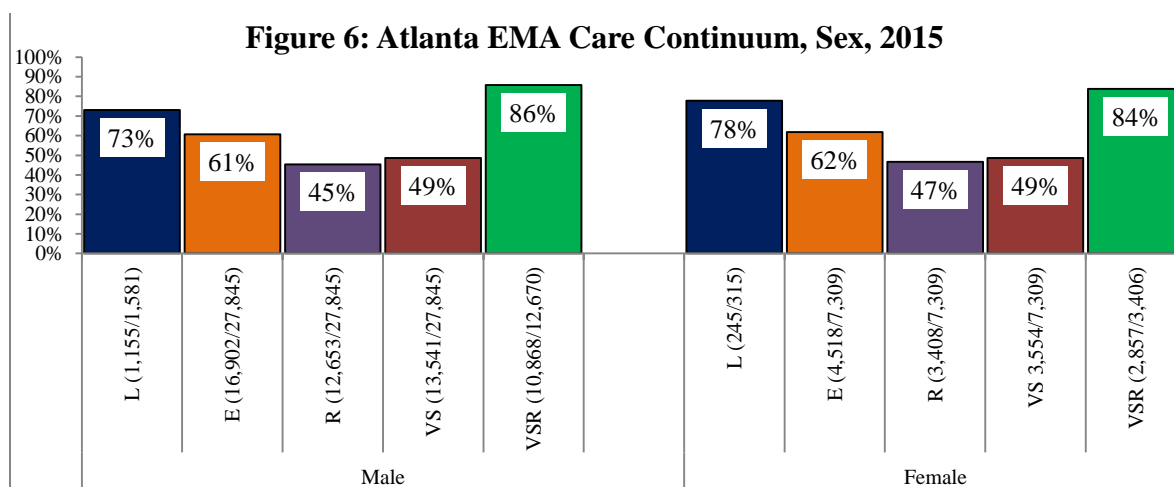
- VS rates for males and females are both 49%. There were no significant differences in VSR.
- VS rates show Whites at 46%, Black/AA at 49% and Hispanic females at 50. This pattern shifts when examining VSR with Whites having a 86% rate, Black/AA with 83% and Hispanics at 87%.
- 45% of Black/AA were virally suppressed compared to 49% of Hispanics and 57% of Whites. VSR rates for Black/AA were only 66% compared to 80% of Hispanics and 84% of Whites.

¹¹ Less than 0.5% of the prevalent population living with HIV in the EMA is American Indian/Alaska Native, Asian or Native Hawaiian/Other Pacific Islander. Because of small sizes when stratified by the 20 counties, distribution by race/ethnicity is only reported for Blacks, Hispanic/Latinos, and Whites in this report.

- Among MSM, only 46% of Black/AA PLWH were virally suppressed compared to 58% of Whites and 50% of Hispanics. VSR numbers show a greater disparity with Black/AA at 82% compared to 94% of Whites and 88% of Hispanics.
- The lowest VS rates are among the 20-29 age group (43%) compared to percentages around 50% for PLWH over 40 and 59% for those 13-29.
- Among Black/AA MSM in the EMA rates were lowest in the 25-44 and 65+ age groups at 44% compared to 46% of 13-24 and 50% of 45-64.
- MSM were more likely to be retained in care (40%) than heterosexuals (39%).

Below are care continuums illustrating disparities. To make the charts more legible, “Diagnosed” has been removed but is represented by the denominator for all stages except Linked to Care.

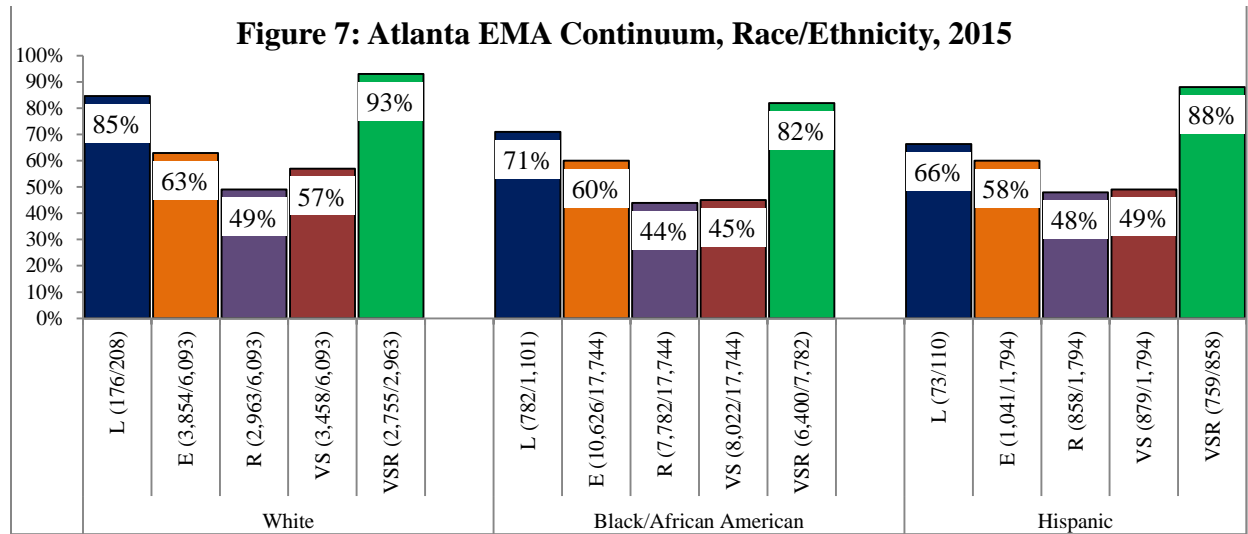
Sex (Figure 6): There were almost four times as many males as females diagnosed through September 30, 2014 and living through December 31, 2015. There are insufficient data for transgender women to develop a HIV Care Continuum at this time (see Resolution of Challenges section). Females were linked to care at a higher percentage than males (78% v 73%)¹² but retention and viral suppression were almost equal. Unmet need for males was 55% and 53% for females. Part A served 47% of all female PLWH in the EMA diagnosed through September 30, 2014 and living through December 31, 2015.



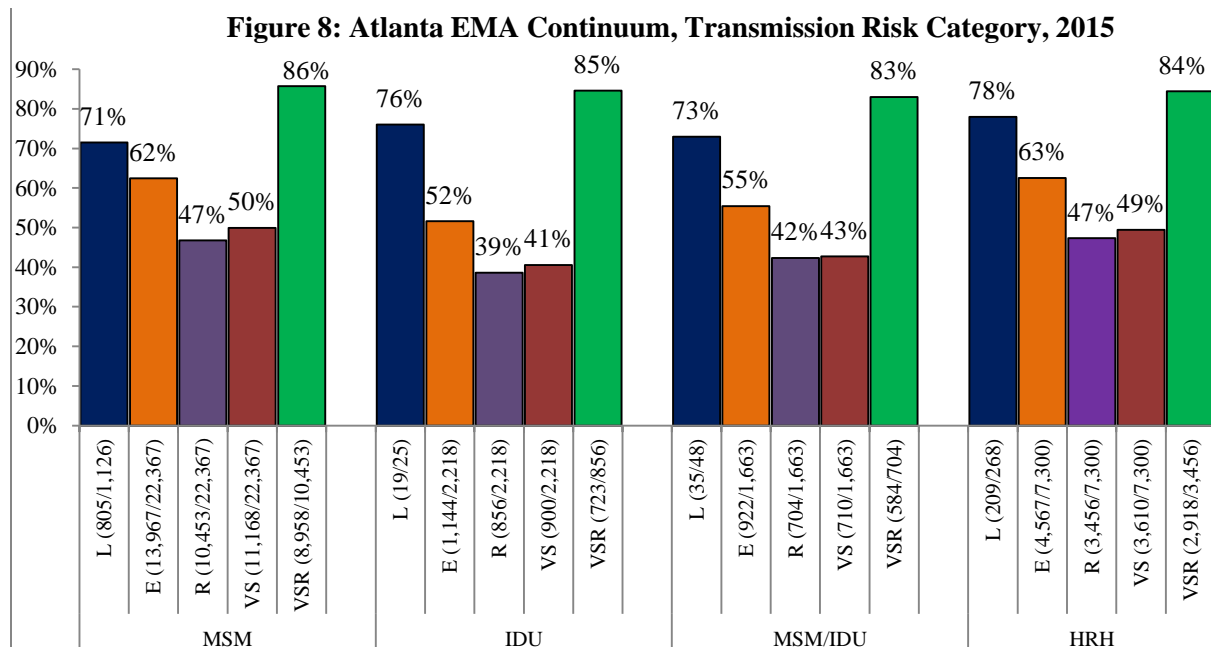
Race and Ethnicity (Figure 7): At 17,744 there were roughly 10 times more Black/AA diagnosed through September 30, 2014 and living through December 31, 2015 than Hispanics and approximately 3 times more than Whites. There were roughly 3 times as many Whites as Hispanics (of any race) diagnosed during this same time period. L rates for Black/AA were significantly less than for Whites (14 percentage points) and less than for Hispanics (5 percentage points). A lower percentage of Black/AAs were virally suppressed compared to Whites - the magnitude of the difference was 12 percentage points and 11 percentage points when looking at VSR. A lower percentage of Black/AAs were virally suppressed compared to Hispanics – though the magnitude of the difference was less at 4 percentage points – the VSR difference was 6 points. Part A served 32% of all White (1,942), 64% of all Black/AA (11,340)

¹²Note: Numbers may not total 100%. When looking at race, for example, the majority of residents of the EMA are either Black/AA or White with small percentages for other races. Other races were excluded from comparisons. Also, totals for race may differ from those for sex, or risk category due to missing data elements in CAREWare (e.g., a person might have been counted in the total for the sex data but excluded from the race total due to because this variable was not included in CAREWare).

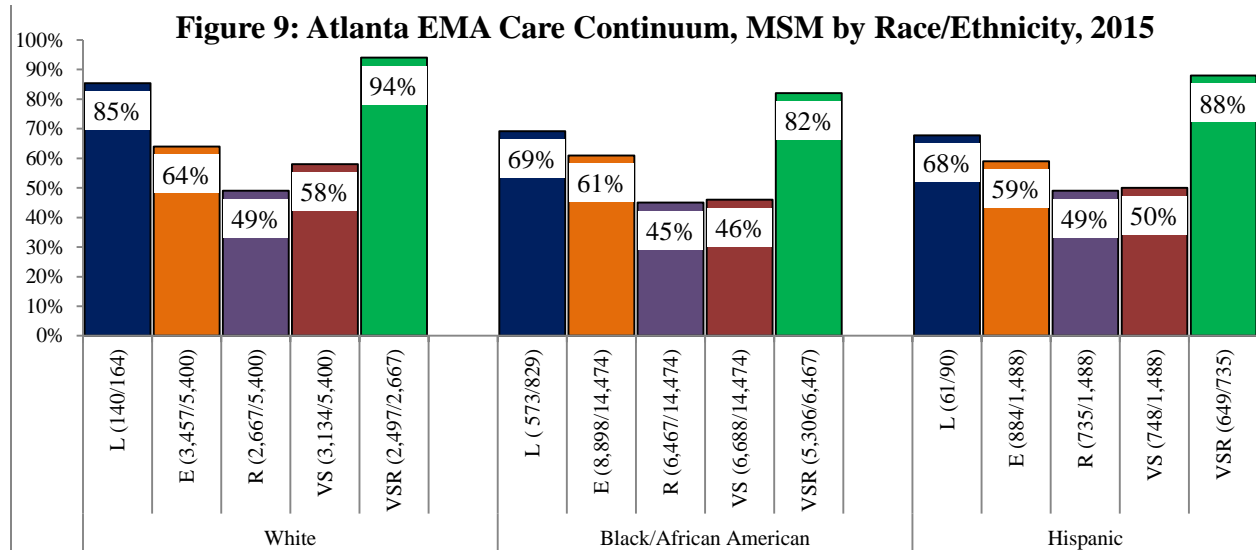
and 47% (844) of all Hispanic PLWH diagnosed through September 30, 2014 and living through December 31, 2015.



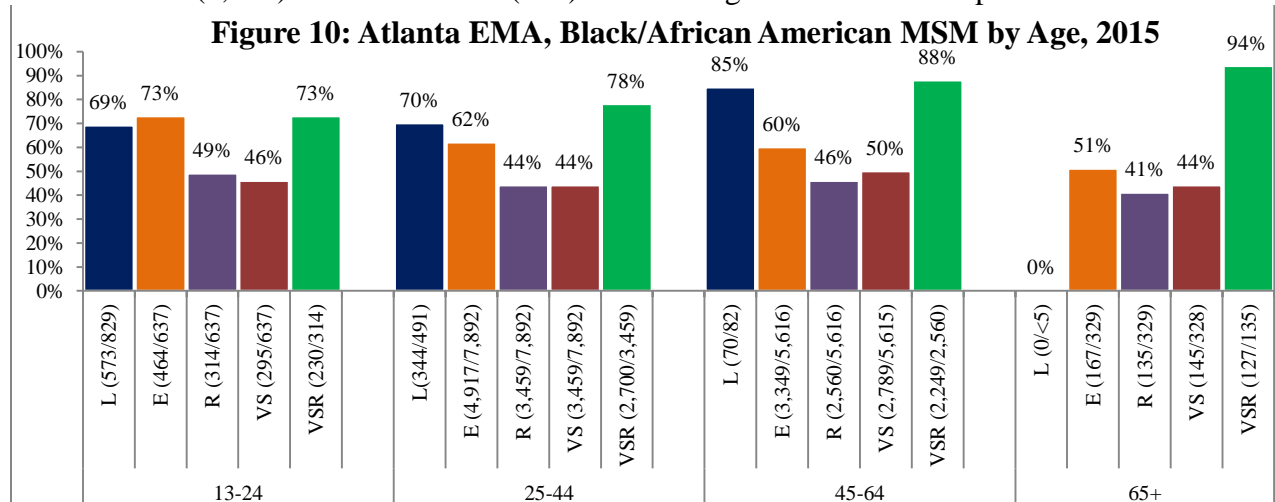
Risk Transmission Category (Figure 8): There were three times more MSM than High Risk Heterosexual (HRH); 10 times more MSM than IDU; and, 3 times more HRH than IDU diagnosed through September 30, 2014 and living through December 31, 2015. VSR rates were virtually the same in all groups. MSM and HRH were virtually the same and there were no remarkable differences in comparison with the total Atlanta EMA continuum (Figure 5). IDUs had the lowest rates in all stages of the continuum with the exception of L where the numbers are too small to consider; in comparison with Figure 5, R rates were 7 percentage points lower and VS rates were 8 points lower. MSM/IDU had lower E, R, and VS than MSM; in comparison with Figure 5, MSM/IDU had comparable E rates, but lower R (4 percentage points) and VS rates (6 points). Part A served 36% of all MSM (7,956), 15% of all IDU, 13% of all MSM/IDU, and 70% of all Black/AA (6,081) and 34% (499) of all Hispanic PLWH diagnosed through September 30, 2014 and living through December 31, 2015.



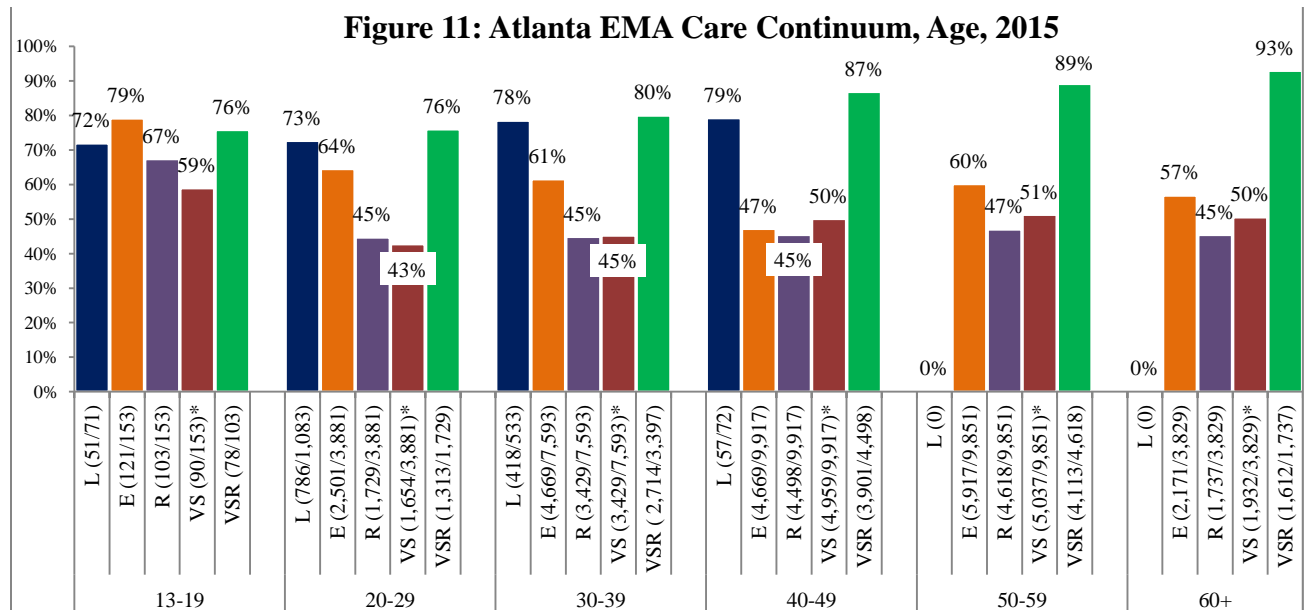
MSM by Race and Ethnicity (Figure 9): There were roughly 10 times more Black/AA MSM diagnosed through September 30, 2014 and living through December 31, 2015 than Hispanics and approximately 2½ times more than Whites. There were roughly 3½ times as many Whites as Hispanics (of any race) diagnosed during this same time period. In comparison with the total Atlanta EMA continuum (Figure 5), White MSM fared better in all categories; Black/AA MSM had comparable rates except for a lower VS rate; Hispanic MSM were engaged at a lower rate, but had slightly higher VS and VSR rates.



Black/AA MSM by Age (Figure 10): The majority of Black/AA MSM PLWH diagnosed through September 30, 2014 and living through December 31, 2015 were in the age group 25-44 (55%), followed by 45-64 (39%), 13-24 (4%). E and R rates are lowest among the 65+ age group, yet VS is comparable to other groups and VSR is highest. The youngest age group, 13-24, had high engagement rates with considerably lower R rates and the lowest VSR rates. In comparison with the continuum for the EMA as a whole (Figure 5): L rates for Black/AA MSM were lower in all age groups except 45-64. E rates for Black/AA MSM 13-24 were higher, and 65+ were lower. R rates were higher for Black/AA MSM 13-24 and lower for 25-44 and 65+. VS rates for Black/AA MSM were lower in groups other than 45-64 which was slightly higher. VSR rates for Black/AA MSM for 13-24 were lowest, higher for 25-44 and highest for 45+. Among Black/AA MSM, by age group, Part A served 71% of 13-24 (455), 55% of all 25-44 (4,376), 52% of 45-64 (2,948) and 52% of 65+ (172) PLWH diagnosed in this time period.

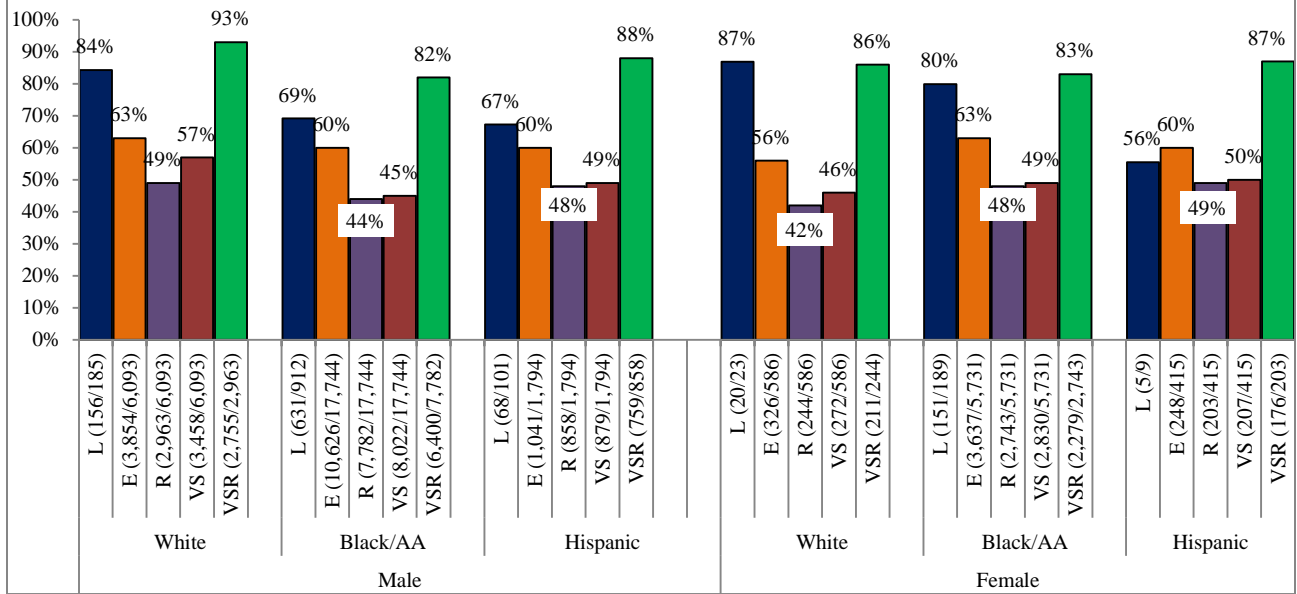


Age (Figure 11): Rates for L, E, R and VS were better among the 13-19 age group than any other group. E, R, and VS drop off significantly between PLWH 13-19 and 20-29 often as clients transition from youth programs to adult programs. Local experience has shown the transition period is the time when these young clients are most at-risk for dropping out of care. In each age group there were large numbers of individuals without lab reports; therefore, VS is unknown: 13-19 had 39 unknown (25%); 20-29 had 1,522 (39%); 30-39 had 3,185 (42%); 40-49 had 4,087 (41%); 50-59 had 4,087 (42%); and, 60+ had 1,734 (45%).



Race/Ethnicity by Sex (Figure 12): The majority of PLWH diagnosed through September 30, 2014 and living through December 31, 2015 were Black/AA males: there were three times as many Black/AA males than White males and 10 times more than Hispanic males. Among females diagnosed through September 30, 2014 and living through December 31, 2015 the majority were Black/AA: there were 10 times as many more than White females and 4 times as many as Hispanic females. White males fared best in all stages of the continuum followed by Hispanics followed by Black/AA males. White females had poorer R and VS rates than Black/AA females but better VSR rates. In comparison with the EMA (Figure 5): White males fared better in all stages; Black/AA males did worse in VS and VSR; Hispanic males fared the same as the overall continuum; White females fared worse in all categories other than VSR; Black/AA females and Hispanic females fared about the same as the overall continuum. The Part A program served 27% (1,659) of all white male PLWH in the EMA; 44% of all Black/AA males (7,854); 37% of all Hispanic males (662); 37% of all White females (216); 46% of all Black/AA females (2,615); and, 34% of all Hispanic females (141).

Figure 12: Atlanta EMA Continuum, Race/Ethnicity by Sex, 2015



a) The HIV Care Continuum is utilized in planning, prioritizing, targeting and monitoring resources;

The EMA and Part A continuums, including population-specific continuums, are provided to the Priorities Committee of the Planning Council. Data are also provided to compare viral suppression among those retained in care by race/ethnicity. These data, among others, were used to inform decisions on the rankings and funding allocations among priority service categories.

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

The HIV Care Continuum is used to target funds to high-risk and high need areas. In addition to targeting MAI funds, OAHS funds were allocated to support a HIV clinic in a targeted underserved area with high morbidity levels.

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

The care continuums were utilized in the development of the “Georgia Integrated HIV Prevention & Care Plan” and to inform the development of goals and objectives to improve outcomes along the various stages of the continuum.

Each Part A subrecipient must develop an implementation plan which tracks health improvements along the continuum. These data are monitored to evaluate the impact on health outcomes by funded priority service category.

b) The HIV care continuum is utilized to improve engagement and outcomes at each stage of the continuum.

The EMA funds core and support services to provide a comprehensive system of care designed to improve client health outcomes. OAHS will impact all stages of the HIV Care Continuum; Patient Navigation and Psychosocial Support services will assist with engagement and retention; Oral Health services will impact overall health and will contribute to viral suppression and improved CD4; Medical Case Management (MCM) services will assist clients in developing an individualized service plans (ISP) to move clients along the HIV Care Continuum; and Mental Health and Substance Abuse treatment will improve general health and impact engagement, retention, and viral suppression.

Diagnosis: CDC-funded targeted HIV screening, routine HIV testing and various demonstration projects for case finding are funded to increase the rate of HIV diagnosis. Efforts are underway to improve opt-out HIV testing in healthcare settings. People in STI and TB clinics are tested for HIV. HIV testing algorithms are being revised to allow for faster test results.

Linkage: Protocols have been modified to allow individuals with a preliminary positive test result to be enrolled in Ryan White care while awaiting confirmatory results. Part A funds may be used to pay for the confirmatory test. Local Ryan White Policies and Procedures are being revised to support provisional enrollment in care while awaiting certain forms of documentation. Part A funds are being used to place a clinician on the mobile HIV testing unit so persons testing positive for HIV can have their first medical appointment in the mobile unit. There are frequent delays (up to 3 months at times) in connecting clients with their first medical appointment. \$1,504,568 has been allocated in FY17 to continue the support of Rapid Entry Clinics – the goal is for a newly diagnosed or newly re-engaged patient to see a clinician to initiate HIV health care, be offered ART, receive treatment counseling, and agree on a sustainable care plan on the day of their diagnosis or re-engagement, or within 2-3 days if same-day initiation is not possible. Rapid Entry Clinics serve as temporary/transitional care providers designed to initiate care and treatment until such time that the client is able to have the first medical appointment with the long-term provider selected by the client; as such, they should have a high client churn rate.

Engagement/Retention: Patient centered services that encourage partnerships between providers and clients which have shown to enhance client engagement in HIV treatments that are in place.¹³ The EMA provides an array of core and support services to facilitate retention in care (e.g., substance abuse services, medical case management, and medical transportation). It is important to recognize that movement along the Care Continuum is bi-directional and clients who have been in care sometimes move out of care. Patient Navigators assist clients with linkage to care and work closely with HIV testing teams to help connect newly diagnosed individuals to care. The EMA funds Patient Navigators at seven sites to facilitate seamless engagement into OAHs through collaboration with linkage coordinators and case managers. In addition, three Part A clinics are working with the Georgia DPH to implement a HIV/AIDS Epidemiology Surveillance Section's Health Information Exchange (HIE) to re-engage those out-of-care persons accessing health care for reasons unrelated to HIV. The HIE sends an alert to a provider indicating the person is out of care and provides information on how to re-engage the client. The EMA provides an array of core and support services to facilitate retention in care (e.g., substance abuse services, medical case management, and medical transportation).

ART: Studies have demonstrated that antiretroviral treatment reduces HIV transmission by more than 96 percent. Thus, the Ryan White HIV/AIDS Program plays a central role in meeting the first National HIV/AIDS Strategy (NHAS) goal- preventing new HIV infections- by ensuring that individuals living with HIV have access to regular care and are started on and adhere to their antiretroviral medications.¹⁴ Systematic approaches to address gaps in antiretroviral use include: 1) Funding for rapid initiation of ART for patients newly enrolling in care (or returning to care) and continued provision until ADAP or Patient Assistance Program coverage begins; 2) Funding ADAP coordinators at care sites to facilitate enrollment/re-enrollment; 3) Electronic applications for ADAP available at all primary care sites and at medical case management offices; 4) New DPH ADAP policy to allow presumptive enrollment while awaiting all necessary client enrollment documentation; 5) Clinicians follow published guidelines, primarily the *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents* (last updated 11/13/2014) and *Guidelines for the Prevention and Treatment of Opportunistic Infections* (last updated 10/28/2014); 6) Increased funding for ART in FY16 and FY17 to allow clients to begin

¹³ Flickinger, T.E. et al. (2013). Higher quality communication and relationships are associated with improved patient engagement in HIV care. *Journal of Acquired Immune Deficiency Syndromes*, 63, 362-366.

¹⁴ Department of Health and Human Services, Fiscal Year 2016, Health Resources and Services Administration, Justification of Estimates for Appropriations Committees. Submitted by Mary K. Wakefield, Administrator.

ART earlier; and, 7) New options for mail-order pharmacy services have been implemented at several providers to enable easier access to medications and remove a potential barrier to care.

Viral Suppression/Viral Suppression among Retained: Within the HIV care continuum, viral suppression is the key goal to improve individual health outcomes and reduce HIV transmission. On-going core and support services are in place to facilitate care and treatment. Some clinics have implemented recognition events to celebrate individuals who have maintained undetectable viral loads (paid for with private funds). Treatment adherence counseling by nurses and case managers facilitate client success with treatment. ADAP Specialists assist clients with re-certification to prevent interruption in medications. Achieving viral suppression requires care access and retention along with adherence to ART.¹⁵ The EMA supports the integrated medical home model which facilitates client retention in care and ART adherence to maximize achievement of viral suppression among clients served – services are patient-centered, encouraging a partnership between provider and client, which has been shown to enhance client engagement in HIV treatment.¹³ New electronic medical record systems have provided agencies with new analytics components which allow timely access and accurate data about care and services. With all client information being located in a single electronic record, individual and aggregate monitoring and reporting are more effective. Data may be extracted to examine trends in viral load suppression and related long term changes. These data will then inform ongoing improvement efforts that are implemented by the clinical team. Staff will have visual representation of peaks and valleys and identify factors that may be impacting care and overall health outcomes. The data will be further used for overall planning as it relates to care coordination and other support needs, with the end goal of viral suppression.

c) Efforts to impact the HIV care continuum are evaluated in the EMA.

HIV/AIDS Bureau (HAB) performance measures are used by the Assessment Committee, Quality Management and Comprehensive Planning Committee to assess the efficacy of programs and to analyze and improve gaps along the continuum. The Part A implementation plan is used to document target goals, objectives, and activities for the year that impact HIV Care Continuum. Subrecipients submit implementation plans to the Recipient with CAREWare performance measures aligned with program activities and reflective of the HIV Care Continuum. Subrecipients are contractually required to enter data into CAREWare following each service encounter. The Ryan White Part A office reviews performance measure data for trends including the HIV Care Continuum measures identified in the implementation plan each quarter. Data are presented to the Assessment, Comprehensive, and QM Committees. Recommendations are made by Committee Members for improvements. The QM Committee and subrecipients submit Work Plans as an addendum to the QM Plan that also highlight very specific goals, and program activities aimed to impact the HIV Care Continuum that may not be measurable by CAREWare. At the end of the fiscal year, the QM Specialist evaluates the Atlanta EMA and subrecipients work plans for outcomes and impact.

d) Dissemination:

Information related to planning and evaluation of the HIV care continuum is disseminated to the Priorities Committee, Assessment Committee, Comprehensive Planning Committee, QM Committee, Integrated Plan Review Team, Planning Council and Fulton County HIV/AIDS Task Force. Information is available to the general public through posting on the Atlanta Part A website: www.ryanwhiteatl.org

C. Demonstrated Need

**1) Early Identification of Individuals with HIV/AIDS (EIIHA)
FY17 EIIHA Plan**

¹⁵ Horstmann, E., et al. (2010). Retaining HIV-infected patients in care: Where are we? Where do we go from here? *Clinical Infectious Diseases*, 50, 752-761.

a) **The FY17 EIIHA Plan for linking people to prevention and care services** focuses on five approaches with advances that align with HRSA’s priorities:

Normalize HIV testing and use of new technologies to detect HIV more quickly: This approach increases the likelihood of identifying individuals who are living with HIV and making them aware of their status so they can undertake the steps necessary to improve health outcomes and also serves to reduce the stigma surrounding HIV disease by integrating HIV testing into regular health care. Moreover, this initiative should reduce the number of “late testers” (in Georgia, 23% of persons diagnosed with HIV were diagnosed with AIDS/Stage 3 within 3 months, in other words they tested late).

Widespread linkage to care options, enabling PLWH to access treatment early: Linkage to care is a critical step on the path to viral suppression. This objective is achieved through revising HIV testing algorithms to use different rapid tests to confirm an original rapid test result so that results may be given immediately and the individual linked to care. If positive, clients are provided with a choice of providers from which to select. Rapid Entry Clinics have been developed to initiate care and treatment for clients who have to wait for an appointment with their “long-term care provider”.

Broad support for PLWH to remain engaged in comprehensive care, including support for treatment adherence: Successful outcomes in HIV depend not only on the rapid initiation of therapy but also upon the rapid establishment of a sustainable HIV care plan. Clients are screened for the need for further assessment for medical case management, mental health, and substance abuse services (EMA screening tool must be used) and linkages made as indicated. Based on the initial assessment of potential barriers to successful linkage to care, a plan is put in place to address both immediate and long-term barriers to HIV treatment and care.

Universal viral suppression among PLWH: Viral suppression not only improves the health outcomes of the individual but also improves population health through the reduction of community viral load. The EMA funds stop-gap ART medications to have on hand for clients for immediate initiation of therapy (clients are encouraged to take the first dose during the visit).

Increase infrastructure and access to biomedical interventions including full access to comprehensive pre-exposure prophylaxis (PrEP) services for those whom it is appropriate and desired, with support for medication adherence for those using PrEP: The overarching objective of increasing existing PrEP services is to target the HIV response to the geographic areas where epidemiological data indicate there are high risks and high prevalence. Surveillance data are analyzed to examine HIV disease prevalence interconnected with other diseases (syndemic approach) such as STI, TB, and hepatitis.

The plan relies on relationships with a variety of stakeholders. **Community Partners utilized to provide services include:** Other Ryan White Parts, Testing and Prevention Programs, Part A subrecipients, Planning Council, local jails, Department of Corrections, Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), Fulton County HIV Task Force, Jurisdictional Prevention Planning Group (JPPG), Department of Public Health (DPH) Surveillance Section, Georgia DPH Office of STD, HOPWA, Georgia Prevention and Care Council (GPACC), Fulton County GIS, Southeast AIDS Training and Education Center (SEATEC), TB programs, Hepatitis Programs, and the Integrated Plan Team.

b) **FY17 EIIHA Activities**

(1) **Primary activities:**

HIV testing is addressed through increasing the number of sites providing routine opt-out HIV screening as part of the battery of tests for all patients (e.g., health care facilities, other services such as housing programs and substance abuse services), media campaigns targeted toward geographic areas identified as having a high community viral load and the presence of other co-morbid conditions, and other testing initiatives that aim to reduce stigma associated with HIV testing (such as social network testing which utilizes peers to encourage HIV screening). Activities include:

- Widespread testing programs such as universal opt-out perinatal HIV screening for pregnant women, expanded routine HIV testing at hospitals, homeless shelters, substance abuse facilities, community clinics and health centers, and HIV testing at health fairs in highly affected neighborhoods. Testing will also take place at beauty salons and barber shops, storefronts, clubs, house parties and sex clubs. Part A and the Fulton County Task Force are working to institute opt-out HIV testing in all Fulton County operated health programs (including Behavioral Health). Once implemented, this approach will be utilized at other health departments in the EMA.
- To ensure a strategic and coordinated approach to routine and targeted testing throughout Fulton and DeKalb Counties, the HIPP launched its *Test Atlanta* initiative. Test Atlanta is a jurisdiction-wide community-government partnership designed to increase efficiency and effectiveness of HIV testing in metro Atlanta. Test Atlanta is a mobilization initiative coordinated by FCDHW with the goal of increasing the proportion of Fulton and DeKalb County residents who know their HIV status and are connected to care, if needed. Test Atlanta is comprised of seven strategic focus areas: Business, Community, Education, Entertainment, Faith, Government and Healthcare. The three overarching objectives are: 1) to make HIV screening a routine part of all medical care in Atlanta; 2) to increase the coordination and coverage of HIV testing efforts; and, 3) to raise awareness and inform the public about HIV testing and HIV care.

Widespread linkage to care options, enabling PLWH to access treatment early will be accomplished through the utilization of patient navigators, insurance navigators, and medical case managers to facilitate access to services and benefits, as well as changes in protocols to facilitate access to care and reduce barriers. Initiatives include:

- Expansion of the patient navigator program in primary care sites to assist linkage coordinators with enrollment and retention in care of newly diagnosed.
- Full implementation of the HIE initiative at all Part A sites.
- Devise new Policies and Procedures for Part A subrecipients to change organizational culture at many health departments that rely on outdated clinical models requiring lab results before the first clinician visit, which was grounded in the premise that viral load results needed to be in place in order to introduce ART.
- Increased coordination between CDC directly-funded organizations and public health departments for the provision of partner services. Expansion of partner services to include availability of non-Ryan White funded OAHS and other core and supportive services.
- Increase in OAHS funding to support rapid entry clinics to ensure newly diagnosed clients receive their first clinician visit within 72 hours and are offered ART. This will address long wait times for OAHS appointments at other Part A clinics.
- Utilize MAI funds to connect late testers to care. Late testing results in missed opportunities for prevention and treatment of HIV infection and emphasizes the need for earlier testing, linkage, and retention in care for persons living with HIV infection.
- Through MAI funding, establish support care teams to assist youth as they transition from Teen Clinic to Adult Clinic.

Engagement in comprehensive care, including support for treatment adherence is accomplished by giving clients clear guidance on how to obtain support and remain connected to clinical providers. Clinicians and Medical Case Managers establish contingency plans to identify potential problems such as missed appointments, missed dosages of ART, inability to fill medications at the pharmacy, etc. Strategies to improve health outcomes of clients involve:

- Allocation of additional funds for insurance navigators to augment limited resources in the EMA for enrolling HIV positive individuals in insurance coverage through the Marketplace.
- Clarify policies and procedures related to: documentation required for Ryan White eligibility; acceptable documentation of HIV status (increased flexibility); implementation of presumptive eligibility; and, the use of modified adjusted gross income in situations where gross income is just shy of the FPL.

- Raise the financial eligibility requirement from 300% of federal poverty level to 400% to allow more individuals to qualify.
- Ensure linkage coordinators are co-located with all HIV testing programs.
- Utilization of Social Marketing, Media and Mobilization to encourage people in highly burdened areas to get tested, know their status, get in care and become virally suppressed through “Greater Than AIDS” and “We Are Family” initiatives.
- Formulation of a re-engagement plan for those who are identified as out-of-care using the eHARS data and to develop an internal database to track all positive clients identified through HIPP and verified through eHARS, as well as the various surveillance databases.
- Undertake Continuous Quality Improvement (CQI) initiatives to decrease long clinic wait times (this refers to the time the client waits at the clinic from check-in to meeting with the clinician).

Universal viral suppression is a key factor in establishing treatment as prevention. The Atlanta EMA ensures that stop-gap medications are available at Rapid Entry Clinics and traditional clinics. In addition, eligibility staff expedites enrollment in ADAP through an electronic process as well as assist with enrollment in the Patient Assistance Programs. Other activities involve:

- Increase funding of stop-gap medications which allow immediate initiation of ART while awaiting coverage by ADAP or patient assistance programs.
- Revise medical case management RFP to have greater emphasis on treatment adherence.
- Increase funding for medical case managers and clinicians who will provide treatment adherence.
- Utilize SEATEC to train clinicians on protocols for initiating ART in the absence of documented CD4 and viral load lab results.
- Expedite enrollment in Health Insurance Continuation Plan (HICP) for eligible patients to enhance access to medical care and ART through insurance.
- Establish systems for pharmacies to communicate with patient and clinician immediately when a prescription is not picked up.

PrEP clinics have been established in the EMA including one which focuses on uninsured individuals. Individuals who test negative for HIV but who are high-risk are linked with PrEP clinics and other prevention modalities. Educational campaigns have been launched and Part A medical providers are sharing their knowledge with other agencies who prescribe PrEP.

Strategies to garner access:

- Increase community awareness and education about PrEP especially among disproportionately affected populations and in high prevalence geographic areas.
- In conjunction with DPH and SEATEC, increase awareness and knowledge of PrEP among care providers.
- Administer on-the-spot PrEP meds and linkage to ongoing PrEP care for high-risk negatives.
- Coordination with prevention and disease control/intervention programs to refer clients who tested negative to appropriate prevention services, including PrEP clinics.
- Explore the development of multiple access points for PrEP including PrEP clinics in college and university health services, FQHCs, pharmacies, urgent care clinics and community based organizations (CBOs).

(2) Major collaborations including prevention and surveillance involve:

- The Atlanta Part A program, unlike those in many other areas, is not a part of a health department. As such, we have had to rely on surveillance staff at DPH and local health departments. The FY17 budget includes funding for an epidemiologist who will be embedded in the surveillance section of DPH.
- Assisting Counseling, Testing and Linkage (CTL) sites in verifying enrollment in primary care and receiving tests for CD4 and viral load through the CAREWare database.
- Part A CAREWare data match with DPH surveillance section’s eHARS database to complete case reporting variables including gender, race, and risk.

- Coordination between the prevention program’s linkage staff and Rapid Entry Clinics.
- Part A developed a new relationship with a FQHC in a high impact area that has been underserved. Part A is funding a Rapid Entry Clinic and the FQHC is introducing HIV care and treatment into its menu of services and is initiating a PrEP clinic. By integrating HIV services with other programs this reduces the stigma associated with receiving services at a dedicated HIV clinic. This new service will foster HIV discordant partners in receiving healthcare at the same location.
- Evaluate methods for improving data collection with the surveillance section of DPH for those testing negative for HIV, as these data will serve as indicators of high risk behavior and can be used for geospatial analysis.
- The EMA will continue to work with DPH in the development and dissemination of anti-stigma campaigns.
- Work with Georgia Medical Association to ensure practitioners are aware of recent changes to the Official Code of Georgia Annotated requiring pregnant women be tested in the first and third trimesters as a means of addressing perinatal transmission.
- Collaboration is taking place through the Integrated HIV Prevention and Care planning group for evaluation of progress toward meeting NHAS goals and objectives.
- Work with HIV Task Force to have local governments authorize syringe access programs for the legitimate medical purpose of preventing HIV, HBV and HCV, and other blood-borne infections.
- For transgendered individuals, there has been a lack of surveillance data on indicators across the HIV care spectrum. Collaboration with DPH is taking place on improving transgender data collection including the revision of forms to include sex at birth and current gender.
- Participation of Part A Planning Council members on GPACC Fulton County JPPG. The Director of the Ryan White Program also serves on GPACC.
- Part A Planning Council Members and the Director of the Ryan White Program serve on the recently established “Fulton County HIV Task Force” which is developing a roadmap for the elimination of new AIDS cases in Fulton County.
- Part A Planning Council members and the Ryan White Director serve on DPH’s Legal and Ethical Workgroup.
- Inclusion of HIV counseling and testing at the annual Atlanta Area Outreach Initiative (AAOI) to identify HIV positives aware and unaware of their status and facilitate enrollment in care. This year’s AAOI will include a housing fair supported, in part, by HOPWA.

(3) Anticipated outcomes of the EIIHA Program include:

- HIV screening expansion in individuals testing negative.
- Seamless entry from CTL sites into OAHS with services and strategies in place to retain clients in care.
- A coordinated system for CTL, prevention and treatment programs in the EMA that reduces duplication of services and maximizes all funding sources.
- Ongoing reduction in health disparities and access to care through geographically located primary care sites, provision of antiretroviral medications, and allocation of all MAI funding to the medical treatment of minority populations.
- Increased use of PrEP (prevention) and increased use of ART (prevention).

c) The proposed EIIHA Plan contributes to the goals of the NHAS 2020

(1) The EIIHA Plan contributes to the NHAS goals through the provision of activities and services targeting HIV positive persons to:

Reduce new HIV infections through a system designed for rapid enrollment into OAHS and provision of HIV medications; setting the framework for expanded access to sterile syringes and other injection equipment to minimize infections from injection drug use; access to PrEP; and, insurance enrollment.

Increase access to care and improve health outcomes through: the provision OAHs at a number of sites including a new clinic in a historically underserved geographic area; access to HIV medications, adherence counseling, medical case management and insurance navigators; services that promote retention in care including funding of mental health, substance abuse, food, and oral health services; mobile clinic staffed with prevention and care staff; Rapid Entry Clinics; and, reducing barriers to access care and retention through policy revisions.

Reduce HIV-related health disparities: Steps are in place to move towards the NHAS goals through normalizing HIV screening, targeting HIV tests using spatial epidemiology, and care and treatment activities. Efforts to reduce disparities include: addressing cultural issues (through methods such as CLAS Standards, *The Roots of Health Inequity*, Title VI compliance) to engage specific populations and promote evidence-based approaches for HIV treatment and through the provision of integrated services to help address the underlying social determinants which lead to disparities; syndemic approach to addressing co-morbidities and inequitable social determinates of health; targeting prevention and treatment efforts to populations most impacted and areas with highest prevalence; anti-stigma campaign; and greater focus on Black/AA MSM and women.

The proposed **EIHA Plan contributes to improving health outcomes along the HIV Care Continuum** by: 1) linking newly identified HIV persons through the support of a rapid entry clinic to ensure access to primary care and HIV medications within 72 hours; 2) engaging and retaining HIV persons in care through geographically located primary care sites, medical case management, adherence counseling, HIV medications, and patient navigators; 3) ensuring clinicians are compliant with HIV treatment guidelines for prescribing ART; and, 4) addressing the high risk populations including Black/AA MSM to achieve viral suppression.

(2) Three innovative approaches used to address barriers to testing and treatment.

- Fulton County's High Impact Prevention Program (HIPP) purchased a mobile clinic for HIV testing that can be transported throughout the most highly-impacted areas. HIV testing algorithms are being revised to allow for faster test results with confirmatory results available within 20 minutes. Part A funds provide for a Physician's Assistant to travel with the clinic and to provide individuals who test positive for HIV with the first clinical appointment prior to leaving the mobile clinic. If the client is ready, ARVs can be provided immediately.
- Frequently there are long wait times for the client's first medical visit. Funding has been provided to establish three Rapid Entry Clinics which will serve as temporary/transitional care providers designed to initiate care and treatment until a long-term provider is selected by the client. The goal is for a newly diagnosed or newly re-engaged patient to see a clinician to initiate HIV health care, be offered ART, receive counseling, and agree on a sustainable care plan on the day of their diagnosis or re-engagement, or within 2-3 days if same-day initiation is not possible.
- Local Ryan White Policies and Procedures are being revised to support provisional enrollment in care. Ideally, all documentation should be provided prior to enrollment into services. However, lack of proper documentation should not impede enrollment into care. If a client is able to provide proof of HIV status but does not have income or residency documentation, that client may only be enrolled into outpatient ambulatory health services, mental health services, substance abuse services, or medical case management only. The individual is also eligible to utilize medical transportation services. It is understood that eligibility documentation **MUST** be provided at the next visit or the visit must be rescheduled until such time that documentation is provided. All eligibility documentation must be provided prior to initiation of any other service.

(3) Collaborations to strengthen outcomes across continuum include additional non-Ryan White funded community based organizations providing testing and/or care and treatment. Additional safety net providers (i.e., FQHCs or community health centers, DBHDD) to identify

additional subrecipients within the EMA to provide mental health and substance abuse services are also being pursued.

(4) EIIHA data are compared with the demographic breakdowns within the stages of the HIV Care Continuum to monitor progress for each population toward the NHAS. This analytical approach is incorporated in the priority setting and allocation process to ensure focus of funding on high risk populations and to address gaps along the care continuum.

d) To estimate the percentages of unmet need based upon the HIV care continuum Georgia DPH conducted cross-matching of multiple databases. Part A staff also analyzed CAREWare data to develop a care continuum for Ryan White clients including the percent out of care.

The Unmet Need estimates by population and subpopulations inform and relate to the EIIHA planned activities by identifying populations not in care and not virally suppressed by race, gender, age, and risk factor along with geographic location by zip code to assist Prevention Programs and the Planning Council with priority setting for testing and care programs. These efforts have helped identify previously unaware individuals, and link newly diagnosed and out-of-care PLWHA to HIV treatment. Unmet need data also guided the selection of the targeted populations and the MAI plan.

e) The FY16 EIIHA Plan influenced the development of the plan for FY17 by building upon the progress which has been achieved over the last few years (increased testing events, increased linkage to care, steps to improve retention and viral suppression). Evaluation of the EIIHA FY16 plan along with data analysis led to refinement of the target populations in the FY17 plan. Target populations in FY16 were Black/AA MSM 15-29, Black/AA MSM 30-45, and Black/AA heterosexuals. In FY17, the MSM age groups were revised to 13-24 and 25-44 and Black/AA heterosexuals was redefined to Black/AA women to better reflect the disproportionate burden among these subpopulations. The FY16 Plan, for example, focused services on YBMSM which led to the recognition that there were significant losses in retention and viral suppression as this group aged out of the Teen Clinics at age 25. Analysis of testing data showed that there were a large number of individuals testing late in a local ER and there were challenges in getting clients into care which influenced the decision to include linkage to care for this population in the MAI plan. Outcomes in the plan remain the same so that results can be monitored through HAB measures and chart review data.

f) Planned efforts to remove legal barriers, including laws and regulations, to routine HIV testing will be undertaken in 2017 to repeal HIV criminalization laws. Under current law, anyone who is aware of their HIV status and/or who is actively in care is vulnerable to prosecution under this statute if they do not disclose their HIV status regardless of how HIV transmission occurred or whether there was intent to infect another person. It is anticipated that legislation will be introduced that would modernize and reform Georgia's current HIV criminalization statutes to reflect the scientific understanding of how HIV is and is not transmitted and to ensure that the rights of people living with, and at risk for, HIV/AIDS are protected. This would result in a stronger public health system and eliminate barriers to HIV testing and the receiving of HIV medical care and services.

It is anticipated that another "Religious Freedom Bill" will be introduced in 2017. While this would likely have the effect of nullifying Fulton County's non-discrimination policies as they relate to sexual orientation and gender identity; passage could also prove problematic to people living with HIV/AIDS as it might allow agencies/individuals to refuse to offer testing (e.g., pharmacies and other business could refuse to provide home HIV-testing kits), counseling or other services to PLWH if an individual felt that to do so was morally objectionable. Furthermore, this could specifically be used to create barriers to accessing Pre-Exposure Prophylaxis (PrEP) as a means of preventing HIV transmission. The language in any bill will be extremely important, especially in light of the U.S. Supreme Court's ruling on the federal Religious Freedom Restoration Act in 2014.

g) The three target populations for the FY17 EIIHA Plan are YBMSM ages 13-24, Black/AA MSM 25-44, and Black/AA females (greater detail on these populations is available in Section 4 Minority AIDS Initiative).

(1) The target populations were chosen for the following reasons:

YBMSM: prevalence of HIV and increase in AIDS incidence cases reported over last three years; unmet need of 51% and 46% viral suppression; MSM are over forty times more likely to become infected with HIV compared with other men, and young Black men are the only population in the U.S. in which the rate of new HIV infections are increasing.

Black/AA MSM 25-44: identified based on analysis of prevalence data and the unmet need of 56% and viral suppression at 44%; gay and bisexual men continue to be most affected by the HIV epidemic in the U.S. At current rates, 1 in 6 MSM will be diagnosed with HIV in their lifetime, including 1 in 2 Black/AA MSM.¹⁶

Black/AA Females: African Americans are by far the most affected racial or ethnic group with a lifetime HIV risk of 1 in 48 for females (compared to 1 in 880 for White females; unmet need is 52% and viral suppression is at 49%).

These groups now are in alignment with the targeted population groups of JPPG and the Integrated Care and Prevention Plan.

(2) Challenges/opportunities for working with the targeted population include barriers that obstruct awareness of HIV status including access to general HIV information and the benefits of early treatment, lack of targeted prevention messages, poverty, stigma, access to regular health care, racism and reluctance to talk about sex and drug use. Additional challenges are identified in trying to inform individuals of their status after they have moved and counselors are unable to contact relocated clients. Additionally, the inadequate number of public health staff to assist all testing sites in locating and informing individuals of their status also remains an issue.

YBMSM: Stigma, homophobia, and discrimination put MSM of all races and ethnicities at risk for multiple physical and mental health problems, poverty, and lack of insurance affect whether MSM seek and obtain high-quality health services. Negative attitudes about homosexuality (including complacency), discriminatory acts, bullying and violence can make it difficult for some MSM to be open about same-sex behaviors with others, which can increase stress, limit social support, and negatively affect health.¹⁷ A meta-analysis, presented to the 19th International AIDS Conference shows that the exceptionally high rates of HIV infection seen in Black/AA MSM cannot be explained by the factors very often thought to drive HIV epidemics – frequency of having sex without a condom, number of sexual partners, drug use and so forth. In comparison with MSM of other ethnic groups, Black/AA men have either comparable rates of risky behavior, or less. But they are much more likely to report socioeconomic problems and barriers to accessing care, suggesting that the explanation may lie at the structural rather than individual level. Opportunities for working with this population include engagement with Part D clients, the YBMSM advisory group, Thrive SS, the Young Black Gay Men’s Leadership Institute, the consumer caucus of the Planning Council, the Fulton County HIV Task Force and support groups to determine issues, barriers and opportunities to increase success along the care continuum.

Black/AA Females: Not recognizing risk of HIV infection; being unaware of their sexual partners’ HIV risks is a primary factor placing Black/AA females at risk for infection; competing needs (e.g., child care, substance use, mental health, lack of self-care, etc.); no regular health care or health insurance; intimate partner violence; and, HIV medical care not tailored to the needs of women. Opportunities include working with Part D clients, SisterLove, the Center for

¹⁶ <http://www.cdc.gov/hiv/group/raciaethnic/africanamericans/>

¹⁷ <http://www.cdc.gov/hiv/group/msm/brief.html>

Black Women's Wellness, and the Women's Interagency HIV Study, the Women's advisory group, the Fulton County HIV Task Force and support groups to determine issues, barriers and opportunities to increase the bars of the care continuum.

Opportunities to work with both populations include: 1) outreach services conducted by community based organizations funded by prevention programs of DPH and the Fulton County Department of Health and Wellness (FCDHW) for targeted testing in clinical and non-clinical settings; 2) outreach activities for high risk populations and those not returning for test results through designated health department staff; 3) offering counseling and testing of high risk populations at the EMA's AAOI; and, 4) the statewide social marketing campaign targeted at high risk populations to encourage and increase testing efforts.

(3) Specific activities that will be utilized with the target population that is in alignment with the Integrated Plan include increased HIV testing in geographical areas with high burden of disease among priority populations; utilization of mobile HIV testing units in zip codes with high HIV incidence and prevalence; enrolling clients with preliminary HIV diagnosis in care within 72 hours to lessen the time between diagnosis and entry in care; and, link identified out of care individuals living in the Atlanta EMA to HIV care within 7 days.

(4) Objectives for each component of EIIHA for the target populations include:

- **(Identify)** - Increase the number of test events for the target populations by 5% (CY15 – 72,414) from January 1, 2016 through December 31, 2016.
- **(Inform)** - Increase the number of positive test events by 5% (CY15 – 733) from January 1, 2016 through December 31, 2016.
- **(Inform)** Increase the number of confirmed positive test events with client interviewed for Partner Services by 5% (CY15 – 359) from January 1, 2016 through December 31, 2016.
- **(Refer)** - Increase the number of confirmed positive test events by 5% (CY15 – 590) from January 1, 2016 through December 31, 2016.
- **(Refer)** Increase the number of confirmed positive test events with client referred to prevention services by 5% (CY15 – 549) from January 1, 2016 through December 31, 2016.
- **(Link to Care)** - Increase the number of positive test events with client linked to/or re-engaged into HIV medical care by 90% (CY15 – 756) from January 1, 2016 through December 31, 2016.

(5) Responsible parties for ensuring each of the activities are implemented and their respective roles involve the DPH Prevention Program, DeKalb County Board of Health, CBOs, FCDHW, CDC-funded sites and local Health Departments. Monitoring of testing data by site to ensure accurate data are captured on reporting forms, completing referral forms and documenting linkage to medical care by linkage coordinators are the responsibilities of each program.

(6) Planned outcomes as a result of implementing the EIIHA Plan:

Increase the number of individuals who are aware of their HIV status through intensive testing efforts.

Reduce new HIV infections by increasing the number of HIV negative individuals referred to services that contribute to keeping them HIV negative, such as PrEP and nPEP.

Increase the number of PLWH who are in medical care, prescribed ART and retained in care through linkage coordinators and patient navigators.

Increase access to care and improve health outcomes by utilizing mobile testing and rapid entry clinics.

Reduce HIV-related health disparities and health inequities by addressing inequitable social determinates of health through targeted prevention and treatment efforts for populations most impacted and areas with highest prevalence.

Increase coordination of HIV programs to institute integrated planning process for the delivery of prevention and treatment services.

h) EIIHA data are utilized in planning for services during the priority setting and allocation process. In FY 16, EIIHA data analysis substantiated the need for increased funding to support additional service provision. Subsequently, funding was increased for Rapid Entry Clinics (including non-medical case management and medical transportation), patient navigation services, and stop gap medications.

i) Evaluation efforts to impact the EIIHA population

Goals and objectives, based on the measures indicated in the Integrated Plan, will be monitored by the Part B Program staff, in collaboration with Prevention staff and colleagues across other Ryan White Programs. Progress will be evaluated and periodic updates provided to colleagues throughout the state, particularly those participating in the recent meetings to establish the Plan.

Evaluation focus will include both formative assessment and summative assessment to determine the impact of proposed activities. Quantitative data from Georgia DPH program data sources will incorporate HIV Surveillance, HIV Counseling and Testing data via CDC-sponsored EvaluationWeb, STD Surveillance, CAREWare, Performance Measure reports from State Regional Coordinators and other related sources. Qualitative data will be available from narrative reports submitted to State Regional Coordinators, community focus groups, training and TA surveys, and GPACC engagement sessions. The data collection design will allow for monthly, quarterly or annual ongoing monitoring and evaluation of the Integrated Plan.

j) Dissemination of information related to planning and evaluation of the EIIHA data.

EIIHA activities and outcomes will be shared with Ryan White and HIV Prevention funded agencies through program websites and email correspondence. Agencies will be encouraged to disseminate the Plan to consumers and local stakeholders, including the Planning Council, JPPG, GPACC, and local Ryan White Part B consortia.

With input from Part A staff and relevant Planning Council committees and workgroups, the Council's Comprehensive Planning Committee will be responsible for updating EMA progress on Plan implementation. Plan updates will be provided quarterly at Planning Council meetings and feedback solicited. This feedback along with progress and success in meeting established strategy timelines will be used to make Plan improvements if needed. EMA Integrated Plan progress will be also shared at regularly scheduled GPACC and JPPG meetings.

2) Unmet Need

Current Methodology: Unmet Need Framework Estimate

a) Narrative of Unmet Need for FY17

(1) Estimation method: Estimation used consistent methodology based on *A Practical Guide to Measuring Unmet Need for HIV Related Primary Medical Care, Using the Unmet Need Framework* developed by the University of California, San Francisco in 2003. Data used only includes the Public Health Laboratory and the eHARS database of the Georgia DPH) HIV/AIDS Epidemiology Section for CY15 and was "frozen" on June 30, 2016:

- The number of PLWH living at the end of the calendar year being examined, in this case, 2015;
- The number of PLWH who received the specified HIV primary medical care during the 12-month period ending December 31, 2015. Specified HIV medical care includes documentation of at least one of three elements: viral load testing, CD4 count and/or provision of ART (DPH does not receive information about antiretroviral prescribing so this element is not included);
- These outcomes are then stratified according to the person's HIV status into those living with HIV non-AIDS and those living with AIDS (Stage 3);
- Additional stratification is performed on gender, transmission category, and age.

The level of unmet need is calculated by subtracting those who have had HIV medical care from the total number of people living with HIV non-AIDS or AIDS. In the EMA, it is estimated that **38%** of persons diagnosed, reported, and presumed to be living with HIV or AIDS are currently **not in care**. This estimate represents **35%** of PLWA and **40%** PLWH who are not receiving medical care. See **Attachment 4: Unmet Need Framework**.

(2) Assessment of Unmet Need:

(a) Demographics and Geographic Locations

Demographics: In analyzing PLWH not in care, it is noticeable that PLWH non AIDS are more likely to **not** be in care than PLWA. Among PLWH non AIDS, 40% were not in HIV medical care in 2015 compared to 35% of PLWA. Among males, 39% of male PLWH non AIDS were not in care compared to 43% of female PLWH non AIDS. PLWA was more similar among the genders (36% vs 32%). However, looking at females in their reproductive ages of 15-44 years, regardless of race, 45% of female PLWH non AIDS were not in care and 30% of female PLWA were not in care. Black/AA females of reproductive age had similar results with 42% of female PLWH non AIDS and 31% of female PLWA not in care. **Female PLWH have greater unmet need than males.**

Black/AA, all genders, PLWH non AIDS were more likely than Whites or Hispanics to **not** be in care (42% vs 33% vs 40%). There was less difference among PLWA but Black/AA PLWA were still more likely to not be in care than the other two groups (35% vs 39% vs 40%).

Black/AA PLWA have a greater number with unmet need than other racial groups.

PLWH non AIDS who were classed as MSM had a lower proportion not in care (36%) than IDU (47%) and MSM/IDU (41%) and the same rate as Heterosexuals (36%). Similarly, PLWA who were MSM or Heterosexual had lower proportions not in care (34%, 31% respectively) than IDU or MSM/IDU (50%, 46% respectively). **Any PLWA that includes transmission through drug use has a greater unmet need than those without drug use.**

As PLWA age, they are in more need of medical care than the younger PLWA. Those aged 30-39 have unmet need of 28%, and those aged 50-59, 39% had unmet need. Older PLWA (50-59 years) have greater unmet need (39%) than younger 30-39 year old PLWA. PLWH non AIDS have greater unmet need than PLWA. **PLWA have more, and PLWH non AIDS have less unmet need when aged 50-59 than when aged 30-39 years.**

Geographic Locations: Using the current methodology has allowed identification of geographic areas where unmet need is the greatest. In one county, Fulton County, 23 of 88 zip codes had unmet need higher than the EMA average of 38%, ranging from 39% to as high as 59%. In all, 15 of the 20 counties that comprise the Atlanta EMA had at least one zip code containing PLWH who had an unmet need in excess of 38%. These zip codes will be mapped using geographic information systems and targeted for improved HIV medical care.

(b) Description of Unmet Need Trends

Table 7. Quantified Estimate of Unmet Need for HIV Primary Care, Atlanta EMA						
Population		Total				
		2011	2012	2013	2014	2015
Row G	PLWA who did not receive the specified HIV primary medical care as of the end of the calendar year	7,142 43%	7,547 41%	7,346 39%	7,262 38%	6,969 35%
Row H	PLWH non-AIDS/aware who did not receive the specified HIV primary medical care as of the end of the calendar year	5,143 43%	6,964 46%	7,982 48%	7,131 42%	7,271 40%

Row I	Total HIV+/aware not receiving the specified HIV primary medical care as of the end of the calendar year (Quantified Estimate of Unmet Need)	12,285 43%	14,511 43%	15,328 43%	14,393 40%	14,240 38%
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Over the last 5 years, there has been a **steady decline in the overall unmet need** using the current methodology, declining from 43% in 2011 to 38% in 2015 (12% reduction) (Table 7 The need has also declined among PLWH non AIDS from 43% to 40% and among PLWA has declined from 43% to 35% (7% reduction). **Unmet need is greater in PLWH non AIDS than PLWA.**

(c) Assessment of service needs, gaps, and barriers for PLWH not in care:

The clinical paradigm has changed significantly such that ongoing and effective treatment can not only enhance the quality and length of life but also can suppress the virus and reduce further infections. Thus, the Part A program has a significant public health impact on HIV incidence. It is essential that the Part A service system support PLWH, not only through outpatient medical care, but through those core and support services that ensure HIV positive people are linked to care and introduced to antiretroviral therapy as early as possible. The Atlanta EMA has evaluated service needs not currently being met for all PLWH, including persons not in care, through the use of client needs assessments (including focus groups), input from the Consumer Caucus of the Planning Council, utilization patterns, cost per client and cost per unit, availability of other funding sources, and testimony from community experts to guide allocation in supporting the EMA continuum of care.

New Methodology: Unmet Need Estimate based on the HIV Care Continuum Framework

a) The HIV Care Continuum Framework will be referred to as the New Methodology. The Current Methodology for determining unmet need estimates **14,240 (38%)** PLWH will have unmet need in 2017. Using the New Methodology, **19,162 (54%)** PLWH were **not** retained in care in 2015, **Attachment 4. Table 2. Unmet Need Calculated Using HIV Care Continuum Framework.** The New Methodology estimate reflects that an additional **4,922** will have an unmet need in 2017. The number of people in care and receiving primary care, CD4 or viral load tests in the Current Methodology for unmet need most closely aligns with Retained in Care in the New Methodology. Unmet need is the converse of those receiving care or retained in care.¹⁸

b) In comparing the Unmet Need estimate for 2016 and 2017 using the HIV Care Continuum methodology, **134** additional persons will have an unmet need in 2017 than in 2016.

Table 8. Unmet Need Calculated Using HIV Care Continuum Framework			
	Stage of Continuum	2016	2017
A	HIV-Diagnosed	31,157	35,244
B	Retained in Care	12,129	16,082
A-B	Not in Care (unmet need)	19,028	19,162

- c) Data used to determine Unmet Need using the HIV Care Continuum methodology include:
- The numbers of PLWH living at the end of the calendar year being examined, in this case, 2015: **35,244.**
 - The numbers of PLWH who had two or more CD4 or viral load tests at least 3 months apart, referred to as *Retained in Care* in the new methodology: **16,082.**
 - Unmet Need: Number diagnosed *minus* number retained in care: **19,162.**

¹⁸ US DHHS, HRSA, Funding Opportunity Announcement, p16, August 15, 2016.

d) The **definition** for Retained in Care utilized in the EMA is the **same** as the one provided by HRSA.

e) **Challenges of using Retained in Care measure to calculate unmet need.**

The HIV Care Continuum methodology does not take into account or adjust for the number of persons who are healthy and virally suppressed who attend medical visits less frequently (estimated to be 14%-18%), thus they would be seen as out of care when, in fact, they had successfully moved through the continuum of care. To account for this, engagement in care might serve as a suitable proxy and is used by the EMA.

EvaluationWeb (testing database) does not include names making it difficult to monitor linked to care electronically. Identifying information is available on case reports. Part A has provided access to CAREWare to linkage staff to verify linkage, engagement, and retention in care for individuals receiving services at Part A funded sites.

For the EMA-wide HIV Care Continuum, viral suppression data are calculated based upon lab results submitted to DPH. Lab reports frequently lack sufficient information to match the data to a case in eHARS. As a result, there are relatively large percentages of “unknown” viral suppression, therefore, VS and VSR may not capture all persons with viral suppression. Part A provides DPH with CAREWare client level data so they might perform record matches to collect missing information. Sharing of HIV surveillance data by the State has been unidirectional with data provided to DPH but not from DPH. New Georgia law allows sharing HIV information (reciprocal) with private clinicians which will facilitate efforts to locate out-of-care clients and to work with providers to complete missing variables on case reports.

Missing data is an ongoing problem in routinely collected data or large-scale epidemiologic studies. Because a substantial proportion of persons with diagnosed HIV infection are reported to the Georgia DPH without an identified risk factor, multiple imputation methods are used to assign transmission categories to those persons whose diagnoses are reported without a risk factor. Multiple imputations (MI) is a statistical approach in which missing transmission categories for each person are replaced with plausible values that represent the uncertainty regarding the actual, but missing, values. This is the same statistical strategy that the CDC uses to assign transmission categories to those reported without a risk factor in the national dataset. Whether these transmission category adjustments using MI introduce any systematic bias in overestimation or underestimation of percentages of HIV infection attributed to specific categories is unknown. Instead of estimating the risk factor distribution probabilities for cases with missing risk factors by a simple redistribution approach, MI draws a random sample of the missing values from its distribution. Then, instead of filling in a single value for each missing value, MI replaces each missing value with a set of plausible values that reserve the statistical distribution of the imputed variable and the relationship with other variables in the imputation model. The multiply-imputed datasets are then analyzed by using standard procedures for complete data. Results from these analyses are then combined to get the final estimates. MI is considered a sound approach for large datasets. In an analysis comparing the Care Continuum for the Georgia HIV prevalent population in 2012, stratified by transmission category, estimated with and without use of MI, little difference was found, similar to the experience with the national dataset.¹⁹

There have been challenges in collecting Transgender identity data in eHARS. Thus, it is not possible to accurately develop a reasonable care continuum. DPH is working on protocols and updating forms to better capture these data (e.g., forms will capture current sex and sex at birth).

Current evidence suggests that efforts must focus not only on getting individuals tested and linked to care, but on long-term retention to care. A retrospective cohort study of retention and virologic suppression among 650 patients of the Infectious Diseases Program of the Grady

¹⁹ Georgia Department of Public Health, HIV/AIDS Epidemiology Section HIV Care Continuum Report by Health District, Georgia, 2014 <https://dph.georgia.gov/data---fact---sheet---summaries>, Published July 2016 [Accessed: September 2016]

Health System in Atlanta (IDP) was recently released. This study followed clients over a 36-month period and evaluated the difference in rates of short-term and long-term retention and viral suppression showing that a great majority of patients in the cohort were able to achieve both retention and viral suppression at a single point in time, however long-term (24 and 36 month) retention and viral suppression were suboptimal. The data suggest that the current HIV care continuum model may portray falsely optimistic retention and viral suppression rates. The goal of HIV care is maintenance of viral suppression. As a tool for depicting the HIV care process, the care continuum should reflect the benchmarks of retention and viral suppression over longer periods of time than 12 - 15 months.²⁰



f) How the estimate derived from Care Continuum framework impacts approach to unmet need estimate.

(1) Does it require the EMA to modify or revise the strategy for identifying unmet need?

Both estimates are used; however, community members are more familiar with the HIV Care Continuum and have greater understanding of “unmet need” when used in the context of not being retained in care. Otherwise, there is a great deal of confusion in the community regarding “unmet need” and “gaps in services” with many thinking they are the same.

(2) Characteristics of population identified.

Males (55%) have a higher unmet need than females (53%). Black/AA (56%), Black/AA males (56%) and Black/AA MSM (55%) have the highest unmet need in their respective cohorts. White females have higher unmet need (58%) than Black/AA females (52%) and Hispanic females (51%). IDU (61%) and MSM/IDU (58%) had higher unmet needs than MSM (53%) and HRH (53%). Any PLWH that includes transmission through drug use has a greater unmet need than those without drug use. Younger age groups, 13-19 (33%) and YBMSM 13-24 (51%) have the lowest unmet need of any age group and the rates increase substantially in moving to the 20-29 (55%) age group and the Black/AA MSM 25-44 age group (56%) which supports concerns for improving L, E, and R for young people as they age out of youth clinics.

(3) Strategies used to link populations back into care and eliminate barriers.

Linkage coordinators work with clients to ensure connection with a care provider (often times accompanying the client to the appointment, and assist with follow-up if the client fails to keep appointment. In an effort to lessen the barrier of clients having to repeatedly produce eligibility documents, CAREWare has been modified to allow for eligibility documents to be scanned and

²⁰ Colasanti, J. et al: A Longitudinal Approach to Retention and Virologic Suppression across the HIV Care Continuum. 22nd CROI (Abstract 1068), Seattle, WA, 2015.

uploaded - these documents are available to other service providers. Clients may initiate care even if certain pieces of required documentation are not available with the understanding that all documents must be produced within 30 days. Clients may receive mental health, substance abuse, and case management services for 6 months contingent on development of an ISP to guide the client in readying for care. EMA Policies and Procedures have been modified to clarify procedures, for example reiterating that State issued ID is not required (clients were delayed in getting into care as they found a way to pay for a birth certificate to be used as proof in acquiring State ID and in other instances, undocumented residents simply chose not to enter care). Patient navigators help clients enroll/re-enroll into care, Medical Case Managers help clients address barriers by facilitating access to benefits and services, Disease Investigation Specialists and Community Health Workers help locate lost clients, appointment reminders and follow-up calls are made. Insurance navigators assist eligible clients in accessing insurance coverage and the State Health Insurance Continuation Program (HICP) assists with premiums and co-pays as necessary. The Health Information Exchange will help identify clients lost to care or who are HIV positive and have never entered care. Support services such as medical transportation, meal vouchers and meal replacements, child care, and translation services assist the client with keeping appointments.

g) **The Unmet Need estimate is utilized in planning for services in the EMA.**

The “Georgia Integrated HIV Prevention & Care Plan” was developed using results from the needs assessments, unmet need estimates, and analysis of epidemiologic, HIV testing and HIV care service utilization data. The plan identifies overarching goals and objectives for the next five years and guides specific implementation efforts.

During both priority-ranking and allocation-setting, the Priorities Committee assesses how individual service categories contribute to mitigating unmet need identified in the local unmet need estimates from the HIV Care Continuums (overall and by special population), and how delivery of the service impacts unmet need. The Committee evaluates whether the service’s contribution to unmet need or its potential impact on unmet need merits higher prioritization and/or additional allocations. The Committee also considers the rates of unmet need in order to define an acceptable standard and expectation in future years.

The Assessment Committee used unmet need data in a report developed to identify and locate PLWH with disparate health outcomes within the 20 county EMA. The report helped guide plans for increasing services to underserved areas with high unmet need. (See Resolution of Challenges – Table 10.)

Unmet needs data are used in the implementation and evaluation of the EIIHA plan.

h) **How are strategies evaluated? Are programs evaluated?**

HIV/AIDS Bureau (HAB) performance measures are used by the Assessment Committee, Quality Management and Comprehensive Planning Committee to assess the efficacy of programs and to analyze and improve gaps along the continuum including unmet need as measured by retention levels. Part A QM staff and data staff assist each primary care provider in developing an agency continuum to evaluate performance and success in meeting quality standards. Each Part A subrecipient must develop an implementation plan which tracks health improvements along the continuum and seeks to improve unmet need by increasing retention. These data are monitored to evaluate the impact on health outcomes by funded priority service category. Progress toward improvements is evaluated in the vendor selection process and the new risk analysis undertaken before contracting with an agency.

i) **Information related to planning/evaluation of the Unmet Need estimate is disseminated**

via distribution of the Integrated Plan and each annual Part A funding application to HRSA. Documents are provided to the Priorities Committee, Assessment Committee, Comprehensive Planning Committee, QM Committee, Integrated Plan Review Team, Planning Council and Fulton County HIV/AIDS Task Force. Information is available to the general public through posting on the Part A website: www.ryanwhiteatl.org.

3) Service Gaps

The clinical paradigm has changed significantly such that ongoing and effective treatment can not only enhance the quality and length of life but can suppress the virus and reduce further infections thereby lessening community viral load. Thus, the Part A program has a significant public health impact on HIV incidence. It is essential that the Part A service system support PLWH along the HIV Care Continuum, not only through OAHS, but through those core and support services that ensure PLWH are linked to care and introduced to antiretroviral therapy as early as possible. The Atlanta EMA has evaluated service needs not currently being met for all PLWH through the use of client needs assessments (including focus groups), unmet need, input from the Consumer Caucus of the Planning Council, utilization patterns, cost per client and cost per unit, availability of other funding sources, and testimony from community experts.

a) **Identified Service Gaps along the HIV Care Continuum**

Needs assessment data help increase understanding of issues experienced among HIV-positive persons at various stages of the HIV Care Continuum. Needs assessment data are directly related to HIV Care Continuum stages; II. Linked to Care, III. Retained in Care, IV. Prescribed Antiretrovirals and V. Viral Suppression.

The Atlanta EMA collected data on service needs, gaps and barriers to care through consumer surveys conducted in 2011 and 2013 supplemented with focus groups. A total of 715 PLWH in the EMA completed the survey. *The Consumer Survey*, a component of the EMA needs assessment, includes questions to collect information about types of services identified as needed but not necessarily received among individuals eligible for Ryan White services. The EMA is addressing these needs and/or gaps in services by allocating funding to those categories listed in Attachment 8 and discussed below.

The Planning Council's Assessment Committee recently completed a comprehensive assessment of health disparities. The assessment concluded that Black/AA males are the most significantly impacted. Assessment findings also indicated that zip codes with the highest concentration of PLWH with unmet need geographically correspond with areas containing the highest concentration of poor health outcomes. A review of service provider locations and times needed to travel to and from medical appointments utilizing the public transportation system ranged from 30 to 125 minutes. In response to these findings, Support Services-Medical Transportation funding was awarded to fund small dollar value gas vouchers (e.g., 2 gallons for round-trip travel) in a more remote area without a public transportation system during FY14. Assessment report findings relate to stages; II. Linkage to Care, III. Retained in Care, IV. Prescribed ART, and V. Virally Suppressed.

The EMA also conducted chart reviews in FY15 and FY16. Data obtained from these chart reviews directly relate to Retention in Care, ART Prescription, and Viral Suppression stages of the HIV Care Continuum. Analysis indicated that 84% of Ryan White clients achieved viral suppression; 89% achieved viral suppression within 6 months of initiating ART; 93% of clients were maintained in care as measured by 2 or more medical visits within the reporting period; and, 90% of clients had 2 or more CD4 counts within the reporting period.

Data from a Statewide Client Satisfaction Survey conducted in 2013 relate to the Retained in Care stage of the HIV Care Continuum. Satisfaction of services was 94% or higher among survey respondents. Client satisfaction surveys may help identify the reasons why clients achieve high retention (stage III) rates. Conversely, these data may help us understand why clients drop out of care. Additionally, clients who expressed high levels of satisfaction with their services may be more likely to be compliant with medication regimens and achieve positive health outcomes (stages IV and V). The EMA will continue to monitor the potential correlation between satisfaction and positive health outcomes. Identified gaps within the jurisdiction include:

Oral Health Services (Retained in Care, Viral Suppression). 2015 Performance measure data #3:²¹ 2,910/3,191=91%²²

According to the Bureau of Labor statistics, dental expenses are the second highest out-of-pocket health expenditure for consumers in the U.S. second only to prescription medications²³.

Needs Assessment: In the 2011 Consumer Survey, treatment for dental problems was the #1 service needed among core services but not received with a gap of 28%, followed by emergency dental care ranked #2 with a gap of 25%, followed by preventative dental care ranked at #3 with a gap of at 24%. Oral health services ranked among the top three unmet needs among females (29%), transgender (63%), Black/AAs (30%), Latinos (31%), Whites (33%), and young heterosexuals (38%). In the 2014 survey, there was an identified gap of 33% between those needing the service and those receiving the service; a gap of 28% for preventative dental care; and, 31% for non-emergency dental care.

The national average of dentists per 10,000 people is 6.0. The average number of dentists per 10,000 people in Georgia is 4.4 which is 27% less than the national average of 6.0.²⁴

Medical Nutrition Therapy (Linked, Retained, Antiretroviral Use, Viral Suppression). 2015 Performance measure data #4: 1,186/1,420=84%.

People with HIV infection are at nutritional risk at any point during their illness. Although weight loss and wasting remain common in HIV infection, nutrition-related problems such as obesity, diabetes, hyperlipidemia and hypertension also increasingly affect people living with HIV. A shift in causes of death from acute opportunistic infections to other causes, such as diabetes and heart disease, indicates the need for a more comprehensive approach to healthy living for people with HIV.

Proper nutrition is needed to increase absorption of medication, reduce side effects, and maintain healthy body weight.²⁵

Needs Assessment: Ranked #5 in gaps in services with a 14% gap between those reporting a need for the service and those who received the service in the 2011 survey. Ranked #3 among males of all races with a gap of 30% and #1 among Latinos (39%). The gap increased to 26.6% in the 2014 survey and the gap for nutritional supplements was 37.6%.

Medical Case Management (Linked, Retained, Antiretroviral Use, Viral Suppression): 2015 Performance measure data #5: 5,788/8,131=71%. 2015 Performance measure data #6: 6,005/8,131=74%.

Needs Assessment: Ranked #9 in gaps in core services with a 7% gap between those reporting a need for the service and those who received the service (2011); the gap increased to 10.7% in the 2014 survey.

The *2012-2015 State of Georgia Statewide Comprehensive HIV Services Plan* lists Medical Case Management as 2nd among the five most needed services.

Mental Health (Linked, Retained). 2015 Performance measure data #7: 1,937/2,551=76%. National data state that PLWH who receive mental health counseling have improved retention in medical care, and treatment adherence^{26, 27}.

A recently published outcome study demonstrated significantly improved psychological well-being after 3 months of mental health services in a sample that included mental health

²¹ Performance measurement data correspond to the measures detailed in Section A. Clinical Quality Management (CQM) 2) (a) Description of CQM Program Performance Measures.

²² CY2015 Part A CAREWare.

²³ Glasman, P: Oral Health Quality Improvement in the Era of Accountability. WK Kellogg Fdn. Dec. 2011.

²⁴ <http://www.cdc.gov/nchs/data/hus/2012/103.pdf>

²⁵ Aidala A. HIV/AIDS, Food and Nutrition Service Needs. CHAIN Brief Report 2011-5. October 2011.

²⁶ Israelski, D, Prentiss, DD, Lubega, G, Balmas E Psychiatric co-morbidity in vulnerable populations receiving medical care for HIV/AIDS (2007)AIDS Care.

²⁷ Magnus M., Schmidt N., Brown B. et al. A profile of an HIV-and child-specific programme in New Orleans, Louisiana, USA. *AIDS Care*. 2002;14(suppl 1):S85-94.

clients in Atlanta.²⁸

Depression was tied for the second most frequently cited reason Consumer Survey respondents gave for being out of HIV care, underlining the crucial role of mental health treatment in supporting retention in care. Untreated mental health disorders are associated with decreased HIV primary care access, reduced medical adherence, and poor health outcomes.²⁹ Needs Assessment: In the 2011 survey, 31% of respondents (n=223) reported having received substance abuse-outpatient services. Of those, 43% reported having multiple services, 35% received group counseling, 12% received 1-on-1 counseling, and 3% received group counseling. Ranked #10 in core services needed but not received with a gap of 7%. The gap increased to 14.8% for individual counseling and 16.7% for group counseling in the 2014 survey.

One in three women in the United States experiences intimate partner violence. For women living with HIV, it is one in two. Having an abusive partner is associated with a higher risk for HIV and, for those living with HIV, worse health outcomes.³⁰ Intimate partner violence trauma has been shown to decrease immune functioning, negatively affect medication adherence and, for many survivors, lead to depression and post-traumatic stress disorder (PTSD).³¹

“Providers recognize that patients may have past trauma, but what few realize is how prevalent it is and how much it affects patients’ health. Findings showed that 1 out of every 2 HIV-positive patients who walk through the door—regardless of gender—have a history of [intimate partner] violence and/or childhood sexual abuse.”³²

Substance Abuse Services-Outpatient (Linked to Care, Retained in Care). 2015 Performance measure data #8: 877/1,135=77%.

Needs Assessment: In the 2011 survey, 31% (n=223) reported having received substance abuse services since becoming HIV-positive. Of those, 43% had received multiple services, 35% had received group counseling and 12% had received 1-on-1 counseling. The need for 1-to-1 or group substance abuse counseling ranked as the #10 highest core service needed but not received with a gap of 7%. In the 2014 survey, there was a gap of 15% between those needing individual counseling and those receiving it and a gap of 17% for group counseling.

HIV+ alcohol users remain an underserved group at high risk for medication non-adherence and rapid disease progression, medication toxicities, organ failure, and poor viremic control leading to increased risk of transmission and premature death.³³

Health Insurance Continuation Program (HICP): (Linked, Retained, Antiretroviral Use, Viral Suppression). Health outcome data are not available.

Needs Assessment: In the 2011 survey, 51% had some type of health insurance (of those, 60% had Medicaid). The need for pharmaceutical assistance was ranked #6 with a gap of 11%. In the 2014 survey, 54.6% had some type of insurance coverage – 15% had signed-up for insurance via the ACA. 36.7% reported having a need for Premium Assistance (n=117) with 35.9% having that need unmet. When asked of the need for Medication Co-Pay Assistance, 46.4% (n=147) indicated a need with 23.8% indicating the need was not met.

Many clients with lower incomes will have difficulty paying their portion of the insurance premiums, and some clients have faced excessive medication co-insurance payments for their antiretroviral medications. These drugs have been priced in the highest pricing tiers requiring significant out-of-pocket co-payments.

²⁸ Farber et al. (2011). Personal meaning as a predictor of psychological well-being over time in individuals receiving HIV-related mental health services. *General Hospital Psychiatry*, 33, 469-475.

²⁹ Treisman, GJ, & Angelino, AF: *The Psychiatry of AIDS*, Johns Hopkins University Press, 2004.

³⁰ Kaiser Family Foundation, *Women, HIV & Intimate Partner Violence: New Campaign Puts Spotlight on Little-Known Issue During National Domestic Violence Awareness Month, Major Players in Domestic Violence, HIV and Women's Health Confront Silence and Barriers to Care*

³¹ *ibid.*

³² HRSA Care Action, September 2009 <http://hab.hrsa.gov/newspublications/careactionnewsletter/sept2009.pdf>

³³ NIH: Research on Comparative Effectiveness and Implementation of HIV/AIDS and Alcohol Interventions (R01) (R02) 2013

Non-Medical Case Management (Linked to Care, Retained, Antiretroviral Therapy Use). 2015 Performance measure data #9: 7,491/9,470=79%. 2015 Performance measure data #10: 7,556/9,470=80%.

Needs Assessment: In the 2011 Consumer Survey, the need for benefits counseling (a component of case management non-medical) ranked at #6 of gaps in need for support services (15%). In the 2014 survey, 37.4% indicated need for the service with 19% indicating an inability to get the service.

Food Bank/Home Delivered Meals (Retained in Care, Viral Suppression). 2015 Performance measure data #11: 1,084/1,535=71%.

Needs Assessment: In the 2011 Consumer Survey, food vouchers was the #1 service needed but not received among support services with a gap of 40%, followed by food pantry ranked #4 with a gap of 19%, followed by home delivered meals at #7 with a gap of 14%. The gap in need for food vouchers was ranked #1 among males (39%) and females (44%), #1 among Black/AAs (39%), #2 among Latinos (38%), #1 among Whites (42%), #3 among young MSM (40%), and #1 among persons over 50 years old (34%). The gap in need for food pantry was ranked #2 among transgender (50%).

Psychosocial Support Services (Linked to Care, Retained in Care). 2015 Performance measure data #12: 1,234/1,657=74%.

Needs Assessment: In the 2011 Consumer Survey, the need for patient navigation services (a component of psychosocial support) was the #10 support service needed but not received with a gap of 11%. In the 2014 survey, there was a gap of 29% for peer counseling/support groups and a gap of 28% for patient navigation services.

Medical Transportation (Linked, Retained, Antiretroviral Use). 2015 Performance measure data #13: 2,191/2,987=74%.

Needs Assessment: Medical transportation was not identified as one of the top 10 gaps in service for support services in the 2011 survey. In the 2014 survey 28.8% of all respondents identified a need for the service; there was a gap of 32.6% between those identifying a need for the service and those who received the service.

Legal Assistance Services (Linked to Care, Retained in Care, Viral Suppression). 2015 Performance measure data #14: 80/118=68%.

Needs Assessment: In the 2011 Consumer Survey, the need for legal assistance services was the #5 support service needed but not received with a gap of 19%. In the 2014 survey, there was a gap of 51%.

CDC, in its Revised Guidelines to HIV Counseling, Testing, and Referral, recommends that “[c]lients who test positive for HIV should be referred to legal services as soon as possible after learning their test result for counseling on how to prevent discrimination in employment, housing, and public accommodation by only disclosing their status to those who have a legal need to know”³⁴. CDC recognizes that legal services are an essential part of the continuum of care from the date of diagnosis throughout the disease progression by preserving confidentiality rights and by combating discrimination against those living with HIV/AIDS.

HRSA issued a policy brief in 2000 that assessed the role of legal services in helping people living with HIV/AIDS access health and related services. The HRSA brief examined how legal services address the barriers to care for people with HIV/AIDS. The brief found that “...legal services for people with HIV/AIDS play a central role in their ability to access and maintain health care services” and that legal services help people living with HIV/AIDS meet their basic subsistence needs, such as housing, employment, and access to public benefits³⁵.

Linguistics Services (Linked to Care, Retained in Care, Antiretroviral Therapy, Viral Suppression). 2015 Performance measure data #15: 343/365=94%.

³⁴ Morbidity and Mortality Weekly Report, November 9, 2001, Vol. 50, page 37

³⁵ Directions in HIV Service Delivery & Care: A Policy Brief, Number 4, "Reducing Barriers to Care", 2000, page 17.

Needs Assessment: In the 2011 Consumer Survey, the need for linguistics services did not rank among the top 10 gaps in services. In the 2014 survey, there was a gap of 12%.

It is difficult for clients with limited or no ability to understand English to understand providers' instructions without a translator. It is also more likely that they will be unaware of available services and how to access them.

Child Care Services (Retained in Care). 2015 Performance measure data #16: 126/144=88%.

Needs Assessment: In the 2011 Consumer Survey, the need for child care services did not rank among the top 10 gaps in services. In the 2014 survey, there was a gap of 20%.

b) **Method used to prioritize the service gaps**

The Priorities Committee of the Planning Council is responsible for analyzing data, including service gap data, and developing recommendations to the Executive Committee and Planning Council on the prioritization of services to address gaps. The Committee also considered information from *The Consumer Survey*.

The Committee began by examining consumer survey results, other information provided including five-year utilization patterns, availability of other funding sources, the impact each service category would have on improving the HIV Care Continuum for the various populations to be served, trends analysis, and barriers to care. The Committee then independently examined the rankings for each of the FY16 priority service areas to determine if trends supported continuation of the current priority ranking for FY17. The Committee examined the core service categories first due to their essential role in supporting clients as they move through the continuum of care: OAHs retained #1 ranking as the foundation for care and treatment. This category was expanded in FY16 and FY17 to include Rapid Entry Clinic to improve linkage to care; Oral Health Care retained the #2 ranking due to the overwhelming gap in services; ADAP stayed #3 as a reflection of the importance of making life-saving medications available to those who might not otherwise be able to afford them; #4 is Medical Nutrition Therapy which remained this ranking due to the significant increase in service gaps between 2011 and 2014; the ranking of #5 supports the pivotal role Medical Case Management has in efforts to link clients to care, retain them in care, provide access to ART and achieve viral suppression; Mental Health and Substance Abuse retained the 6th and 7th rankings respectively due to their inter-related role in addressing comorbid factors that would otherwise remain barriers to care and treatment; HICP continues to be ranked highly #8 as a reflection of the need to support individuals who are newly insured and struggling to meet co-payments and deductibles.

The Committee then evaluated and ranked the essential Support Services: #9 Non-medical Case Management is a key factor in connecting clients with ADAP and other benefits; #10 Housing Services was moved up from #17 lack of housing leads to a lack of successful integration into the system of care and treatment. #11 Food Bank/Home Delivered Meals continue to be high on the list of services for which clients have indicated a gap in service; #12 Emergency Financial Assistance is important in assisting clients to access housing services and in balancing finances to meet the daily costs of living.; #13 is Psychosocial Support which includes the Patient Navigation Program developed in response to client requests for assistance in navigating through unfamiliar health and social service systems; #14 Medical Transportation supports access to all other service categories; #15 Legal Services was the support service category with the 5th highest gap in services; #16 Linguistics Services were ranked due to the importance this service has in providing services that are culturally responsible; and, Child Care Services were ranked #17 as a means of supporting our services to women, infants, children, and youth (WICY).

The process was completed for MAI funds and funds were prioritized for OAHs as the most concrete method of reducing disparities and achieving improved health outcomes among communities of color.

Once approved by the Priorities Committee, the recommendations were next considered and

approved by the Executive Committee followed by the Planning Council.

c) **Gaps will be addressed with FY17 funding.**

Ranges were established for allocations of funds among the established Priority Service Categories:

- Flat Funding: Allocations would remain the same as FY16.
- Increase of \$1 to \$2,229,815: FY16 percentages would be applied against new award amount.
- Increase of \$2,229,816 to \$4,459,630: Funds would be equally distributed among OAHS, OAHS ADAP Formulary Stop-Gap Medications, OAHS Rapid Entry Clinics, and Oral Health.
- Decrease of \$1 to \$250,000 would be equally applied against all priority categories.
- Decrease ≥ \$250,001: Priorities Committee would reconvene to set allocations.
- Ranges

State ADAP (#3): The category was not funded due to the availability of Part B ADAP funds in the amount of \$54,023,517 (a 48% increase from 2014 funding of \$34,468,630). Housing (#10) and Emergency Financial Assistance (#12) were not funded due to the availability of HOPWA funding (\$18,078,087 in 2015 and increased by 26% to \$22,867,304 in 2016).

4) **Minority AIDS Initiative (MAI)**

In the United States, HIV is concentrated in men who have sex with men (around 2% of the population but 61% of new infections) and in Black/AA people (14% of the population but 44% of new infections). There is a particular concentration in men who belong to both categories – compared to the general Black/AA population, Black/AA MSM have 22 times the odds of being HIV positive. In one cohort of Black/AA MSM, 3% of men acquire HIV every year.³⁶

a) **The most impacted population** is Black/AA MSM particularly the subpopulations of YBMSM 13-24 years of age, Black/AA MSM 25-44 years of age, and Black/AA Women (all ages). Table 9 compares these populations with the overall care continuum for the EMA. Areas in which the population group had better outcomes are indicated in red blocks, areas in which the population group compared more or less equally are in yellow blocks, and areas in which the population group compared more favorably are in green.

Table 9. Comparison of subpopulation against overall Care Continuum

ATLANTA EMA CARE CONTINUUM				
All				
L	E	R	VS	VSR
74% (1,400/1,896)	61% (21,433/35,244)	46% (16,082/35,244)	49% (17,101/35,244)	85% (13,728/16,082)
Black/African American MSM, Age 13-24				
69% (573/829)	73% (464/637)	49% (314/637)	46% (295/637)	73% (230/314)
Black/African American MSM, Age 25-44				
70% (344/491)	62% (4,917/7,892)	44% (3,459/7,892)	44% (3,459/7,892)	78% (2,700/3,459)
Black/African American Female				
80% (151/189)	63% (3,637/5,731)	48% (2,743/5,731)	49% (2,830/5,731)	83% (2,279/2,743)
Legend:	Better	Same	Worse	

³⁶ <http://www.aidsmap.com/The-paradox-of-HIV-in-black-MSM-in-the-US-very-high-infection-rates-despite-no-more-risky-sex-and-more-precautions/page/2450837/>

b)

(1) Planning Process for determining needs.

Each of the planning bodies involved in the development of the Integrated Plan had undertaken processes to determine the needs of the minority populations identified in the Epidemiologic Overview with similar results. For Part A, the populations were identified by the Assessment, Comprehensive Planning, and Priorities Committees. In determining need, the process involved review of client needs assessment data and focus groups, surveillance data, unmet need data, care continuums by populations, the existing comprehensive plan, EIIHA, and the *Atlanta EMA Populations and Communities with Disparate Health Outcomes: A Report of the Assessment Committee of the Ryan White Part A Atlanta EMA HIV Health Services Planning Council* and current literature.

(2) Culturally appropriate, population-tailored interventions and community partnerships utilized to increase bars on care continuum.

Programs will meet the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care (<https://www.thinkculturalhealth.hhs.gov/>) which are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

MAI funds are directed to the OAHs priority category to provide culturally appropriate services to improve HIV care access, retention and treatment adherence leading to viral suppression among minority populations disproportionately impacted by HIV in the EMA. Minority populations targeted with MAI funds in the Atlanta EMA appropriately are Black/AA (all sexes and ages), YBMSM 13-24 years of age, and Hispanic (all sexes and ages). MAI-supported programming and service delivery are designed to respond to unique barriers and challenges faced by minorities and vulnerable populations most severely impacted by HIV. Successful engagement of the target populations with MAI-funded activities yields increased viral suppression rates and other improved health outcomes, contributing towards decreased health disparities among PLWH in the Atlanta EMA.

Atlanta is among the highest ranked U.S. cities for new diagnoses of HIV. Experts say that's because routine HIV testing is not offered in the places where most people get their health care. By the time patients are diagnosed in Atlanta, almost one-third have advanced to Stage 3 (clinical AIDS). Late testing results in missed opportunities for prevention and treatment of HIV infection and emphasizes the need for earlier testing, linkage, and retention in care for persons living with HIV infection. Since starting a routine testing program in 2013, Grady Hospital (one of the largest public hospitals in the southeastern United States) has seen an average of 1 percent of their emergency room patients test positive for HIV. Often, that is as many as two or three new diagnoses in a day. Finding out whether you are infected with HIV is the first step to getting connected to life-saving care. A study examining data from across the country also found that, for socioeconomic reasons, nonwhite men and particularly nonwhite women residing in the South experience the worst clinical outcomes after being diagnosed with HIV³⁷. MAI funds will support care and treatment for individuals who have been tested in Grady Health System's emergency department, Grady Neighborhood Clinics, and clients released from Grady's inpatient facilities regardless of the client's acuity level as well as individuals linked from other facilities/programs in the EMA. This will include support for linkage to Grady's outpatient care system. The Grady Health System has an OAHs facility known as the Infectious Disease Program (IDP) which has a Main Clinic that serves primarily adult men while the Women's Clinic and Family and Youth Clinic³⁸ that serve adult women and infants, children and youth up

³⁷ Journal of Infectious Diseases. Sex, Race, and Geographic Region Influence Clinical Outcomes Following Primary HIV-1 Infection, February 2011, 203(4):442-51

³⁸ The Family and Youth Clinic served 480 HIV+ youth ages 13-24 in CY15, ranging from newly-diagnosed cases to those with advanced AIDS. This is a 12% increase in the number served in that age group in CY14. Males account for 38% and there are 8 transgender females.

to age 24, respectively. In addition, IDP also has the Transition Center which is a specialty clinic for adults with severe mental health or substance use issues and/or homelessness. The IDP sees the largest number of OAHS clients in the EMA and has a majority minority population. The Part A Recipient worked with IDP to initiate an optimization effort at the end of calendar year 2015 to help streamline clinic processes so more MAI patients could be seen and new patients could have their initial provider visit sooner. These efforts resulted in the piloting of a revised enrollment process. The aim of this initiative is to facilitate more rapid initial provider visits, and to decrease “no-shows”, the time to initiation of ART, and the time to viral suppression. As part of the new Rapid Enrollment clinic, IDP collaborated with the Part A Recipient to eliminate previous documentation barriers. Newly enrolled patients are given a 30-day window to provide documents and are provided extensive support by IDP staff to help obtain the documents. More importantly, these clients are assigned to a designated clinical care team who work together with the client on adherence and retention in care. The Clinical Care Team coordinates services with behavioral health and MCM to help the client address barriers to care. During this time they are able to see a medical provider and initiate ART, as deemed appropriate by the provider.³⁹ During the pilot, 100 patients newly enrolling in IDP were served. For those 100 patients, the median time to the scheduled first provider visit was 72 hours. Twenty-four patients received a same day visit and 56 patients had visits within 72 hours with 78% of patients attending their initial provider visit. In addition, 75% of patients were prescribed ART at that first visit. **Finally, the median time to viral suppression was just 21 days (IQR 17, 34).** Based on the success of the pilot, 2017 MAI funds will be utilized to support IDP’s truncated enrollment initiative. This full implementation of Rapid Enrollment means that all new MAI patients will be able to see a provider within 72 hours. Re-enrolling patients and patients being discharged from Grady Hospital will also have expedited scheduling of appointments.

Another component is for the Clinical Care Team to coordinate the transition of young clients, with a focus on YBMSM, from the Teen Clinic to the adult clinic. The Clinical Care Team will coordinate with Part A and Part D funded medical case managers who will continue to be assigned to the client in the adult clinic. The transition period is the time when these young clients are most at-risk for dropping out of care which is apparent in the differences in the engagement and care rates for Black/AA MSM by Age (Figure 10) which shows an engagement rate with an 11 percentage point drop from the 13-24 age group to the 25-44 age group and a 6 percentage point drop in retention. This pattern is repeated when looking at difference in age groups among the overall PLWH population where there is a 15 percentage point decrease in engagement and a 22 percentage point drop in retention.

Consistent with the socio-demographic characteristics of clients living with HIV/AIDS in the Atlanta EMA, the IDP serves a diverse clientele with respect to racial and ethnic background, gender, gender identity, sexual orientation, and age. Some face physical challenges related to HIV disease or other co-occurring illnesses that limit physical mobility and/or ease of ability to manage activities of daily living. Many experience social stigma related to their HIV status, sexual orientation, gender identification, mental illness, and/or substance abuse. NCLAS are incorporated into all aspects of care at the IDP including staff recruitment, education/training, language assistance, educational materials for clients, documentation, grievance procedures, and program planning. Discussion of cultural influences on client perceptions and attitudes regarding HIV disease, health beliefs, health care systems, and treatment is emphasized in clinical case conferences and program planning meetings, and contributes to the development and implementation of culturally competent clinical services. The facility provides full physical access for clients with disabilities. The multidisciplinary staff, composed of persons from diverse cultural and racial backgrounds and life experiences, shows a strong commitment to the population. Several IDP staff members are themselves living with HIV/AIDS or are affected by HIV disease in their personal life, which provides experience-based knowledge to both staff and

³⁹ With few exceptions, these medications are paid for through Patient Assistance Programs and 340(b) rebates.

clients. This experience continually informs the ongoing process of creating a culturally competent care environment in which the perspectives and experiences of clients from diverse backgrounds are appreciated, honored, and respected. Staff members are expected to listen to clients carefully, openly, and non-judgmentally to ensure that client perceptions and concerns regarding their treatment services are understood and addressed. Annual training is mandated for all Grady and Emory staff on: corporate compliance, customer service (including a cultural competency component), environment of care, confidentiality (HIPAA) and the Joint Commission Ambulatory Care National Patient Safety Goals. Additional training is routinely provided on working with special populations based on: race/ethnicity, sexual orientation, gender identity, or cultural groups.

This initiative differs from the Rapid Enrollment Clinics being initiated in FY16 which are designed to be stand-alone clinics dedicated to ensuring first clinician appointments within 72 hours that will provide temporary care until an appointment becomes available at one of our “long-term care facilities”. Rapid Entry Clinics will not be MAI-focused (although the majority of clients served will be of the targeted populations).

(3) Impact

The **impact** will be stable or improved viral suppression. The impact will be **evaluated** by examining progress in meeting goals set for the HRSA HIV/AIDS Bureau indicators:

#1 **Outcome:** Increase in the percentage of MAI clients with a viral load <200 copies/mL at last HIV viral load test during the measurement year.

Indicator: Percent and number of clients who have achieved a viral load <200 copies/mL.

Target: 80% of MAI clients served will have achieved a viral load <200 copies/mL during the measurement year.

#2 **Outcome:** Increase in the percentage of MAI clients with HIV prescribed antiretroviral therapy during the measurement year.

Indicator: Percentage of MAI patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.

Target: 95% of MAI patients will have been prescribed antiretroviral therapy during the measurement year.

The impact of MAI interventions will be **disseminated** to Priorities Committee, Assessment Committee, Comprehensive Planning Committee and QM Committee, Integrated Plan Review Team, Planning Council, Fulton County HIV/AIDS Task Force, and the general public through posting on the Atlanta Part A website: www.ryanwhiteatl.org

5) Special Populations and Complexity of Providing Care

a) **Emerging Communities:** There are no new emerging groups identified in 2015.

Communities of focus continue to be: YBMSM (15-30 years old), Black/AA MSM (30-45), and Black/AA High Risk Heterosexuals.

b) **Under-represented Populations:** In 2015, there were 14,516 PLWH served at Ryan White facilities in the Atlanta EMA. Males made up 75%, Black/AAs 78%, those aged in their twenties 16%. To determine underrepresentation, EMA data presented in the epidemiology section, including **Attachment 3**, and CAREWare data from the Part A Ryan White funded sites were used. There are a number of populations that are not represented in these sites to the same degree as the PLWH in the EMA. However, it is difficult to estimate the number of PLWH who are aware of their infection and who would also be eligible for care at the Ryan White clinics. On the assumption that all are eligible, likely true since they have all been included in the denominator for the HIV Care Continuum the most significantly under-represented are:

▪ **Youth living with HIV**, those aged between 20 and 29 years:

Data from the Care Continuum strongly suggests that youth aged less than 30 years are poorly compliant with their health care with only 56% retained in care, the lowest of any age group. That means there are 44% of youth not receiving care, all of whom are eligible for

treatment in the Ryan White program. Their viral suppression is also low at 57%, also the lowest of any age group;

- **Black/AA of all stages of HIV disease:**

Unmet need data suggest 55% of Black/AA have not been retained in care, compared to 52% of Whites; Black/AA with AIDS have less unmet need than those with HIV non-AIDS (35% compared to 42%).

- **Black/AA MSM:**

Black/AA PLWH have greater unmet need than Whites, 55% vs 51% respectively: Continuum data show that only 45% of Black/AA MSM are retained in care compared to 49% of Whites.

The viral suppression rate among Black/AA MSM is only 46% compared to 58% in Whites. Of Black/AA MSM who are retained in care, 82% are virally suppressed compared to 94% of White MSM;

- **Transgender PLWH:**

Small in number, transgender PLWH have retention of only 45% and VS of only 49%.

c) Co-morbidities

Including costs for inpatient and outpatient care and medications, the mean annual expenditures per person for HIV care in 2006 were estimated at \$19,912 (Gebo et al., 2010).⁴⁰ For those with CD4 cell counts 50 cell/mL or less, the cost was significantly greater, at \$40,678. Of the 21,784 EMA cases for which CD4 counts are available there were 1,029 (5%) with lowest CD4 count of 50 or less in 2015, and 20,755 cases with lowest CD4 count over 50 in 2015. Thus, the cost would be more than \$450 million. If the same were applied to the 14,420 estimated to be out of care assuming 5% with CD4 cell counts 50 cell/mL or less (712), an additional \$298 million would be needed. In addition, this cost is exacerbated by the presence of other comorbid conditions:

(1) Hepatitis C Virus

In 2012 there were 2,008 reported cases of confirmed Hepatitis C infection in the Atlanta EMA of which 89 (4%) were co-infected with HIV. That had increased to 6,237 in 2015. If we use the same proportion as co-infected we can expect about 250 PLWH needing treatment for both HIV and HCV, similar to the alternate calculation below.

Among Ryan White clients, 2% had reported or had positive lab results for HCV during 2015. The consumer survey found 4% had been diagnosed with HCV. Among those incarcerated and released during 2015, 163 had HCV. In order to determine the cost of managing HCV we have used 2% of the Ryan White population (14,510 clients) resulting in 290 HCV clients at a basic cost of \$64,500 each.⁴¹ Thus the cost will be **\$18,705,000** (\$64,500 x 290).

(2) STD/STI rates

Chlamydia:

Among PLWH receiving care in the Part A Ryan White funded clinics in the EMA, 5% (395) had documented chlamydial infection in 2015.⁴² However, only 61% of all clients had been screened for chlamydia.⁴² In determining the **additional** cost of treating chlamydia we will assume the proportion of PLWH who have chlamydia to be 5% of all clients or 636. Black/AAs accounted for 87% and Whites 8%, MSM accounted for 80%.⁴²

Studies have determined a range of costs of treating various STI's, the most reliable seems to be that from the Guttmacher Institute (\$227 per episode) and which have been used here for

⁴⁰ **AIDS**. 2010 Nov 13;24(17):2705-15. doi: 10.1097/QAD.0b013e32833f3c14, Contemporary costs of HIV healthcare in the HAART era. Gebo KA¹, Fleishman JA, Conviser R, Hellinger J, Hellinger FJ, Josephs JS, Keiser P, Gaist P, Moore RD; HIV Research Network.

⁴¹ Overview of Cost, Reimbursement, and Cost-Effectiveness Considerations for Hepatitis C Treatment Regimens. The American Association for the Study of Liver Diseases and The Infectious Disease Society of America. August 20, 2015.

⁴² Ryan White Part A CAREWare data, Fulton County, Atlanta, August 2014

costing calculations.⁴³ The cost to treat 6% of clients for chlamydial infection in FY2017 will be **\$144,372** (\$227 x 636).

Chlamydial infection in the Part A Ryan White population is found in Black/AAs, males and MSM.

Gonorrhea:

Among clients at Part A Ryan White clinics in the EMA, 417 clients (5%) had been diagnosed with gonorrhea in 2015.⁴² However, only 61% of all clients had been screened for gonorrhea (7,772 screened). We have assumed 5% of the total clients have evidence of gonorrhea. These cases were male (87%), Black/AA (91%) and MSM (87%).⁴² If we extrapolate screening to 100% of the population we could expect 636 cases.

Gonorrhea is easy and inexpensive to treat. Using the cost of treatment and lab investigations as \$73 per episode,⁴³ 6% of potential clients in FY 2017 results in a total **additional** cost of **\$46,428** (\$73 x 636).

Gonorrheal infection in the Part A Ryan White population is found in Black/AAs, males and MSM.

Syphilis:

Metropolitan Atlanta is ranked 1st among all MSAs.⁴⁴ PLWH being treated at Part A Ryan White funded sites there were 2,564 clients in 2015 who were positive for syphilis, out of 9,299 who were tested. This represents 28% of all clients in 2015. If we extrapolate to 100% of clients for FY17 using 28% positivity rate there would be 4,063 cases (28% of 14,510).⁴² Black/AAs made up 82% of these cases of which 93% were male and 82% MSM.⁴² New cases were fairly evenly spread among all age groups with 30% aged in their thirties and 25% in their forties.

It is estimated that the cost of investigating and treating primary and secondary syphilis is \$444 per episode.⁴³ Using the proportion identified here, the possible number of clients needing syphilis treatment in FY17 would be 3,175. As detailed earlier, the potential **additional** cost of treating syphilis in the 17% of clients expected in FY16 would be **\$1,409,700** (\$444 x (11,340 x .28)).

Syphilis infection in the Part A Ryan White population is found in Black/AAs, males and MSM.

(3) Prevalence of homelessness

The City of Atlanta homeless census targeted the unsheltered homeless who are sleeping in outdoor locations such as sidewalks, parks, encampments and under bridges. The Atlanta Housing Continuum of Care 2015 Point-In-Time also included the sheltered homeless, who are staying in emergency shelters and transitional housing programs. There were 3,280 sheltered individuals and 1,037 unsheltered for a total of 4,317. It is difficult to know how many are living with HIV, therefore, CAREWare data are used.

In 2015, among clients of Part A Ryan White funded sites, 1,079 (8%) of 13,749 persons for whom data were available were homeless or in “unstable” housing conditions, 77% were male, 83% were Black/AA, 58% were MSM and 34% HRH.⁴² Among Black/AA males, 73% were MSM and 20% HRH.

The costs for managing Ryan White clients was calculated by the Ryan White Part A Program using CAREWare data and expenditure reports from the EMA in 2015. Results

⁴³ The estimated direct medical costs of sexually transmitted disease among American youth, 2000. The Guttmacher Institute. Chesson HW, et al. Perspectives on Sexual and Reproductive Health, Vol 36, 1, February 2004.

⁴⁴ 2014 Sexually Transmitted Disease Surveillance, Table 30. Primary and Secondary Syphilis - Reported Cases and Rates of Reported Cases in Selected Metropolitan Statistical Areas (MSAs), United States, 2010-2014 Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Centers for Disease Control and Prevention.

indicated the annual cost of outpatient/ambulatory medical care in 2015 was \$1,223 per client. The number of homeless PLWH in the EMA in FY17 is estimated to be 8% of the total PLWH (14,510) or 1,161 clients.

To determine the cost of managing homeless clients, we have included basic cost of providing OAHS to the homeless PLWH in FY17 would be **\$1,419,903** (\$1,223 x 1,161).

(4) Formerly incarcerated

In CY15, there were 16,882 inmates released from Georgia Correctional Facilities of whom 8,625 (44%) were from the EMA. There were 305 released in 2015 **known** to be infected with HIV. In 2015, 70% of PLWH were in the Atlanta EMA. It is only reasonable to assume that approximately 70% of infected released inmates will also be from the EMA, or 214 inmates. A total of 87% of released inmates were taking anti-retroviral therapy.⁴⁶ This number did not include those still unaware of their infection nor those in smaller county jails (among the total number of PLWH in the EMA, the proportion taking anti-retroviral therapy was 88%⁴⁵).

In 2011, a consumer survey found 11% (1,543) had been incarcerated for some duration in the previous year of which 74% reported receiving HIV care while incarcerated and 37% received a supply of antiretroviral medicines on discharge. The number of previously incarcerated individuals with HIV needing care includes the 214 released inmates.

Thirty-nine percent had drug problems.⁴⁶ These high risk activities provide a great potential for further spread of HIV while incarcerated or on their return to society. This is supported by blood testing of inmates that found among those released, 2% were infected with HIV, 88% of whom were male. In addition, 1.2% had syphilis. 34% (163) of reported results had HCV (only 482 were tested, but 163 represents 2.7% of the total inmate population).⁴⁶ Drugs, their use, sale or distribution accounted for 21% of all inmates.

The cost of care for previously incarcerated persons uses the cost of providing HCV treatment (\$64,500 annually⁴⁷) for 2.7% of that population, with basic OAHS for the remaining 97.8%. Thus the cost for FY17 would be **\$388,276** (\$64,500 x (214 x 1%) + (\$1,223 x 214)

(5) Mental illness

Estimates of the level of mental health disease in PLWH are varied.⁴⁸ Several studies suggested 22% of PLWH had clinical depression,^{49,50} while others suggest 30%.^{51,52}

The number of clients who received any form of mental health care at the Part A Ryan White funded sites in 2015 was 2,484 or 18% of all clients.⁴² They had a median of 3.8 visits each. The vast majority was Black/AA (79%) followed by Whites (18%). Black/AA MSM contributed 41% and HRH 31% of all mental health clients. White MSM accounted for 13% and HRH 3%.⁴² In contrast, there were 220 White PLWH of whom 75% were MSM and 16% HRH.

The presence of mental health disease renders treatment of underlying HIV disease more complex. People with any mental health issues are more likely to have poor adherence keeping

⁴⁵ Medical Monitoring Project, Georgia Department of Public Health, 2010

⁴⁶ Inmate statistical Profile, Inmates Released During CY2015, pp 70-73. Georgia Department of Corrections. 01/02/2016.

⁴⁷ Overview of Cost, Reimbursement, and Cost-Effectiveness Considerations for Hepatitis C Treatment Regimens. The American Association for the Study of Liver Diseases and The Infectious Disease Society of America. August 20, 2015.

⁴⁸ *Mental Illness and HIV Disease*. HRSACareAction, HRSA Washington, DC, 2001.

⁴⁹ HIV and Clinical Depression. American Psychiatric Association, Virginia, undated

⁵⁰ *Prevalence of depression and role of support groups in its management: A study of adult HIV/AIDS patients attending HIV/AIDS clinic in a tertiary health facility in south-eastern Nigeria*. Ndu A, et al, Journal of Public Health and Epidemiology, 34, 182-186, April 2011.

⁵¹ *HIV-1 in Inpatients*. Lee, HK, et al. Hospital and Community Psychiatry, 43, 181-182, 1995.

⁵² *Depression, Alcohol Use and Adherence to Antiretroviral Therapy in Sub-Saharan Africa: A Systematic Review*. Mpungu E, et al. AIDS Behavior, 16, 2101-2118, 2012.

medical appointments and with medications⁵³ resulting in reduced or no viral suppression rendering them more capable of transmitting HIV. There is some evidence that mental illness may reduce the person's immunological responses thus worsening the disease process.⁵⁴

In addition to mental illness as a separate and distinct condition, some depression and anxiety arise from commencement of treatment with ART, which has been estimated to be as high as 80%; although other studies suggest just the reverse, a decline in mental illness with ART.⁵⁵

The cost of providing mental health services to clients at Part A Ryan White funded sites was calculated using data from CAREWare for 2015 and resulted in a cost of \$1,766 per client per year, including OAHS.⁴⁰ Hence, the total cost of providing mental health services to 18% of clients in FY17 will be **\$4,638,557** ($\$1,766 \times (14,510 \times .18)$).

Mental health disease primarily is affecting Black/AAs and MSM.

(6) Substance abuse

In the EMA IDU contributed 8% of cumulatively reported cases of all stages of HIV infection and 6% of PLWH through 2015.⁵⁶

The number of clients who received any form of substance abuse care at the Part A Ryan White funded sites in 2015 was 984 or 7% of all clients.⁴² They had a median of 4.5 visits each. The majority were Black/AA(87%), MSM 56% followed by HRH 35%; 55% of Black/AAs were MSM and 38% HRH; 71% of Whites were MSM and 16% were HRH.⁴²

The cost of treating substance abusing clients was determined from the utilization data in the CAREWare database at \$2,203⁴⁰ per client per year and includes the cost of primary health care. Hence, the total will be **\$2,237,587** ($\$2,203 \times (14,510 \times .07)$).

d) Impact of co-morbidities on the cost and complexity of care (See Attachment 5).

The comorbidities described here have a significant impact in additional costs of managing PLWH. We have made no attempt to determine the indirect costs of loss of a day's work. The additional direct financial costs are detailed below for each of the comorbidities described earlier. The number of clients to be served in FY17 was estimated earlier to be 14,510. To summarize the costs of treating the co-morbid conditions: HCV C infection: \$18,705,000; Chlamydial infection: \$144,372; Gonorrhea: \$46,428; Primary and secondary syphilis: \$1,409,700; Homeless: \$141,990; Formerly incarcerated: \$388,276; Mental health:\$4,638,557; and, Substance abuse: \$2,237,587.

Costs were calculated using published references and often included a range of costs. However, this does not take into account the potential complexity of managing HIV with other co-existent disease. HCV itself is difficult to manage and usually requires specialist involvement further increasing costs. The prevalence of this infection has also risen alarmingly in the last 3 years alone, almost tripling in the number of reported case in the EMA. Sexually transmitted diseases have also shown a marked increase in the last 5 years

The cost of treating the homeless is complicated by the range of other conditions co-existent, such as mental health issues, substance abuse and other disease such as diabetes and cardiovascular disease that are poorly managed in this population. These other "normal" diseases will prove to be far costlier to manage which is impossible to estimate.

⁵³ *The Impact of DSM-IV Mental Disorders on Adherence to Combination Antiretroviral Therapy Among Adult Persons Living with HIV/AIDS: A Systematic Review.* Springer SA, Dushaj A, Azar MM. AIDS and Behavior, 16, 8, 2119-2143, 2012.

⁵⁴ *HIV and psychiatric co-morbidities: What do we know and what can we do?* Psychology and AIDS Exchange Newsletter, American Psychological Association, January 2013.

⁵⁵ *Impact of HIV antiretroviral therapy on depression and mental health among clients with HIV in Uganda.* Wagner GJ, et al. Psychosomatic Medicine, 74, 9, 883-890, 2012

⁵⁶ *HIV Surveillance Summary, Georgia, 2016.* Georgia Department of Public Health, HIV/AIDS Epidemiology Program.

6) **AIDS Pharmaceutical Assistance** – Not Applicable. The EMA does not support an AIDS Pharmaceutical Assistance program.

METHODOLOGY

A. Impact of Funding

1) Impact and Response to Reduction in RWHAP Formula Funding

- a) The EMA did not experience a decline in formula funds.
- b) Not Applicable

2) Impact of the Changing Health Care Landscape

a) Uninsured and poverty:

EMA General Population:^{57,58}

	Insurance Type	#	%
(1)	Medicaid	798,857	15.1
	Medicare	675,834	12.8
	Marketplace	564,955	10.7
(2)	Uninsured	896,800	17.0

	Poverty Level	#	%
(3)	125% FPL	7,119	20.2
	200% FPL	11,983	34.1
	Poverty @ 138%, 400%, and 300% Unavailable.		

If these percentages were to be applied to the number of PLWH in the EMA the figures would be:

	Insurance Type	#	%
(1)	Medicaid	5,322	15.1
	Medicare	4,434	12.8
	Marketplace	3,771	10.7
(2)	Uninsured	5,991	17.0

	Poverty Level	#	%
(3)	125% FPL	1,051,071	20.2
	200% FPL	1,772,516	34.1
	Poverty @ 138%, 400%, and 300% Unavailable.		

Ryan White CAREWare numbers indicate the numbers and percentages of Ryan White for clients served in 2015.

Atlanta EMA Part A:

	Insurance Type	#	% ⁵⁹
(1)	Medicaid	1,803	12.4
	Medicare	2,386	16.4
	Marketplace	697	4.8
(2)	Uninsured	7,707	53.1

	Poverty Level	#	%
(3)	≤ 138% FPL	10,534	72.6
	≤ 400% FPL	13,423	92.5
	≤ 300 % FPL ⁶⁰	12,853	88.5

Georgia 2015 CAREWare EMA Clients utilizing ADAP and HICP:

	Insurance Type	#	% ⁶¹
(1)	Medicaid	97	1.7%
	Medicare	269	4.8%
	Marketplace	457	8.1%
(2)	Uninsured	4,796	85.4%

	Poverty Level	#	%
(3)	≤ 138% FPL	17,894	72.9
	≤ 400% FPL	24,426	99.5
	≤ 300 % FPL	24,350	99.2

⁵⁷ United States Census Bureau/American FactFinder. “S2701: Health Insurance Coverage Status.” 2010 – 2014 American Community Survey. U.S. Census Bureau’s American Community Survey Office, 2011. Web. September 2015. <<http://factfinder2.census.gov>>.

⁵⁸ United States Census Bureau/American FactFinder. “S1701: Poverty Status in the Past 12 Months.” 2010 – 2014 American Community Survey. U.S. Census Bureau’s American Community Survey Office, 2011. Web. September 2015. <<http://factfinder2.census.gov>>.

⁵⁹ % of 14,510 clients served in 2015.

⁶⁰ FPL to determine RWHAP eligibility in the Atlanta EMA.

⁶¹ % of 24,548 clients served in 2015.

b) Impact of insurance expansion:

It is essential that the Part A service system supports PLWH along the HIV Care Continuum, not only through OAHS, but through those core and support services not covered by insurance. The implementation of the Affordable Care Act (ACA) had a variety of impacts in the Atlanta EMA. Georgia has opted not to expand Medicaid, resulting in roughly two-thirds of the FY15 Part A client population not being qualified for Medicaid. In the absence of expansion, these clients will continue to rely on the Part A program for their care and treatment. Approximately one-third of the FY15 Part A client population has incomes that qualify for insurance through the ACA Marketplace. Part A providers guided clients to health insurance navigators to assist with enrollment; however, determining the actual number of clients who have successfully enrolled in, and maintained, private insurance has been a challenge due to a lack of access to insurance rolls. Some clients enrolled in an ACA Marketplace plans, or other third party insurances, have experienced challenges with accessing medications through their insurance. The cost of HIV medications has been set in the highest pricing tiers resulting in unaffordable out-of-pocket expenses. Over time, Georgia's HICP will result in cost-savings to the Ryan White Program in that it is more cost effective to pay for the insurance premiums and other out-of-pocket expenses than to support 100% of the cost of treatment. Providers throughout the EMA have achieved great success in utilizing other payer sources enabling insured clients to have continued access to their medications. For example, clients have accessed prescription co-payment cards and the Patient Access Network (PAN) Foundation to receive assistance with costly out-of-pocket medication co-insurance payments.

(1) Service provision and complexity of providing care:

HRSA's FY14 Congressional Justification for Ryan White Funding stated that "It is anticipated that on average, [ACA] coverage will not be adequate for the care and treatment of people living with HIV/AIDS (PLWH) due to plan limitations on the scope of coverage... Other Ryan White services that may not be covered include oral health care, medical case management, treatment adherence counseling, psychosocial support services, outreach and a host of other support services that in many cases are critical to identifying, linking and maintaining people living with HIV and AIDS in care."

Perhaps the most pivotal change to the health care landscape was the elimination of pre-existing conditions as a consideration for health insurance coverage. Additionally, the ACA addresses discrimination and yearly/lifetime spending caps. For PLWH, this means no longer being denied coverage based on an HIV/AIDS diagnosis and (for PLWH who had managed to secure health insurance) no longer being confined to unreasonable expense thresholds for care.

RW funding is critical in helping maintain a safety net for those most underserved. While the ACA ushered in significant progress, the entire state of Georgia has suffered from the lack of Medicaid expansion. The State's denial of this expansion has left hundreds of thousands of Georgia's most vulnerable residents, including PLWH, without access to affordable coverage. Because Georgia also refused to develop a state-run marketplace exchange, plan prices are also higher than those in states that do facilitate their own exchange. These factors create a system that still leaves individuals locked out of coverage, particularly those in low-income households or those with strained financial resources. Many patients are continuing to need assistance with high medication costs due to ARVs being placed in Tiers 4 and 5 of insurance formularies. This has resulted in high annual medication deductibles and high co-pays on many plans. Patients are connected by case managers and financial counselors with other resources such as the Patient Assistance Network (PAN) an independent non-profit that provides assistance to under-insured patients for their out-of-pocket expenses for life-saving medications.

While Part A has always had the option of purchasing health insurance on behalf of clients the infrastructure does not exist to support such an undertaking and upstarting it would unlikely

be cost effective. The EMA has relied upon Part B, which administers ADAP and HICP, to provide this service.

Part A continues to serve PLWH by providing OAHS and other core services (e.g., medical case management, oral health, mental health, etc.) and essential supportive services (e.g., psychosocial support including patient navigation, case management non-medical including ADAP enrollment specialists and insurance navigators).

(2) Changes in allocations, activities related to health insurance premium assistance.

HICP continues to be ranked as a needed service. In 2014 and 2015, Part A provided funding to assist with insurance co-pays and deductibles; however, Part B received a substantial increase in funding and indicated that residents of the EMA would be covered without the need for Part A assistance. Thus, Part A funds were not allocated.

As clients have attempted to enroll in marketplace programs and worked with insurance navigators they have described frustration at the lack of knowledge of the HIV care system or the needs of PLWH. In response, Part A has funded insurance navigators that are intimately familiar with the HIV care and support system and PLWH needs and can better assist clients in selecting the most appropriate coverage. \$150,000 was allocated in FY16 and has increased to \$164,248 for FY17 (a 9% increase).

(3) Cost including service costs, cost-sharing, cost-savings.

Georgia DPH HICP will result in **cost-savings** to the Ryan White Program in that it is more cost effective to pay for the insurance premiums and other out-of-pocket expenses than to support 100% of the cost of treatment. Providers throughout the EMA have achieved great success in utilizing other payer sources enabling insured clients to have continued access to their medications. For example, clients have accessed prescription co-payment cards and PAN Foundation to receive assistance with costly out-of-pocket medication co-insurance payments. For those not falling into the Medicaid gap, there are premium tax credits and health insurance premium assistance available for PLWH meeting certain criteria. These tax credits and assistance make monthly payments affordable to those that would otherwise not be able to meet the financial obligations of an insurance plan.

c) Outreach and enrollment:

The RWHAP recipient has provided various efforts to reach out to clients and provide information regarding the ACA, and how it may affect the way in which they receive healthcare services.

(1) How outreach and enrollment efforts were conducted.

The RWHAP Part A recipient included the requirements outlined in HAB Policy Clarification Notices 13-01 and 13-04 in the FY16 contracts. Prior to implementing the new policies, agencies had an opportunity to comment and provide feedback on the proposed changes. Agencies were provided directives to document their efforts to enroll clients, as well as to outline their processes for enrolling eligible clients into third party insurance plans.

Each subrecipient is contractually required to vigorously pursue enrollment of clients into health care coverage for which they may be eligible. Each agency describes its process as part of the application for Part A funds. Part A Project Officers review the process with subrecipients during site visits. As part of the client enrollment process, financial counselors screen client information to determine if the client currently has insurance (verified through Passport). If client is uninsured, yet meets the financial threshold at which point the client is required to seek health insurance according to the Individual Mandate rule of the Client Protection and Affordable Care Act 2010, he or she is notified of that requirement and advised of the tax penalties which will be incurred if they elect not to pursue coverage. Staff then provides clients with education and information about the Marketplace, types of plans available in their county of residence and arrange for them to meet with a Healthcare Navigator or Certified Application Counselor either

onsite or at Navigator sites to discuss enrollment options. Patient Guides (Patient Navigators, Peer Navigators, or Case Managers) contact patients regarding upcoming enrollment dates and relevant workshops. A Patient Guide also inquires if the person needs assistance in the enrollment process. If the patient requires assistance, the Patient Guide can schedule an appointment or a referral is provided to a Certified Application Counselor. Additionally, links to helpful sites regarding insurance, the marketplace and other assistance institutions are easy to access on the many subrecipients' web sites. In the event that a client refuses to pursue other viable payer sources or enroll in insurance coverage for their Ryan White funded service, staff will thoroughly document efforts to encourage and guide the client to do so. If the Marketplace Insurance open enrollment deadline has passed at the time of initial intake, staff will encourage client to enroll during the next upcoming enrollment period and follow up again with client at that time to assist them with that enrollment. However, subrecipients will not refuse to provide services to the client if he/she chooses not to pursue insurance options but will document this in the client's electronic record. The client will be required to sign the insurance screening tool to confirm that they have received information about the insurance programs they may be eligible for. Clients will also be informed in writing that, under no circumstances, will the subrecipient assist them with paying any tax penalties they may incur due to failure to elect insurance coverage. If a client is determined to have viable insurance coverage for a Ryan White funded service, staff will proceed with necessary documentation and billing procedures to appropriately report encounter(s) so that the finance/billing department can bill the insurance provider for service. Patient Guides contact patients regarding upcoming enrollment dates and relevant workshops. A Patient Guide also inquires if the person needs assistance in the enrollment process. If the patient requires assistance, the Patient Guide can schedule an appointment or a referral is provided to a Certified Application Counselor. Additionally, links to helpful sites regarding insurance, the marketplace and other assistance institutions are easy to access on the agency's web site.

(2) Coordination efforts.

Technical assistance was offered and provided to agencies to enroll as providers with participating insurance carriers. Additional technical assistance was provided to agencies to learn practices that will maximize opportunities for generating revenue as third-party billers. Enrolling as providers has been an ongoing challenging for some of the EMA's service providers. The recipient coordinated with DPH, the Ryan White Part B recipient, The Health Initiative, also work with Georgia Equality and Georgians for a Healthy Future to develop uniform policies regarding the Health Insurance Program. It has been a challenge to track the number of clients who have successfully enrolled and maintained their insurance through the ACA Marketplace.

(3) Challenges.

The most challenging piece to outreach and enrollment efforts is the State's lack of Medicaid expansion. Due to this, the most vulnerable Georgians do not qualify for affordable coverage. The result can often be outreach efforts that routinely end in exemption forms being filled out, instead of an enrollment in an insurance plan. The politically charged discourse surrounding the ACA can make outreach efforts difficult, as consumers may have already received misinformation regarding the law and options available to them. Excessive amounts of time can be spent on dispelling myths and explaining the realities of the law. Additionally, there are very few insurance navigators that specialize in the intersection of health insurance and programs related to HIV resources. Because of this, outreach to PLWH is limited and many may not be receiving targeted outreach messages, especially those not currently in care with an AIDS Service Organization (ASO).

(4) Facilitators to outreach and enrollment.

Outreach and enrollment is most successful with full participation from all ASO's in the EMA. Clients are more likely to engage in services when everyone from the front desk staff to case managers are aware of available enrollment resources and deadlines. Partnerships with organizations focused on ACA enrollments boost the ability to fully serve PLWH in connection

to the health insurance marketplace. When clients have the ability to meet with insurance navigators in a facility they are already connected to (i.e. an ASO they are currently in care with), part of the barrier to accessing services is removed. This also allows the insurance navigators and ASO staff members to work together in a collaborative way that best meet the needs of clients. The development of marketing materials that are specific to PLWH has been key to conducting well-received outreach. The marketing materials available through Centers of Medicaid/Medicare Service (CMS) do not specifically address PLWH or particular things to be mindful of when selecting a plan, if you already have a diagnosis. Creating materials that outline these things, and also take into consideration factors specific to Georgia, have greatly assisted in PLWH feeling comfortable in engaging services and has also made individuals more prepared for enrollment appointments.

d) Marketplace options:

(1) How plans affect provider accessibility.

It has been a challenge to track the exact number of clients who have successfully enrolled and maintained their insurance through the ACA Marketplace. cursory analysis indicates that the proportion of the population having discontinuous or uncoordinated HIV/AIDS care as a side effect of gaining health care coverage is less than 1%. The majority of clients continued with their existing provider once insured or with another Part A provider due to experience working with HIV disease. Reasons for discontinuous care include: formulary restrictions and shifting of ARTs to Tier 4 medications, resulting in high out of pocket costs; lack of clarity during open enrollment regarding providers participating in qualified health plans (QHP) and other commercial health insurance provider networks, as well as coverage of ARTs, resulting in selection of plans that did not meet the needs of HIV+ clients; limited participation of HIV-experienced providers in QHP and other commercial health insurance provider networks, particularly in suburban and rural parts of the EMA; and, challenges experienced by newly insured patients that are unfamiliar with health insurers' utilization management and other requirements, such as prior authorization.

The State of Georgia participates in the Federal Marketplace Exchange. Marketplace plan options differ significantly from county to county. For example, in Fulton County in 2016 there were 68 plans available, but in Paulding County there were only 24 plans available. The difference in plan options is also rooted in the number of health insurance companies offering plans through the Marketplace; whereas Fulton County has eight companies Paulding County has only three. It must be noted however, that three of the nine carriers that currently offer exchange plans in Georgia will exit the exchange at the end of 2016. They are United Healthcare, Cigna, and Aetna. As a result of these three exiting the exchange, Blue Cross Blue Shield of Georgia will be the only carrier that will offer exchange plans in all 159 counties in Georgia. Atlanta metro area will still have plans available from all remaining six providers, but some more rural areas will have far fewer choices for people shopping the exchange. Furthermore, a more pressing challenge in affordability of insurance of our clients is all six carriers have requested to raise their rates in 2017 as follows:

- Blue Cross Blue Shield of Georgia: 15.1 percent, but with Aetna's exit, and the assumption that many of Aetna's current enrollees will switch to BCBSGA, the carrier has said they're reconsidering their rate proposal, and may request a larger rate increase for 2017.
- Harken Health Insurance: 41.4 percent
- Humana: 67.5 percent
- Kaiser Permanente: 18 percent
- Ambetter from Peach State Health Plan: 7.4 percent to 8.3 percent, depending on whether dental/vision are included
- Alliant: 10 percent ⁶²

⁶² <https://www.healthinsurance.org/georgia-state-health-insurance-exchange>

(2) How the plans affect care and medications.

Within our EMA, PLWH have noted concerns when switching to a private insurance carrier. Although Ryan Part A is a payer of last resort, the high out of cost expenses for labs and prescription medications have financially impacted our clients who once used Ryan White funding to cover their care costs. As with any individual dealing with unexpected/high medical bills, the anguish of having harassing phone calls from bill collectors and the potential for your credit rating being damaged due to unpaid medical bills adds more stress to our clients. On the other hand, the Atlanta EMA is addressing the population previously mentioned by supporting continuous comprehensive care along the continuum. RWHAP funds help supplement gaps to ensure that clients continue to receive access to needed services within the continuum. For newly diagnosed people, services are in place to link clients to care in the public or private sector with various options available depending on the insurance the client has. For retention in care, medical case managers are available to assist clients in accessing benefits to help balance the financial challenges which some clients have seen as a result of choosing plans with high out-of-pocket costs. Patient Navigators help clients work through an unfamiliar system (for many clients, this is the first time they have had insurance coverage as an adult). Clients are eligible to receive OAHS at several Part A sites and are able to avail themselves of services which might not be covered by insurance (oral health care, transportation assistance, food services, etc.).

Many Ryan White providers accept a limited number of insurance plans. This has a direct impact on insurance cost beyond the premium (i.e. co-pays, co-insurance, deductibles and other costs tied to obtaining medical services). When consumers have issues (not related to their support they are getting for HIV care) if they go to another facility the costs tied to services they receive through the Ryan White Program often times are not covered so they have higher out of pockets costs. Correspondingly, another challenge is consumers assuming once they have insurance that they can use their insurance with any provider. It is of fundamental importance that the consumer utilizes clinics and medical personnel that are in-network to ensure maximized cost savings.

In FY13, prior to the roll-out of marketplace insurance, five Part A clients (0.04%) had private-individual insurance. In FY14, that number increased to 509 people (3.6%). In FY15, that number increased to 697 (4.8%).

(3) Planning and Resource Allocation

a) Description of the Community Input Process

(1) Describe the overall structure of the community input process.

The community input process is multi-faceted including: the survey of consumer needs and gaps in services; input from the Consumer Caucus (including consumers who are not Council members); participation by Council committee's (each of which has consumer members and a Vice-Chair who is living with HIV); and, public discussions at meetings of the Planning Council which also includes members of JPPG and GPACC.

The annual priority setting and allocations process begins with the deliberations of the Priorities Committee. At the announcement of the need to convene the Priorities Committee, an orientation/refresher is conducted to review Section 2602(b)(4)(C) of the PHS Act. All members on the Priorities Committee are screened for conflict of interest and attest to unaligned status. The importance of establishing priorities for the allocation of funds within the EMA is reviewed as well as conflict of interest provisions. Members are shown sample reports and process questions are answered.

Public meetings of the committee are held each year over a period of 3-5 days. The Committee reviews a variety of data including, but not limited to: consumer needs and gaps in services; service utilization patterns; cost per client and unit of service for each priority category; availability of other funds; epidemiology of the epidemic in the EMA; previous year final allocations and expenditures; unmet need data from the existing framework; the HIV Care

Continuums by population and unmet need; current literature regarding HIV, EMA progress in meeting HAB performance measures and EMA indicators, impact of the Affordable Care Act, and the most current Part A application to HRSA and Attachments. Data are augmented with reports from various groups such as the Consumer Caucus, the Assessment Committee, the Comprehensive Planning Committee, AAOI, and HOPWA staff. Epidemiology and Surveillance staff from DPH provide the most current HIV Care Continuum as well as data by race/ethnicity, age, sex, and mode of transmission and answer questions. The Part A Program Office provides information on client satisfaction surveys and Community Advisory Board comments/suggestions to help inform the Committee's deliberations.

In setting priority rankings and service allocations the committee reviews the priority categories which impact the various stages of the HIV Care Continuum and the differing needs of individuals as they move through the continuum. The committee then makes recommendations for a system of services to support individuals from diagnosis, to linkage to care, to engagement in care, to retention in care and to viral suppression. Recommendations are sent to the Executive Committee with final approval being made by the full Council.

**(2) Describe the specific prioritization and allocation process of the Council:
PLWH not retained in care, persons unaware of their HIV status; historically underserved populations:**

(a) How the needs of the following were considered:

Unmet need data are presented from the existing framework by sex, race/ethnicity, age, transmission risk category and zip code groupings as well as the overall HIV Care Continuum for the EMA and the Part A Program and population-specific continuums which indicates PLWH not in care. HIV testing data are provided and include numbers who did not receive their test results and presumably are unaware of their status. Underserved population information is provided through the previous year's HRSA application, the EIIHA plan, and the Assessment Committee's report on disparate health outcomes. The Priorities Committee assesses how individual service categories contribute to mitigating unmet need identified in the local unmet need estimates and how delivery of the service impacts unmet need and evaluates whether the service's contribution to unmet need or its potential impact on unmet need merits higher prioritization and/or additional allocations. Additionally, Black/AA MSMs, within the EMA have the most disparate health outcomes especially those between the ages of 15 and 24 years old. The most underserved communities are comprised of seven zip codes in which individuals with the worst health outcomes reside. These neighborhoods are characterized by limited access to health care services. Recommendations included increasing access to health care through co-location of services and enhanced transportation options. In FY16 a new service provider was identified in this area and funded for OAHS, non-medical case management, and medical transportation.

(b) How PLWH are involved and their priorities considered.

The consumer needs assessments inform the committee on PLWH priorities obtained through surveys and focus groups including individuals not in care. PLWH needs are discussed throughout the year through updates from the Consumer Caucus. There are 14 members: eight consumers of Ryan White services, three PLWH who are not consumers, and three additional members with varying degrees of expertise in consumer representation and experience with housing and HIV prevention services. Many of the members serve in dual capacities as members of the Consumer Caucus, historically underserved populations, affected Communities, and prevention – committee members bring an understanding of their needs and the needs of their peers. Leadership of the Council includes the Chair and two Vice-chairs who are living with HIV. The annual AAOI provides a variety of perspectives on the needs and challenges faced by consumers and persons not in care. All of these inputs provide a framework for ensuring the needs of the people we seek to serve are at the forefront of deliberations.

(c) How the input of the community was considered and whether it adequately addressed

any funding increases or decreases in the RWHAP Part A award.

Consumers, other PLWH, and community stakeholders are involved in every step of the Priority setting and resource allocation processes. Input helped inform decisions on changes to priority categories and allocations. The Committee developed various scenarios based on anticipated funding levels. The first decision was to maintain the FY16 levels as the base for FY17. Increased funds in an amount up to \$2.229 million would be equally distributed to meet consumer demand for services. Funding above that level would be equally divided among OAHs; OAHs stop-gap medications; Rapid Entry Clinics; and, Oral Health as a reflection of the need to improve access and retention to care and to address the need for oral health service which is the #1 consumer ranked category of service needed yet not received. Should the EMA receive a reduction in funding up to \$250,000 the reductions would be applied equally across all categories; any increase >\$250,000 would require the Priorities Committee to reconvene to determine how reductions should be applied. Increased funding in FY16 allowed the EMA to fund insurance navigators and Rapid Entry Clinics to respond to PLWH-identified need.

(d) How MAI funding was considered to enhance services to minority populations.

During FY17 deliberations the Priorities Committee discussed the importance of increasing and maintaining access to care for minority populations. Minority populations continue to present with HIV and AIDS at an alarmingly higher rate than other demographics and have had challenges linking to care. Given the trend of late diagnosis, lower linkage, retention and viral suppression rates within the HIV Care Continuum, the Committee voted to continue the allocation of MAI funds to the core service category of OAHs. The use of MAI funding for this purpose is consistent with the EMA's prioritization of OAHs as the number one core priority service category.

(e) How data were used to increase access to core medical services and to reduce disparities in access to HIV/AIDS care in the EMA.

In an effort to respond to the needs of persons at risk for HIV infection and people living with HIV disease data from other federally and non-federally funded HIV/AIDS programs were considered, along with service utilization data and performance measure data. Committee members received statistical data and presentations from the Georgia DPH, Georgia Ryan White Part B Program, HIV Surveillance, and HIV Prevention. Georgia's Care and Prevention in the United States (CAPUS), as well as local presentations 1) counseling, testing and linkage services; 2) current and anticipated funding for ADAP and HICP; 3) mental health and substance abuse funding; and, 4) HOPWA funding.

In addition to funding the continuation of most FY16 services to respond to the different stages of the HIV Care Continuum, new initiatives funded in FY16 were included as part of the base for FY17: insurance navigators with specific knowledge of the needs of PLWH to facilitate linkage to care and retention in care; up to funding in OAHs (and Non-Medical Case Management, and Medical Transportation) to support quicker linkage to care, access to ARVs to achieve and maintain viral suppression without the need to diminish funding for OAHs services provided to existing clients to support retention in care and access to ARVs to achieve and maintain viral suppression.

(f) How changes and trends in HIV/AIDS epidemiology data were used.

The epidemiology data from the FY16 HRSA application were examined and compared against the most recent epi data by sex, race/ethnicity, age and transmission risk category. In the Atlanta EMA, epidemiology data continue to show a disproportionate impact among Black/AA (particularly MSM, YBMSM, and women). Utilization patterns mirror the epidemic in the EMA and services correspond to the needs identified in all recent assessments. Given the relative constant nature of the epidemiology in the EMA (as further Epidemiologic Overview of this application), it was determined that wholesale revisions to the current continuum of care were not warranted. However the need to increase care and retention of Black/AA MSMs ages 15-24 through the Patient Navigation Program, and Rapid Entry programs was emphasized.

(g) How cost data were used in making funding allocation decisions.

The FY15 Unit Cost Analysis continues to be used as a reference document in discussions concerning the average cost per service visit and cost per client. The Unit Cost Analysis provides the basis for making comparisons across service categories and evaluating cost effectiveness as well as serving as a benchmark for performance measurement. The unit cost analysis included data for each of the core and support services and illustrated the total expenditures for each service category across Ryan White Parts A, B, C, and D, highlighting the amount supported by Part A funds. These data are important to better understand the costs involved in providing services and for estimating the number of clients that can be served based upon funding.

(h) How data from other federally funded HIV/AIDS programs were used in developing priorities.

In an effort to respond to the needs of persons at risk for HIV infection and people living with HIV disease data from other federally and non-federally funded HIV/AIDS programs were considered. Committee members received statistical data and presentations from the Georgia DPH, Georgia Ryan White Part B Program, HIV Surveillance, and HIV Prevention. Georgia's Care and Prevention in the United States (CAPUS), as well as local presentations on food and nutrition, patient navigation, and mental health/substance abuse were utilized in the process.

The Priorities Committee heard presentations and assessments on the availability of other federal funds for: 1) counseling, testing and linkage services; 2) current and anticipated funding for ADAP and HICP; 3) mental health and substance abuse funding; and, 4) HOPWA funding.

(i) How anticipated changes, due to the changing health care landscape, were considered in developing priorities.

The purpose of the Atlanta EMA Ryan White Part A program is to improve the availability and quality of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease in the 20-County Atlanta EMA. Funds support a continuum of care, including both core medical and support services. Due to the lack of Medicaid expansion and the decision not to establish a State Marketplace, options for private insurance coverage are less robust than in other states. The majority of clients served by Part A (72.6%) as well as ADAP/HICP (72.9%) have incomes \leq 138% of FPL and are not eligible for coverage under ACA. As a result, the Priorities Committee continued substantial allocations of funds (90%) to core medical services. For those clients eligible for ACA coverage, insurance navigators were funded to support access. The EMA continues to work with the State Part B program to ensure the availability of ADAP and HICP funds and funds enrollment specialists who assist clients with accessing these services.

(j) What efforts have or will be taken to integrate prevention and care planning in order to maximally provide high-quality care and treatment and help prevent new infections in the jurisdiction.

The EMA continues to integrate prevention and care planning at the Part A level. Some specific activities include:

- The Atlanta EMA has completed the development of its first Integrated Prevention and Care plan. Through a very robust committee structure that was led by the Planning Council's Comprehensive Planning Committee, the Council and Recipient held a total of sixteen Integrated Plan planning meetings during the period of September 16, 2015 through August 10, 2016. The plan reflects the joint work of the Ryan White Part B Program, Ryan White Part A, and the CDC High Impact Prevention Programs (HIPP).
- Cross-pollination between the Ryan White Part A Planning Council and the Fulton DeKalb JPPG. Six of the eight committees of the Planning Council have members who also serve on the JPPG; and four of five committees of the Prevention planning body have members who also serve on the Planning Council.
- The Georgia DPH and FCDHW presented information to members of the QM Committee and shared information and identified opportunities to coordinate services to avoid duplication.
- The Part A Planning Council Project Officer and Planning Council members participate on

the High Impact Prevention Program and DPH Community Planning Committee in order to keep the Planning Council apprised of activities so that initiatives can be combined, i.e., counseling, testing, and linkage activities at AAOI.

- The EMA shares epidemiological data with prevention funders to assist with targeting of counseling and testing in high-risk populations and geographical locations.
- Additional funding has been allocated to Patient Navigation and up to eight RWHAP primary care sites will be funded. Navigators will work with linkage coordinators to ensure enrollment and retention in OAHS.
- The annual AAOI has fully integrated a prevention component in both the planning and delivery of educational sessions.

b) Letter of Assurance from Planning Council Chair (Attachment 6)

c) Coordination of Services and Funding Stream

(1) Financial Resources Inventory

(a) Resource Inventory (Attachment 7)

(b) Different funding sources interact to ensure continuity of HIV prevention, care, and treatment services:

The Atlanta EMA is committed to using Part A funds for the most affected populations and as funding of last resort by continuously assessing other available resources throughout the EMA. **Attachment 7** describes availability of other public funding in the EMA. Clients receive services from other Ryan White funded and non-funded programs that enhance and augment the comprehensive range of services required by individuals and families. For example, clients receive housing assistance through the HOPWA program; WICY receive assistance through Part D funds; and Primary Care and Counseling & Testing are provided through Part C funds. In this environment of limited funding for HIV/AIDS and the increased prevalence among emerging populations, integration and coordination of services ensures timely, uninterrupted care.

Part A leverages funds from local, state, and federal sources to avoid duplication. Part B grant funds managed by Georgia DPH provide funding to local health departments; provide ADAP medications, and health insurance assistance.

As the largest division in the Georgia Department of Community Health (DCH), the Medical Assistance Plans Division administers the Medicaid and PeachCare for Kids[®] (SCHIP) programs which provide health care for children, pregnant women, and people who are aging, blind and/or disabled. Medicare provides limited health coverage to U.S. citizens or legal residents age 65 and older and people with disabilities who have received Social Security Disability Insurance (SSDI) for two years. Because of its limited coverage, Medicare alone does not provide sufficient health care, particularly for people living with HIV/AIDS. Case managers work with DCA to assist clients in accessing benefits to which they may be entitled. Most low-income children qualify for PeachCare for Kids and as a result Part A funds are not used for medical coverage of PLWH under 18.

Services to WICY and their families are coordinated through Part D. There is one Part D-funded program in the EMA: Grady IDP serves women, children, youth and families infected or affected by HIV/AIDS who reside in the five core Metropolitan Atlanta counties (Fulton, DeKalb, Cobb, Clayton and Gwinnett) and the surrounding 15 Metro counties in the 20 county Atlanta EMA. The Grady IDP serves the vast majority of children and adolescents in the 20-county EMA because other sites do not have the expertise on-site to provide that care. The IDP also enrolls their HIV+ mothers and follows them all in the Family Clinic (FC) which combines WICY patients on a dedicated floor of the building. IDP Family and Youth Clinic staff work closely with High Risk OB Nurse in the Grady Women's Health high risk OB Clinic for HIV+ Women to ensure pregnant women living with HIV receive coordinated services. A Grady IDP social worker provides case management services onsite at the weekly OB clinic. In addition, two of the Physician Assistants (PAs) from the Family Clinic visit the HIV OB clinic on the first and third Wednesday of the month so that the PAs can meet with future patients and establish a

relationship with them. It also allows the PAs to help the Grady Women's Part D nurse and the Grady IDP social worker in addressing enrollment issues that the women in the OB clinic may encounter in enrolling for services at the IDP postpartum. To facilitate enrollment, joint maternal and infant six week appointments are made at the IDP Family Clinic. Grady IDP receives Part B funding to provide care for infants and children living outside the 20-county EMA. All primary care clients within the EMA are screened for ADAP eligibility. If eligible, applications are submitted to DPH to complete the enrollment process. DPH contracts with the Grady Health System, which participates in the State's ADAP Contract Pharmacy (ACP) Network. The pharmacy is co-located within the Grady IDP (Part D recipient as well as one of the Part A funded primary care providers). IDP clients within the Atlanta EMA can pick up their ADAP medications.

There are 19 Ryan White Part C recipients operating in Georgia, providing early intervention and primary care services. Five of the Part C-funded sites are also the recipients of Part A funds and each is expected to allocate Part C and Part A resources individually for services supported by both funding streams.

There is no Part F dental program in the EMA; services are funded by Part A and DCH.

The VA hospital in Atlanta serves veterans from the region and Part A funds case managers at the VA to assist with access to other needed services.

Housing, and related supportive services are coordinated through the City of Atlanta's HOPWA Program which covers the entire EMA. Funds are used locally for housing placement, assistance, housing specialists, informational services and housing supportive services. The Planning Council's Housing Committee (chaired by one of the grants managers for the City's HOPWA program) and the Part A Office work with the City to ensure that services are not duplicated and to ensure that individuals enrolled in HOPWA services have access to care and treatment.

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

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

Patient Navigators assist clients with linkage to care and work closely with HIV testing teams to help connect newly diagnosed individuals to care. The EMA funds Patient Navigators at seven sites to facilitate seamless engagement into OAHs through collaboration with linkage coordinators and case managers. Patient Navigators also work with Linkage to Care Coordinators funded by CDC, Part B, and private entities.

Georgia's Prevention Program maximizes CDC funding by leveraging existing resources through Ryan White Part B and CAPUS programs. One significant CAPUS component available

to users across the State is the Resource Hub. The Resource Hub has four components: 1) an eligibility portal to help determine pre-eligibility for Ryan White services and facilitate more timely linkage to needed care; 2) mapping and testing to easily identify locations for HIV, STD, TB and Viral Hepatitis testing throughout Georgia; 3) an online resource directory to locate HIV medical services, housing assistance, mental health services and other support services in local communities for people living with HIV/AIDS; and 4) medical information for people living with HIV/AIDS, HIV service providers, and people wanting more information on HIV/AIDS. Development of the Resource Hub included collaborations with Ryan White Parts A and B, Metro and Rural area health department staff, academic partners, FQHCs, non-profit health providers and community members. Examples of this interaction include linkage services to Ryan White clinics provided to newly diagnosed individuals through the Prevention programs. The Ryan White Parts A and B programs incorporated language into the policies and procedures that emphasize that clinics do not need a confirmatory test in order to begin the linkage process with an aim at shortening any wait times for clients to begin receiving care. As eligibility documentation is often a major obstacle to enter care, an Eligibility Portal was built into the Resource Hub to facilitate entry into the Ryan White Program and pre-screen potential clients. If identified as pre-eligible for Ryan White services, users can provide their contact information and request to be contacted directly by a trained linkage staff member in their local area who will determine final eligibility. They are also provided with a checklist of key documents that will be needed to complete the eligibility verification process. This will help reduce barriers to program enrollment and expedite clinic admission for patients. The anticipation is that linkage to care will increase, and the time to linkage will decrease.

The Georgia Department of Corrections (DOC) provides HIV testing upon intake and release. HIV positive inmates are provided with HIV medications and treatment while incarcerated. The Ryan White Part B Program provides funding to DOC for pre-release and case management planning in order to link HIV positive inmates to services upon release. In local jails, HIV positive inmates are provided with HIV medications and treatment while incarcerated. The Ryan White Part A Program provides funding to Fulton County, DeKalb County, and City of Atlanta jails for pre-release and case management planning in order to link HIV positive inmates to services upon release. These programs work in conjunction with the CDC-funded jail program of Emory University.

HIV Prevention and Ryan White programs are working closely to implement data to care activities in collaboration with HIE and other similar efforts. As the HIV/AIDS Epidemiology Surveillance identifies clients out of HIV care, prevention linkage coordinators work with the Ryan White clinics to re-engage clients.

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

Part A funds support “stop gap” medications which provides clients an avenue to access ADAP formulary medications while waiting for final ADAP approval.

The core of substance abuse and mental health treatment services in Georgia is funded through the Georgia DBHDD. Georgia has a set-aside for services to PLWH in substance abuse treatment funding from SAMHSA for HIV/AIDS services through DBHDD. HIV/STD Programs are co-located in health departments in the EMA. Persons who test positive in the STD clinics are counseled and escorted to the Ryan White clinic so that they are not lost in the system. Part A and D providers use health department disease investigators for partner notification and assistance in directing clients to primary care sites.

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

(c) Resources and/or services needed which are not being provided and steps taken to secure them:

The EMA recognizes the need for resources to support the delivery and expansion of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) among persons at increased risk for HIV infection. Current CDC guidelines restrict the use of prevention funds for medication, including PrEP. PrEP and nPEP are widely promoted public health strategies that can nearly eliminate risk of infection. The availability of such resources would have a significant impact on HIV incidence in Georgia. Currently, the FCDHW is operating a PrEP clinic with existing resources augmented with volunteer clinician time. The prevention program provides staff support and HIV testing; STD clinic offers screening and labs; the state has supported the clinic with a nurse. Currently accepted clients to the program must be insured, have ability for self-pay, or qualify for the patient assistance program with Gilead. This model is not sustainable without additional resources to support the infrastructure and client assistance for medication. HRSA Ryan White funds may not be used for the purchase of PrEP medications either. Local providers have worked with insurance companies, when available, and patient assistance programs of pharmaceutical companies to obtain the medications. Ryan White Programs are reviewing HRSA's policy to determine feasibility of leveraging funds to support PrEP education.

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

WORK PLAN

A. Funding for Core and Support Services

1) FY17 Service Category Plan.

No core medical services waiver for FY17 has been submitted prior to submission of this application.

a) Service Category Plan Table (Attachment 8)

b) Service Category Plan Narrative

(1) Core Services Prioritized but not funded with Ryan White Program funds include:

AIDS Drug Assistance Program and HICP: Georgia DPH, which administers ADAP, has projected sufficient funds to cover EMA clients (\$54,023,517 which is a 48% increase from 2014 funding of \$34,468,630).

(2) The activities in the Plan promote parity of HIV Services throughout the EMA. The EMA has worked to achieve parity by establishing a comprehensive system of care and services with specific initiatives listed below:

Geographic location of services: With an EMA of 20 counties covering a land area of 6,208.7 square miles (larger than the State of Connecticut) and the level of funding it is challenging to ensure geographic parity so that services are accessible where clients reside or where special populations congregate. Limited resources must be carefully targeted for cost effective results. Services are dispersed through a number of ways.

In a paper published in the *Journal of Urban Health*⁶³, researchers with the Emory Center for AIDS Research (CFAR) determined that the HIV epidemic in metro Atlanta is concentrated primarily in one downtown section of Fulton and DeKalb Counties. This area, consisting of 157 census tracts, has 60% of the city's HIV cases. **The prevalence rate of HIV within the cluster is 1.34% and is compatible with what the World Health Organization would describe as a "generalized epidemic"**. (In comparison, outside the cluster the HIV prevalence is 0.32 %.) Clustered tracts were associated with higher levels of poverty, lower density of multi-racial residents, injection drug use, men having sex with men, and MSM/IDU. Researchers concluded that "efforts targeted to the population living in this area as well as efforts to address the specific needs of these populations may be most beneficial in curtailing the epidemic within the identified cluster." Of Atlanta ASOs identified, 42% were located in the cluster, and average travel time was 13 minutes by car. The Atlanta EMA funded 17 service providers in FY16. Given that the epidemic is largely within Fulton and DeKalb Counties, there is a concentration of providers within these counties. There are 11 primary care clinics that receive Ryan White Part A funds, eight of which are located in Fulton and DeKalb Counties.

The three remaining primary care facilities are located in the suburban and rural regions within the EMA. These facilities also operate satellite clinics to reach clients who do not reside within the urban core. Other core and support services are provided by subrecipients located throughout the entire EMA. Many subrecipients provide a comprehensive array of services, allowing clients convenient access to multiple services. The EMA takes special consideration to ensure that support services, including medical transportation, are available to facilitate access to and retention in OAHs, as well as client choice. With the implementation of the ACA, clients may have access to insurance plans that vary throughout the geographic area.

Part B funds support service provision in four additional health districts in the EMA. In exchange Part A does not request Part B funds for Fulton and DeKalb Counties. For FY17, the Planning Council approved that any increase in funding for OAHs in FY17 be allocated for use in these outlying health districts to allow for expanded services and faster linkage to care.

A new Rapid Entry Clinic located in an underserved areas with some of the highest comorbidities and poor social determinants of health will provide needed access in a community greatly impacted with HIV and will address the absence of an identified primary medical provider and medical home for individuals with newly diagnosed HIV, as well as those individuals who have been lost to care. A full continuum of services will be provided to facilitate, initiate and track individuals identified as HIV positive as they move through the care continuum from diagnosis, to linkage to care, to antiretroviral treatments and ultimately to viral suppression.

Quality: The EMA has adopted standards of care for MCM, Mental Health, Substance Abuse, Medical Nutrition Therapy, Oral Health, OAHs, Peer Counseling, and Legal Services along with EMA Universal and System Level Standards to improve quality of care and to reduce disparities. The QM Committee developed indicators, which were adopted by the Planning Council, to monitor compliance with the standards and the quality of services provided for OAHs and MCM. Contracts with each funded agency include language requiring compliance with standards and development of an agency QM plan which includes a set of key elements to be followed.

Number of available services: The EMA requires subrecipients to provide services within the full continuum of service providers. While subrecipients may not provide every service a client needs, the EMA requires subrecipients to have or to establish formal relationships with other service providers to ensure clients have access to comprehensive services. The Priorities Committee reviews the needs, resources, and gap analysis each year to further ensure that clients

⁶³ *Journal of Urban Health*, 02.2011; Vol. 88; No. 1: P. 129-141; Brooke A. Hixson; Saad B. Omer; Carlos del Rio; Paula M. Frew

have access to comprehensive services and prioritizes service categories accordingly. In, FY16 the Atlanta EMA funded 17 service providers to administer 6 core and 7 support services.

(3) Planned activities assure that services delivered by providers are culturally and linguistically appropriate to the populations served within the Atlanta EMA. The Recipient works closely with the Planning Council, which has adopted “Elements of Cultural Competence” to ensure subrecipients are providing services that are culturally and linguistically specific to the population being served. The EMA adopted a directive for the provision of culturally appropriate treatment and support service programs, which is in compliance with the US Office of Minority Health’s National CLAS Standards. These programs are provided in a language-appropriate manner (e.g. Spanish and Sign Language) and augment other language assistance programs at provider sites. Culturally appropriate services are available in all of the service categories the EMA has identified as priority areas of need. However, the EMA is aware that what may be appropriate in one county may not be appropriate in another and what may be appropriate for sites within a county may vary. Therefore, cultural competence and language appropriateness are determined based upon the demographics of the county or the specific service sites. The Recipient’s Request for Proposals (RFP) for Part A funding requires applicants to describe how current and proposed programs will provide services that are culturally and linguistically competent. The applicants must address “Elements of Cultural Competence” which include: Service/Project Description and Need Justification, Experience or Track Record of Involvement with the Target Population, Community Representation, Gender Identity, Language and Communication, and Staff Qualifications and Training.

In addition, subrecipients are required to comply with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the basis of race, color or national origin under any program or activity receiving Federal Financial Assistance (FFA). Title VI compliance requirements further apply to any Fulton County department or agency that receives FFA. Ryan White subrecipients are contractually required to: provide annual Title VI Certifications and Assurances; display Title VI complaint procedures; maintain Title VI and Limited English Populations (LEP) plan for providing access to LEP; and post copies of the Title VI program information and public notice statement in client service areas. Fulton County conducts annual compliance site reviews of Federal funded recipients and subrecipients to determine whether commitments are being honored, as represented by certification, to comply with the Title VI non-discrimination Civil Rights requirements.

(4) Factors that contributed to changes in funding within service categories include: Georgia has opted to not implement Medicaid expansion. An estimated 80% of the EMA’s Part A clients do not qualify for insurance coverage under the ACA. This led to an increased allocation for **OAHS**. In addition, allocations were increased for psychosocial support for insurance navigators to assist PLWH in accessing insurance coverage and for **HICP** to assist with copays and deductibles. Other core services were maintained to cover services not covered by insurance.

Increased need for linkage to care and access to ARVs led to allocation of funds for rapid entry clinics.

Increases in HOPWA funding in the EMA offset the need for allocations to the **Housing** category and to the **Emergency Financial Assistance** priority category for utility assistance.

(5) The EMA ensures resource allocations to provide services for women, infants, children, and youth (WICY) are in proportion to the percentage of the EMA’s AIDS Cases represented by each priority population.

Each subrecipient must indicate the proposed number of WICY to be served with Part A funds. The Recipient monitors the number of WICY served to ensure that funding is in line with the respective percentages as required by the Ryan White Program. In addition to the specific objectives, on a quarterly basis, the Part A Program Office will apply the following measures to ensure appropriate resource allocation:

- Review Ryan White Service Report (RSR) to monitor the number of WICY served to date.

- Review expenditures for activities funded for services to WICY.
- For FY15, data indicate that services were exceeded for all WICY categories: Women 20.40% of cases v 23.61% served; Infants 0.02% of population v 1.32% served; Children 0.25% of cases v 0.83% served; and, Youth 4.71% of cases v 6.11% served.

(6) Changes to service categories include:

Insurance Navigators: \$164,248. Ryan White is the payer of last resort; therefore, eligible individuals should purchase health insurance plans. To support this effort, funds have been allocated for Insurance Navigators who have knowledge of the special needs of persons living with HIV disease and the programs to best match client needs and close gaps in service. One agency previously funded under ACA to provide navigation had a caseload that was 40% persons living with HIV.

OAHS: \$1,504,568 to include support for rapid entry to care. Due to the high demand for outpatient ambulatory medical care there are periods in which the wait time for a client’s first medical appointment may be 6-8 weeks. In an effort to link clients to care as soon as possible, part of the allocation will be used to support one or more clinics focused on rapid entry. The goal is for the first medical appointment to occur within 72 business hours. Clients will be scheduled for OAHS services at other sites as openings occur and will continue to receive the full complement of care and treatment services at the rapid entry clinic until successfully triaged to their long-term provider. Treatment services will include the provision of medications on the ADAP formulary until such time that the client is covered by ADAP or a patient assistance program. Wait time for appointment was identified as the barrier for 30% of clients in the needs assessment who were not accessing care.

N-MCM: \$135,302 has been allocated to support clients of the Rapid Entry Clinics to assist with enrollment and access to benefits.

Medical Transportation: \$117,377 has been allocated to support transportation services for clients of the Rapid Entry Clinics. Services include: transit passes, cab fare, Uber/Lyft, and gas cards.

MCM: While additional funds were not allocated for FY17 a significant change to the way in which MCM is provided in the EMA is being implemented in FY16. MCM services have been centralized with one agency providing case managers to other subrecipients in the Part A service system. Some providers have indicated that case managers would be even more effective if they were employees of the individual clinics with all of the rights and privileges of other clinic employees (e.g., access to electronic medical records and the ability to include notes). By embedding case managers more fully into the care team is anticipated to increase use of the service and further serve clients as they seek to move along the continuum of care.

c) **Core Medical Services Waiver:** Not Applicable.

B. HIV Care Continuum Work Plan (Attachment 10)

Table 10: Resolution of Challenges

Challenge	Resolution	Outcome	Status
Part A Program			
Lack of surveillance data on transgender persons living with HIV.	Work with DPH’s HIV/AIDS Epidemiology Surveillance Section and DPH and local prevention.	Modified forms to capture gender at birth and current gender. Working with subrecipients on completeness of CAREWare elements prior to data match.	In Process
Clients having to present eligibility documentation	Modify CAREWare to allow subrecipients to	CAREWare modified. Computers and scanners	Deployment of equipment and

at numerous providers create a barrier to care.	upload and share client eligibility documents.	purchased for subrecipients.	training of staff has begun. Will be completed in Q3 of FY16.
Implementation of ACA has been less robust due to a lack of navigators who understand the HIV care system.	Fund insurance navigators experienced in working with PLWH.	Anticipated increase in clients accessing ACA, but too soon to evaluate impact.	Subrecipient selected. Began services in Q2.
Lack of in-house surveillance capacity.	Hire epidemiologist. Embed within Georgia DPH HIV/AIDS Epidemiology Surveillance Section	Position is in process of being established. In discussions with DPH on logistics.	In Process
HIV Care Continuum			
Increase linkage to care in health districts outside of the urban core.	Increase funding for OAHs to allow for additional medical appointments.	Part B has provided allocation formula used to award health districts.	Future
Improve retention rates.	Clients have complained of long wait times at clinics which have resulted in patients leaving without being seen.	Improvements in clinic flow and protocols will lead to reduced wait times resulting in fewer clients lost to care.	The QM Team work with OAHs providers to evaluate current situation and develop best practices.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

A. Clinical Quality Management (CQM)

1) Description of CQM Program Infrastructure:

a) There is a total staff of 1.70 FTE assigned to CQM. The Quality Management Specialist 1.0 FTE, Database Specialist .20 FTE, Senior Health Researcher .20 FTE, Epidemiologic Surveillance Specialist .10 FTE, Assistant Director .10 FTE, Fiscal Manager .05 FTE, and Administrative Coordinator .05 FTE.

b) CQM program staff roles and responsibilities:

Quality Management Specialist: ensures the work of the CQM Committee is in alignment with the HRSA’s requirements, monitors the quality of care are delivered in the Atlanta EMA, and provides technical assistance to RW Program Part A funded agencies related to quality management. The QM Specialist collaborates with Part B QM Core Team and participates in statewide Continuous Quality Improvement (CQI) efforts to improve the quality of care across the 20-county EMA. The QM Specialist will perform tasks including:

- Developing and monitoring contractual requirements such as data collection and presentation of data results to Planning Council Committees (QM, Assessment and Comprehensive Plan).
- Coordinating systems-level CQI projects in collaboration with the Planning Council QM Committee.
- Developing, implementing, and evaluating the QM plan annually and Work Plan quarterly.
- Ensuring QM/QI and other HIV-related training is available to subrecipients and staff.
- Attending educational conferences to maintain current knowledge of Quality Management.

Database Specialist: responsible for managing, maintaining, and enhancing the CAREWare database, Fulton County’s VPN and Server network. The Database Specialist

collaborates with the DPH HIV Epidemiology Section, Part B Data Manager, and Prevention Programs to exchange and utilize available data for QM activities. The Database Specialist acts as a data manager by generating reports from CAREWare to analyze performance measure data; RW Data Reports (RDR); managing Provider Data Imports (PDIs); and reviewing subrecipients' RW Services Reports (RSR) to ensure data completeness. The Database Specialist also performs tasks including: creating graphs, charts, and spreadsheets for data analysis, developing procedures for data collection and evaluation, and providing data-related technical assistance and training to agency data designees and data entry staff.

Senior Health Researcher: responsible for researching and providing quarterly performance measures data analysis of the Ryan White Part A program. The Senior Health Researcher supports consultants with the coordination of systems-level CQI projects in collaboration with the Planning Council Assessment Committee and provides the analysis of Ryan White utilization and cost data, Clinical Chart Review analysis, and Consumer survey reports. The Senior Health Researcher provides technical assistance to subrecipients and Planning Council Committees and prepares and distributes the quarterly QM newsletter.

Epidemiologic Surveillance Specialist: responsible for the monitoring and evaluating current and past trends in HIV data related to the needs of consumers in the Atlanta EMA. Epidemiologic Surveillance Specialist collaborates with Planning Council Committees (Assessment, QM, and Comprehensive Plan) to identify rates of prevalence and incidences of morbidity and mortality, and reporting on the annual Unmet Need and other assessment studies.

Assistant Director: responsible for providing leadership and guidance to the CQM program by enforcing the directives from the Part A Program Office, reviewing agency QM plans, assessing results of EMA-wide chart reviews, working with subrecipients on corrective action plans, and participating in Part A quality-related committees and activities. The Assistant Director identifies consultant(s); manages contract(s) for EMA-wide quality improvement project(s), such as clinical chart reviews; and, attends QM Committee meetings.

Fiscal Manager: responsible for ensuring proper expenditures of funds and allocation to the appropriate fund source.

Administrative Coordinator: responsible for logistics, processing of payments, establishment of vendor codes and staff support.

c) CQM contractors:

A contractor(s) will be identified in FY17 to provide technical assistance on activities that focus on enhancing the quality of HIV/AIDS care provided. Methodologies to establish CQI initiatives, while incorporating data analysis and reporting, will be explored. An additional contractor will be utilized to conduct a clinical chart review at 11 primary care sites. The purpose of the chart review is to examine the extent to which Ryan White Part A funded primary care sites are providing care that meets quality of care indicators adopted by Part A and approved by the Planning Council, as well as HRSA/HAB Performance Measures.

d) Efforts to coordinate CQM activities with other RWHAP recipients in the jurisdiction:

- EMA CAREWare user manual and codebook to assure consistency of service data entry for Parts A, C and D and statewide with Part B
- Participation of EMA QM Committee members and agency representatives in National Quality Center (NQC) webcasts
- Enrollment of all primary care sites in the NQC's in+care campaign to bring patients back into care and keep others from falling out of care
- Attendance by all Parts at EMA QM meetings and Part B QM meetings
- NQC and local QM trainings are jointly attended

2) Description of CQM Program Performance Measures:

a) The funded services categories for FY17 include 6 core services and 7 support services. The performance measures, which are based on the HAB Archived Measure: Medical Visits, are listed in the following table.

TABLE 11. PERFORMANCE MESASURES FOR FUNDED SERVICE CATEGORIES			
#	Category		Performance Measure
1	Outpatient Ambulatory Health Services (OAHS)	N ⁶⁴	# of OAHS clients who had 2 or more documented medical visits, viral load or CD4 tests performed at least 3 months apart during the 12-month measurement period
		D	Clients with at least 1 OAHS visit during the 12-month measurement period
2		N	# of OAHS clients with a viral load of <200 copies/mL at last test during the 12-month measurement period
		D	Clients with at least 1 OAHS visit during the 12-month measurement period
3	Oral Health Services	N	# of oral health clients who had 2 or more documented medical visits, viral load, or CD4 tests performed at least 3 months apart during the 12-month measurement period.
		D	Clients with at least 1 oral health visit during the 12-month measurement period.
4	Medical Nutrition Therapy	N	# of medical nutrition therapy clients who had 2 or more documented medical visits, viral load, or CD4 test performed at least 3 months apart during the 12-month measurement period.
		D	Clients with at least 1 medical nutrition therapy visit during the 12-month measurement period.
5	Medical Case Management (MCM)	N	# of medical case management clients who had 2 or more documented medical visits, viral load or CD4 tests performed at least 3 months apart during the 12-month measurement period.
		D	Clients with at least 1 medical case management visit during the 12-month measurement period.
6		N	# of medical case management clients with a viral load <200 copies /mL at last test during the 12-month measurement period.
		D	All clients with at least 1 medical case management visit during the 12-month measurement period.
7	Mental Health Services	N	# of mental health clients who had 2 or more documented medical visits, viral load or CD4 test performed at least 3 months apart during the 12-month measurement period.
		D	Clients with at least 1 mental health visit during the 12-month measurement period.
8	Substance Abuse Services	N	# of substance abuse clients who had 2 or more documented medical visits, viral load or CD4 tests performed at least three months apart during the 12-month measurement period.
		D	Clients with at least 1 substance abuse visit during the 12-month measurement period.
9	Non-Medical Case Management	N	# of non-medical case management clients who had at least 2 or more documented medical visits, viral load or CD4 tests performed at least 3 months apart during the 12-month measurement period.
		D	Clients with at least 1 non-medical case management encounter during the 12-month measurement period.
10		N	# of non-medical case management clients with a viral load <200 copies /mL at last test during the measurement period
		D	Clients with at least 1 non-medical case management encounter during the 12-month measurement period.
11	Food Bank/Home Delivered	N	# of clients that received food bank/home delivered meal service who had 2 or more documented medical visits, viral load or CD4 tests performed at least 3 months apart during the 12-month measurement period.

⁶⁴ N= Numerator D= Denominator. N÷D=%

	Meals	D	Clients that received at least 1 food bank/home delivered meal service during the 12- month measurement period.
12	Psychosocial Support Services	N	# of psychosocial support clients who had 2 or more documented medical visits, viral load or CD4 tests performed at least 3 months apart during the 12-month measurement period.
		D	Clients with at least 1 psychosocial support visit during the 12-month measurement period.
13	Medical Transportation Services	N	# of clients with medical transportation services who had 2 or more documented medical visits, viral load or CD4 test performed at least 3 months apart during the measurement period
		D	Clients that received at least 1 medical transportation service during the 12-month measurement period.
14	Legal Assistance	N	# of clients with legal services who had 2 or more documented medical visits, viral load or CD4 tests performed at least 3 months apart during the 12-month measurement period.
		D	Clients with at least 1 legal service during the 12-month measurement period.
15	Linguistic Services	N	# of clients with linguistics services who had 2 or more documented medical visits, viral load or CD4 test performed at least 3 months apart during the 12-month measurement period.
		D	Clients that received at least 1 linguistic service during the 12-month measurement period.
16	Child Care Services	N	# of clients with child care services who had two or more documented medical visits, viral load or CD4 test performed at least 3 months apart during the 12-month measurement period.
		D	Clients that received at least 1 child care service during the 12-month measurement period.

b) Performance measure data are collected often for each funded service category.

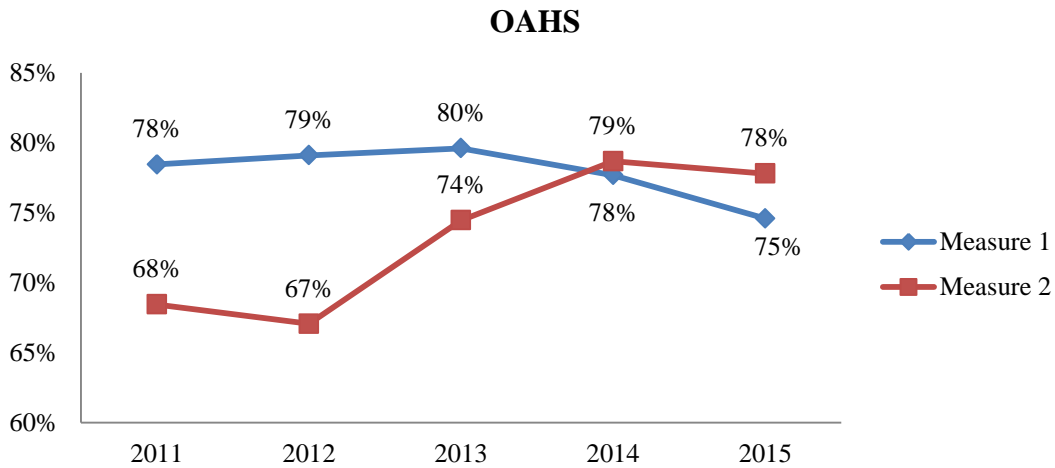
Subrecipients are contractually required to enter data into CAREWare’s centralized server within 14 days of a service encounter. Each quarter, subrecipients submit Progress Reports indicating the total of unduplicated clients and service delivery units for each funded service category. Quarterly submission of the RDR and RSR are also required by subrecipients. The Ryan White Part A office reviews performance measures data for funded service categories and evaluates the performance from the Clinical Chart Review Study from CAREWare each quarter.

c) **In the tables 12 and 13, a summary of performance measure data collected for outpatient ambulatory health services and medical case management** is presented. Trending data analysis includes unduplicated calendar years 2011-2015 CAREWare data.

Table 12. OAHS Performance Measurement Data CY11-CY15

OAHS	2011			2012			2013			2014			2015		
	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
Measure 1	8,116	10,344	78%	8,558	10,819	79%	9,138	11,480	80%	9,801	12,618	78%	9,485	12,718	75%
Measure 2	7,080	10,344	68%	7,255	10,819	67%	8,548	11,480	74%	9,927	12,618	79%	9,894	12,718	78%

Figure 13. OAHS Performance Measurement Data CY11-CY15

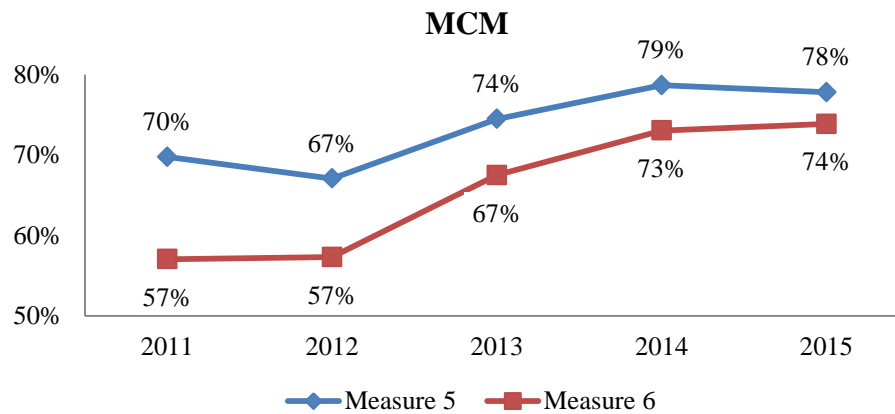


Data show an overall increase of clients satisfying measures for OAHS and MCM. Although the percent change of medical visits (measure 1) for OAHS clients has decreased by 4.9% since CY11, there were a 16.9% percent increase – 8,116 clients in CY11, and 9,485 clients in CY15– in the number of OAHS clients satisfying the numerator metric suggesting more PLWH are receiving OAHS. The percentage for virally suppressed of OAHS clients (measure 2) has increased by 14.4% since CY11 with the largest improvement being from CY12 to CY13 with an increase by 7% that year.

Table 13. MCM Performance Measurement Data CY11-CY15

MCM	2011			2012			2013			2014			2015		
	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
Measure 5	4,945	7,090	70%	4,992	6,979	67%	5,670	7,705	74%	5,558	7,560	79%	5,788	8,131	78%
Measure 6	4,044	7,090	57%	3,998	6,979	57%	5,200	7,705	67%	5,521	7,560	73%	6,005	8,131	74%

Figure 14. MCM Performance Measurement Data CY11-CY15



Overall, the MCM client population size has remained stable as the proportion of clients retained in care and virally suppressed has increased. Medical visits among MCM clients (measure 5) have increased by 11.5% since CY11 with the largest improvement being from CY12 to CY13 with an increase by 11% that year. The percentage for virally suppressed of MCM clients (measure 6) also had the largest percent change from CY12 to CY13 with an increase by 18% that year. The percentage for viral suppressed of MCM clients (measure 2) has increased by 29% since 2011–57% in CY11 and 78% in CY15.

Improvements can be attributed to the past efforts of the Part A staff participating in monitoring campaigns such as in+care, implementing quality improvement projects, streamlining administrative processes such as revising Atlanta EMA screening tool, providing case management trainings, and encouraging the subrecipients to improve performance.

d) Performance measure data are analyzed to evaluate disparities in care through the work of several Planning Council Committees (Assessment, QM, Priorities, and Comprehensive Plan). Data review and analysis of performance measures and CQI projects occur quarterly.

The Planning Council's Assessment Committee recently completed a comprehensive assessment of health disparities. The assessment concluded that Black/AA males are the most significantly impacted by HIV. Assessment findings indicated that zip codes with the highest concentration of PLWHA with unmet need geographically correspond with areas containing the highest concentration of poor health outcomes. A review of service provider locations and times needed to travel to and from medical appointments utilizing the public transportation system ranged from 30 to 125 minutes. In response to these findings and to provide greater access to care for underserved communities, co-location of agencies and non-traditional transportation methods such as gas cards in remote areas and Uber (to reduce travel times) were made available to clients.

Actions taken to eliminate disparities in FY16 included the establishment of three rapid entry clinics to link newly diagnosed persons to care and to ensure that all persons have access to antiretroviral therapy; utilization of two mobile clinics, in partnership with prevention programs, to serve identified zip codes and to improve linkage and access to care; and by providing additional core medical and support services including oral health, mental health, substance abuse, medical transportation and childcare services. Moreover, MAI-supported programming and service delivery further yields increased viral suppression rates and other improved health outcomes, contributing towards decreased health disparities among PLWH in the Atlanta EMA.

e) Stakeholders contribute to the selection of performance measures and receive information about performance measure data.

The Quality Management Committee of the Planning Council is comprised of stakeholders, subrecipients, consumers, and representatives from Ryan White Parts B, C, and D. The QM Committee has a vital role in the selection of performance measures by developing quality management standards, facilitating the development of quality processes, monitoring system-wide measures, and providing oversight for CQM activities. During QM Committee Meetings, members discuss and determine performance measures based on data presented from the clinical chart reviews, HAB performance measures, CAREWare data, and client satisfaction survey results. Performance measure data are presented quarterly during QM Committee Meetings. All quality reports are also presented to the Assessment Committee and Comprehensive Plan Committees of the Planning Council for update and discussion. These reports are shared on the Ryan White website and in the Quarterly QM Newsletter.

3) Description of CQM Program Quality Improvement

a) Quality Improvement Methodology: Atlanta EMA Ryan White Part A utilized the Model for Improvement methodology to guide quality improvement efforts. Quality Management Specialist documents the progression of quality improvement projects using a Model for Improvement worksheet to chronicle all rotations of the Plan-Do-Study-Act cycle. Other

methodologies such as Lean Six Sigma will be explored in the upcoming grant year as a training opportunity for subrecipients.

Prioritization Process: The process to identify priorities for quality improvement occurs at the subrecipient and EMA level. Each subrecipient is contractually required to form an agency QM Committee and to submit an annual QM Plan. Through each agency's internal quality management processes, subrecipients identify opportunities for improvement and set priorities for quality improvement projects to yield improved health outcomes, access to care, and/or more accurate data reporting. Monitoring of the improvement projects is done at the agency level, by the recipient and the QM Committee through review of annual QM plans, agency quarterly progress reports, program monitoring, and through sharing at the QM Committee meetings.

Quality Improvement Projects: The Atlanta EMA engaged in two Quality Improvement (QI) projects in the last grant related to CAREWare utilization and Clinical Performance Measures. The purpose of these projects was to: (1) examine how subrecipients are using CAREWare; (2) standardize CAREWare set-up and use across subrecipients; and, (3) monitor clinical performance measures efficiently. Our quality improvement projects are ongoing and encompass participation from Ryan White Part A QM Team, QM Committee, and subrecipients. In order to ensure the level of care delivered meets the quality measures adopted by the Part A Recipient and approved by the Planning Council, as well as the HAB Performance Measures, subrecipients' data entry and reporting, computer system and CAREWare configuration should be standardized.

Ryan White Part A QM team provided training and technical assistance for subrecipients for CAREWare, which improved accuracy in data reporting. Ryan White Part A QM team monitored performance data and compare against EMA goals. Service providers that underperformed the EMA goals are required to meet and review with their agency Quality Management Committee to study performance data and formulate a Corrective Action Plan. The Corrective Action Plan, a written plan for improvement that includes measures and timeframes, is submitted by sites for additional monitoring by the Recipient.

Monitoring and Supporting Subrecipient Engagement: The processes to monitor and support subrecipient engagement in quality improvement projects are enhancing. With the addition of Quality Management Specialist to the Ryan White Part A Recipient team in June 2016, additional program monitoring tools have been established and continue to expand. The Quality Management Specialist is involved in the program monitoring and support for subrecipients' and is included on all annual site visits and participates in client chart reviews. Site visit protocol extended quality management monitoring segment by incorporating more in-depth review of infrastructure, workforce engagement, technical assistance, QM Plan development and quality improvement activities at the subrecipient sites.

Client chart review tools were revised to align with the HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards. The updated client chart review process includes calculation of chart sample size in proportion to services funded and clients served and a rating scale to highlight agency's compliance to National Monitoring Standards. The Quality Management Specialist also uses QM Committee meetings as a forum to monitor and support subrecipient engagement in quality projects through discussions, assessments, and/or presentations.

In July 2016, Quality Management Specialist presented results of Part A Organizational Assessment, tool developed by NQC, and received feedback about the needs of the QM Committee and subrecipients. In September 2016, QM Committee received training and examples of using the PDSA model for improvement methodology for quality improvement projects system-wide and at the agency level. The Quality Management Specialist will continue to provide opportunities for engagement and deliver materials and training to subrecipients as they conduct their quality improvement projects.

b) Quality Improvement Activities by Recipient: Recipient implemented quality improvement activities in the last grant year that were related to CAREWare to improve the

accuracy of performance data such as HIV viral suppression and prescribed antiretrovirals (ART). In April 2016, Database Specialist updated CAREWare software agency wide from version 4.1 to version 5.0 and trained subrecipients on data entry. May 2016, Recipient examined data entry of subrecipients by reviewing prescribed ART indicator. Six subrecipients were asked to collectively review 2,435 clients whom were missing information in the prescribed ART data field for CY15. Agencies re-entered the information in CAREWare and informed the RW Part Office if the client was a non- active patient, was offered ART but declined, or if the client was prescribed ART. In July 2016, the Database Specialist reviewed prescribed ART for CY15 and yielded improved results. In FY16, the Database Specialist offered two CAREWare training to subrecipients on basic data entry and custom reporting to allow agency's to identify performance issues. ACE TA Center also provided specified trainings geared towards Enrollment Assistants/Navigators, Peer Leaders and Case Managers.

Quality Improvement Activities by Subrecipients: Subrecipients aim to improve HIV viral suppression through agency protocol and care coordination practices. Agency's QM committee develops, implements, and evaluates quality improvement projects to improve HIV viral suppression of clients. Care coordination practices aimed to improve HIV viral suppression by increasing the likelihood clients are retained in care. Common care coordination practices subrecipients utilized are:

- the use of reminder calls to patients the day before all core service appointments resulting in reduced broken appointments throughout the clinic
- reminder calls for non-adherent clients;
- elimination of paperwork resulting in increased efficiency of registration clerks

c) **CQM data were used to improve service delivery** in the EMA, including long-range service delivery planning employing the following methodologies.

- Utilizing chart review monitoring tools for each service category, based on the National Monitoring Standards, resulted in improved compliance with HHS guidelines and assures quality patient care.
- The Atlanta EMA used a case management model that did not meet HRSA's service definition criteria. While all data requirements were being met, the practice of having one service standard for both MCM and N-MCM required segregating and updating to align with HRSA's PCN 16-02, which goes into effect in FY17.
- Historically, Part A medical case managers were recruited, hired, trained and supervised by one subrecipient and was out-stationed at other subrecipient organizations. Over time this model did not afford full service provisions at some sites because MCM's were often not allowed access to client medical records, and were not part of inter-disciplinary medical teams. In FY16, MCM was decentralized and the new data driven MCM model was piloted to better serve PLWH as they seek to move along the continuum of care.
- Data sets and resource documents including unmet need data by zip code, utilization data, and the NHAS were utilized in the development of the Georgia Integrated HIV Prevention and Care Plan, submitted in FY16.

d) **Stakeholders contribute to the improvement activities undertaken by the EMA.**

The QM Committee reviews performance measurement data, and plays a key role in selecting performance measures, developing quality priorities, and implementing quality improvement activities. This diverse work group, organized by the Planning Council, is comprised of consumers, Part A-funded agencies, and representatives from Parts B, C, D, and HOPWA. Stakeholders have the responsibility of selecting and prioritizing system-wide QI projects and Part A staff is responsible for monitoring, analyzing and reporting performance measures and program outcomes. Subrecipients, through its agency level quality management efforts, are contractually required to identify problems in service delivery that impact health-status outcomes at the client and systems level for improvement.

4. Data for Program Reporting.

(a) The information data system used for data collection and reporting operations is as follows:

- The EMA utilizes CAREWare for data reporting for all Part A-funded agencies. All connections use a Cisco AnyConnect VPN client. CAREWare is free, scalable software for managing and monitoring HIV clinical and supportive services and produces a completed Ryan White HIV/AIDS Services Report (RSR) as required by HRSA.
- A centralized data collection system is located at Fulton County Government.
- Fulton County Government Department of Information Technology is responsible for maintaining the security of the database is ensured.
- The Ryan White Database Specialist is responsible for backup, recovery and system availability, and monitoring of data to ensure completeness and accuracy of reporting.
- Backups are completed nightly and sent to a disaster recovery site weekly.
- The Database Specialist utilizes a test server to verify compatibility of CAREWare upgrades and imported data prior to installation on the production server.

(b) The recipient's current client level data capabilities for the completion and submission of the RSR include:

- All (100%) providers are able to report client level data. The recipient's data management and monitoring plan is in place to ensure that all elements are completed within established deadlines for RSR submission at the end of the calendar year.
- Requirements for reporting client level data are included in agency contracts.
- The EMA utilizes a centralized server for data entry of all required variables.
- The recipient monitors data to ensure compliance with requirements for both real time data entry and client level data requirements.
- The recipient's Database Specialist provides oversight for the process to ensure compliance with HRSA's reporting requirements.
- Contracts are updated in CAREWare to assure accuracy for reporting.
- Training needs are assessed to provide relevant technical assistance.
- Technical training is provided to agency staff to ensure data capture and quality.
- Data are imported from other databases utilized by agencies in data collection to reduce staff time required for data entry into CAREWare and improve data accuracy through the Provider Data Import function in CAREWare.
- Client-level data are monitored to ensure completeness and quality.
- Reports are sent to agencies noting discrepancies and include a timeline for correction.
- Client-level data are submitted to meet HRSA's required deadlines using the following process:
 - Updating the CAREWare user manual to align with any changes in the RSR
 - Conducting one-on-one and group training as needed
 - Providing additional technical assistance when discrepancies are detected in the data
 - Ensuring that data entry specialists record data elements uniformly throughout the EMA
 - Performing quality checks periodically to identify missing and/or unknown data elements

ORGANIZATIONAL INFORMATION

A. Grant Administration

1) Program Organization

a) The Board of Commissioners (BOC) is the policy setting body of Fulton County Government responsible for administering RWHAP Part A funds. The Chairman of the Board (Chairman) serves as Chief Elected Official for purposes of Part A and is ultimately responsible for the Part A program. The County Manager, who is responsible for the operations of the government and implementation of BOC policies, reports directly to the BOC; the Ryan White Program is organizationally located in the Office of the County Manager. The Chairman has delegated authority for day-to-day operations of the Program to the Director, Ryan White Program who

serves as the Recipient. The fiscal agent is the Director of the Fulton County Finance Department.

All staff of the Ryan White Program are involved in the planning functions of the program. The program is staffed by 13 FTEs which includes three Planning Council support staff: Planning Council Project Officer, Administrative Coordinator and a Health Coordinator. As of submission of this application, there are four staff vacancies: Senior Health Researcher, Epidemiologic Surveillance Specialist, Planning Council's Administrative Coordinator and Health Coordinator. Two of these vacant positions are being created to accommodate the changing needs of the Ryan White Program. The Epidemiologic Surveillance Specialist duties have been performed utilizing an outside contractor while the duties of the Health Coordinator are being performed by the Planning Council Project Officer until the vacancy is filled. The Senior Health Researcher and the Planning Council Administrative Coordinator's positions have been established in the County's Personnel System and will be advertised in October 2016 with targeted start dates in December 2016 while the vacant Epidemiologic Surveillance Specialist and the Planning Council Health Coordinator's positions are anticipated to be filled at the beginning of December 2016.

b) Providers funded through multiple RWHAP Parts are able to distinguish which clients are served by each individual funding stream to avoid duplication of services. Part A contractually requires that all client-level data be entered into the centralized server assuring uniform reporting. The EMA has a standardized codebook that supports consistency in data collection and entry. Each provider completes a funding source document at the beginning of the contract year indicating the fund source(s) for each of the services under the priority category. Possible funding sources are indicated including Parts A, B, C, D, F or HOPWA. After review of the fund source document with the approved agency budget, the Data Manager sets up 'contracts' in CAREWare on the centralized server to allow data entry for tracking and reporting of services. The EMA reports client-level information in the annual consolidated RSR for all clients receiving Ryan White services.

2) Grant Recipient Accountability

a) Program Oversight

(1) In FY16 the master contract utilized with all funded subrecipients was modified to delineate the National Monitoring Standards (NMS) – including universal standards and standards for each priority category area. In addition, there was a comprehensive review and comparison of the NMS with the Ryan White Part A Manual and site visit tools. Documents were modified as needed to ensure the EMA's ability to monitor the required standards and to ensure compliance with the NMS. During each subrecipient site visit, Project Officers provided technical assistance regarding NMS and what is expected of the agency to meet the standards. Project Officers review subrecipient files to ensure, processes and procedures to ascertain compliance.

Subrecipients were notified of any short-comings and offered technical assistance in how to correct any deficiencies. Client chart reviews are conducted of the core and support services to ensure subrecipients are maintaining client files based on HRSA NMS. The number of charts reviewed (sample size) is based on the number of proposed clients served under each priority category. Chart reviews will be conducted through-out the year until completion. Corrective action plans are implemented as appropriate.

(2) **The process used to conduct subrecipient monitoring** begins during the contract negotiation process when each agency is provided a copy of the *Fulton County Government Ryan White Program Part A Manual*, which delineates reporting requirements, and an electronic spreadsheet of the agency's approved budget by priority categories and line items. Part A contracts were modified to include information about HRSA monitoring standards to improve program efficiency and responsiveness. Initiation of the contract requires: identification of programmatic, fiscal, data, and Title VI designees responsible for compliance with reporting requirements; goals and objectives linked to approved budget; and, copies of subcontractual

agreements. All subrecipients are fiscally monitored on a monthly basis. Subrecipients are required to submit monthly expenditure reports (with appropriate supporting documentation) certified by the programmatic and fiscal designees along with an electronic spreadsheet documenting expenditures by line item and priority category. MAI expenditures are tracked separately through the County's financial system. Any errors, including the over- or under-expenditure of funds within individual line items are corrected prior to reimbursement. By working with subrecipients on a monthly basis, the Part A Program is able to identify potential areas for which the redirection of funds is appropriate. Subrecipients are required to submit quarterly programmatic reports, using a format established by the Recipient. Quarterly reports are used by subrecipients to document progress towards agency goals and objectives, as well as identify challenges, accomplishments, technical assistance needs, complaints/grievances filed by clients, and the results of ongoing client satisfaction surveys. Service utilization data (e.g. number of clients served and units of service provided) receive particular attention during the review of subrecipient programmatic reports. These numbers are compared against the monthly data report submitted by each subrecipient to verify accuracy. The Recipient provides technical assistance to subrecipients that report they are either over-achieving (i.e. served more clients than projected) or under-achieving (i.e. served fewer clients) stated goals and objectives.

(3) Seventeen subrecipients are currently funded in FY16 100% of which have received fiscal and programmatic monitoring site visits. During site visit, Project Officers review subrecipients' compliance with fiscal reporting requirements, progress with audit requirements, and strategies for improving performance, as applicable; goals/objectives, budgets, data issues, and a comprehensive QM site visit is completed where the quality management program is reviewed including their QM plans and QI projects are reviewed. The Fulton County Office of Internal Audits also conducts a Title VI Compliance site review of funded subrecipients. The Programmatic, Fiscal and Data Designees are required to be present during these site visits. Part A Project Officers audit a random sample of client files to verify compliance with eligibility requirements, third party payment sources, medical charts to ensure compliance with NMS. Programmatic and fiscal monitoring site visits will be performed in late October and November for all seventeen recipients. Chart reviews will be conducted throughout the year until completion.

(4) The process and timeline for corrective actions when a fiscal or programmatic related concern is identified begins with a discussion of issues of concern, determination of cause(s) of problem, identification of technical assistance needs, development of a resolution plan which includes clear goals and objectives with concrete timeframes, and, consequences of not correcting the deficiency as agreed. The subrecipients have 30 days to respond to the corrective action. If it is determined that, after the provision of technical assistance, justifiable extensions, or corrective action plans, a subrecipient cannot meet its contractual requirements, some or all of the subrecipients funding may be reallocated to other priority categories and/or subrecipients where additional funds may be needed for direct client services. The Recipient has final determination in suspending and/or terminating subrecipients. Any improper charges by funded subrecipients identified by the Project Officers during reconciliation of invoices and supporting documentation would be denied and the invoice adjusted accordingly (e.g., charges for line items not currently funded). Subrecipients would receive technical assistance to prevent future occurrences.

(5) All subrecipients received technical assistance (TA) for FY16 on data collection and entry and use of CAREWare. The 17 FY16 Part A subrecipients received various types of technical assistance throughout the grant year on such items as programmatic policies, spreadsheet entry, and budget revisions. Each subrecipient was provided a copy of the *Ryan White Part A Program Manual*, which includes detailed information on the Program's policies and procedures (which are being updated in 2016). Subrecipients may request technical assistance from their Project Officer in their quarterly reports or at any time such assistance may be needed. The Project

Officers also provide technical assistance at regular site visits and during regular telephone conferences or webinars.

b) Fiscal Oversight:

(1) The process used by the program and fiscal staff to coordinate activities, ensuring adequate reporting, reconciliation, and tracking of program expenditures requires Project Officers to complete desk audits of expenditures on monthly invoices. At the beginning of the contract year, an electronic version of the required “Contract Budget and Expenditures” Excel Workbook is provided to each funded agency by the Fulton County Ryan White Part A Program. This spreadsheet is comprised of three separate yet interrelated parts:

- the approved contract budget for the relevant fiscal year;
- the expenditure sheet which tracks line-item expenditures by month; and,
- a series of monthly Ryan White Part A “Cumulative Contract Expenditure Report” sheets.

Subrecipients are required to complete the line-item expenditure section each month. The information entered in the expenditures sheet will then populate the appropriate fields of the monthly Cumulative Contract Expenditure Reports. The Cumulative Contract Expenditure Report is printed, signed by the appropriate Programmatic Designee and Fiscal Designee and submitted with the required supporting documentation. The completed spreadsheet is forwarded to the Project Officer who then review and reconcile monthly invoices to ensure that expenses equate to approximately one-twelfth of budgeted funds are accurately reported. The Fiscal Manager processes invoices through the County’s accounting system, applying expenditures to the appropriate fund sources to track expenditures. Quarterly meetings are conducted between the Project Officers and the Fiscal Manager to discuss/review subrecipients budgets along with reviewing formula, supplemental, MAI, Carryover expenditures and balances. Project Officers review invoices for accuracy in comparison to the approved budgets and assign the fund source to be charged for payment. The Fiscal Manager provides Project Officers with monthly reports, generated from the County’s accounting system, showing payments processed and the fund source charged. The Fiscal Manager reviews all reports along with invoices and electronic spreadsheets to ensure accuracy. The Fiscal Manager provides monthly reports to the Director (Recipient) and Assistant Director of unobligated balances.

(2) The process used to separately track formula, supplemental, MAI, and carry over funds, including information on the data systems utilized.

The Recipient separately tracks formula, supplemental, MAI, and carryover funds in the County’s accounting management system (AMS) using individual account codes. The Fiscal Manager monitors and tracks funds in the financial system and provides staff with bi-monthly reports which track all expenditures by fund source. In addition, the Fiscal Manager maintains a detailed spreadsheet of the accounts by line item to track funds by funding source. The Fiscal Manager also audits the budget on a monthly basis to ensure that the County’s Finance Department has accurately applied all charges to the proper fund source. As needed, the Fiscal Manager processes journal vouchers to correct any discrepancies found. Subrecipients are provided electronic spreadsheets of approved budgets based on priority categories and approved line items within their contracts. Subrecipients are required to update and submit spreadsheets monthly along with their monthly invoices. Project Officers audit invoices and distribute reimbursement requests among the appropriate fund source and provide subrecipients with an updated copy of spreadsheets with the approved reimbursement request. In addition, the Fiscal Manager audits the approved invoices before processing for payment to ensure that charges are applied to the appropriate funding source.

(3) The process used to ensure timely monitoring and redistribution of unexpended funds:

To ensure timely monitoring and redistribution of unexpended funds, Project Officers monitor subrecipients’ budgets monthly to determine if expenditures are in line with approved budgets and are expended according to schedule. Each month Project Officers contact subrecipients to discuss the percentage of the subrecipients’ budgets that are unexpended to

determine if funds will be expended by contract expiration. Subrecipients are required to submit a formal expenditure analysis at the end of the first and second quarters and monthly thereafter. The Recipient allows subrecipients to submit budget revisions for funds identified and anticipated as potentially being unexpended as a result of changes in personnel and/or other justified reasons. When a subrecipient's budget revision is not appropriate or not approved, the budget is modified to reflect the reduced budget amount and funds are reallocated. Reallocated funds may be directed to offset shortages in the budgets of other subrecipients funded for services under the same priority category. If the need exists in other agency budgets for services under a different priority category, revisions are reviewed by the Recipient and presented to the Planning Council for approval. Anticipated unexpended funds in the administrative budget, the clinical quality management budget, and the HIV services budget are reprioritized according to the directives of the Priorities Committee and the Planning Council.

(4) The process for reviewing subrecipient compliance with the single audit requirement in Subpart F of the HHS Uniform Guidance (45 CFR §75.500 –520).

The process begins with the subrecipient entering into a contractual relationship with Fulton County by signing the agreement which includes the language requiring compliance with: "Standards for Audit of Governmental Organizations, Programs, Activities and Functions"; Federal standards for financial management set forth in 45 CFR 75 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. Subrecipients expending \$750,000 or more during the fiscal year in Federal awards must have a Single or Program Specific audit conducted for that year in accordance with 2 CFR 75 Subpart F – Audit Requirements. The audit must be prepared by an independent Certified Public Accountant. Contractor must send one copy of the audit to the Ryan White Program Manager and one copy to the Director of Finance, within 180 days following the close of Contractor's fiscal year. At the County's discretion, this time period may be extended beyond the 180 days. Subrecipients expending less than \$750,000 during the fiscal year in Federal awards agrees to have a financial statement audit conducted annually by an independent Certified Public Accountant and further agrees to send one copy of the audit to the Ryan White Program Manager and one copy to the Director of Finance, Fulton County Government, within 180 days following the close of Contractor's fiscal year. At the County's discretion, this time period may be extended beyond the 180 days. Audits are reviewed by Part A Project Officers, the Director, the Fiscal Manager, and the Grants Administrator in the Finance Department.

(5) If there were findings in any subrecipient single audit reports, describe corrective actions.

Based on findings in an agency's independent audit or independent financial statement the Fiscal Manager, the Director, and the Finance Department's Grants Administrator review findings and determine the appropriate response to be taken ranging from the provision of technical assistance to the submission of a formal corrective action plan. Corrective Action Plans are reviewed to ensure that appropriate steps are taken to resolve findings (including reimbursement of disallowable costs). Subsequent meetings are scheduled with providers to validate the proposed actions identified in the corrective action plans. Failure to meet the requirements may result in delayed reimbursement, contract suspension or termination. All seventeen FY15 subrecipients funded were compliant with the audit requirement in the Uniform Administrative Requirements. However, there were two subrecipients with findings in their required FY15 single audit report: AID Atlanta and Positive Impact. The Recipient's Office in conjunction with Fulton County's Grant Compliance Team assessed all subrecipients with findings by conducting a site visit to ensure corrective measures were adhered to as recommended in their audit reports. During AID Atlanta auditor's review, an error was identified resulting in double invoicing in May and June for labs in the amount of \$27,019.91. As a result of this finding, the subrecipient has returned funds to Fulton County and Fulton County has returned funds to HRSA per the Grants Management Specialist's recommendation. During the compliance site visit, it was noted their accounting processes were reviewed to ensure checks

and balances were implemented to correct billing errors, and the agency was compliant with their Auditor's recommendation. During Positive Impact Health Centers, Inc. auditor's review, the auditor noted that the subrecipient overcharged the Recipient for laboratory fees on their January 2016 invoice. The invoice mistakenly included costs to be billed to Ryan White Part B. Also, in the February 2016 invoice, the subrecipient overcharged in Medical Nutritional Supplements. The subrecipient inadvertently entered the total amount of the vendor payment that should have been billed to another grant. As a result of this finding, the subrecipient has returned funds to Fulton County and Fulton County has returned funds to HRSA per the Grants Management Specialist's recommendation. During the compliance site visit, it was noted that subrecipient took immediate steps to bolster their existing internal review procedures. Their accounting processes were reviewed to ensure checks and balances were implemented to correct billing errors, and the agency was compliant with their Auditor's recommendation. All of the above named subrecipients adhered to their auditor's recommendations and have implemented corrective measures. These subrecipients require no further action, TA and/or training from the Recipient's Office. The Recipient's Office will continue to monitor these subrecipients for compliance.

(6) The process for reimbursing subrecipients from the time a voucher/invoice is received to payment begins with Project Officers reviewing invoices for accuracy and updating the Part A expenditure spreadsheet within three business days. Subrecipients are notified if additional supporting documentation is required. Project Officers complete a comparison of approved budget line items and supporting documentation. Once complete and deemed satisfactory, a fund source is assigned to be charged for payment. Invoices are then reviewed and approved by the Director or Assistant Director and forwarded to the Fiscal Manager for entry into the accounting system of Fulton County's Finance Department for processing/disbursement of payment. Subrecipients receive reimbursement within thirty (30) days of approval of invoice. During HRSA's recent site visit, it was noted that vendors were being paid within 3 weeks.

3) Administrative Assessment

a) The FY16 Administrative Assessment was performed by the Evaluations Committee of the Planning Council. There were 17 funded agencies during the FY16 funding cycle. Each FY16 subrecipient was provided a confidential fourteen question assessment which covered: Request for Proposal, Contract, and Financial Performance. Each agency was asked to score each question in accordance to their experience with the Recipient. The scoring ranges were: met none, met some, met most, met all or exceeded; of the fifteen respondents the majority of reported "met all or exceeded". There were **no deficiencies** reported in the review of the administrative mechanism. During this evaluation period the EMA's application for FY16 was received electronically by HRSA prior to the deadline. The Total Part A Funds for FY16 was \$25,023,768, with \$15,263,402.00 Formula, \$7,208,237.00 Supplemental and \$2,338,289.00 MAI. The Recipient met all HRSA deadlines for the submission of FY16 reporting requirements.

FY16 was the second year of a three year contract period so no RFP was issued for the continuation of services. A Funding Opportunity Announcement was released for FY16 to allocate the additional funding received to support Rapid Entry Clinics and for the decentralization of the MCM System. The provision of health insurance navigation was assumed by a currently funded agency. Notifications included the Priority Categories and funding amounts as approved by the Planning Council:

- **Access to Health Insurance:** The first \$150,000 in additional funding in FY16 is allotted to Non-medical Case Management priority category for the purpose of enrolling eligible clients into insurance programs under the ACA.
- **Rapid Entry to Care:** Additional FY16 funding in excess of \$150,000 up to 2 million is allocated to OAHS for rapid entry to care.
- **Health Insurance Premium and Cost Sharing Assistance:** FY16 funding above 2 million up to \$600,000 is allocated to the Health Insurance Premium and Cost Sharing Assistance

priority category for premium payments and /or co-pay assistance.

Proposals were received for all the established Priority Categories and funding has been awarded. During this period the Recipient held several intensive Technical Assistance Workshops which focused on data entry and reporting. These workshops were the first in a series of efforts to improve data collection. In continuation of the effort to enhance data, there was notable collaboration between the Recipient and the Planning Council in the identification of CAREWare entry as a QM project.

This year also marked development of the Atlanta EMA's first Integrated Plan. The plan followed the guidance of the 2013 joint letters from Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA); *"Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2017-2021"*.

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

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

The HRSA-funded **Ryan White Part A Program** provides care and treatment services for residents of the 20-county Atlanta EMA. The Part A planning group is the Metropolitan Atlanta HIV Health Services Planning Council (Planning Council).

Center for Disease Control funded prevention programs in Fulton and DeKalb Counties are administered by the Fulton County Department of Health and Wellness. The City of Atlanta (Fulton/DeKalb Counties) and JPPG provides recommendations for Fulton County's HIPP. The "Georgia Integrated HIV Prevention and Care Plan" identifies HIV prevention and care needs, existing resources, barriers, and gaps within our jurisdictions and outlines the strategies to address them through community developed and adopted Goals and Objectives.

Throughout the process the Recipient in conjunction with the Planning Council, Consumers, Stake-holders, and Subrecipients engaged in a total of sixteen meetings beginning on September 16, 2015 through August 10, 2016. Joint updates were presented to the Planning Council in January, May, July and August of 2016.

The Recipient also provided a program update at each of the Executive and Planning Council meetings. Agency budget revision requests that were between Priority categories were brought to the Executive Committee and Planning Council for approval. An update was received on the completion of FY15 financial and programmatic site visits along with a stats update regarding the progress on ongoing chart review audits for FY16.

b) There were no deficiencies.

4) Third Party Reimbursement

a) **The process used by recipients to ensure subrecipients are monitoring third party reimbursement** begins with the RFP which requires potential vendors to detail their strategies to coordinate service delivery between Part A and other third party payers (including Medicaid, State Children's Health Insurance Program, Medicare including Medicare Part D, VA, and private insurance, including options available under the Health Insurance Marketplace) along with income generated from third party payers in the most recent fiscal year. Once selected, vendors **contractually agree** that: *"funds will not be used to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, by another third party benefits program or by an entity that provides services on a prepaid basis."* Additionally, subrecipients have been advised of HRSA policy updates and will be expected to

vigorously pursue eligibility for other funding sources and to make reasonable efforts to secure non-Ryan White funds whenever possible for services to individual clients. Subrecipients that provide Medicaid-reimbursable services must be Medicaid certified. The recipient permits subrecipients to utilize Ryan White Part A funds to pay for insurance verification systems (e.g., Passport) to ensure that clients are screened for third party payers upon each service visit, as appropriate.

b) Subrecipients document and ensure clients are screened and enrolled in eligible programs (i.e., Medicare, Medicaid, private insurance, or other programs including options in the ACA Health Insurance Marketplace) to coordinate benefits and to ensure that Ryan White funds are the payer of last resort. In order to be compliant with this requirement, agencies must determine client eligibility for private insurance, Medicaid, Medicare, and the Marketplace insurances during intake and at least every 6 months thereafter. A copy of the financial screening tool is included in client files. Self-attestation is allowable once during the 12-month period as long as there are no changes in eligibility requirements. Agency systems include processes to determine and document client income (if the client has no income, documentation must be provided as well as an explanation of how living expenses are provided), assess opportunities for third party enrollment and billing, individual payments and that Part A is the payer of last resort. Required documentation includes paycheck stubs for employed patients which may indicate withdrawals for insurance coverage (for example, employment may be verified by accessing the Georgia Department of Labor database); income (based on W-2 forms, etc.) to determine financial eligibility for Medicaid; VA coverage; eligibility for PeachCare; Medicare and, Marketplace coverage. Primary care subcontractors electronically access the Georgia Health Partnership Portal to determine whether clients are enrolled in PeachCare, Medicaid, and Medicare. The recipient's process for verifying agencies' compliance with payer of last resort requirements includes reviewing a random sample of charts from each agency. As more clients within the EMA begin enrolling in private insurance through the Marketplace, the recipient will require that agencies verify client insurance eligibility through the use of verification tools such as Passport. Each agency has the flexibility to utilize the tool that best integrates with their existing client data and/or billing systems. The Project Officers will verify during site visits that verification tools are utilized and that clients are screened appropriately at the time of each service. Ryan White Part A funds can be utilized, if requested, by the agencies to support the administrative costs incurred to comply with this requirement.

c) The grant recipient monitors tracking and expenditures of any program income during site visits for subrecipients. Project Officers and Fiscal Manager monitor compliance through a review of client files and the quarterly Progress Reports indicating income generated through third party billing. If a subrecipient were found to be non-compliant, the grant recipient's corrective action process would be initiated. The grant recipient does not generate any program income.

5) Maintenance of Effort (MOE)

a) See Attachment 12: Maintenance of Effort Documentation. The narrative is included in the Attachment and illustrates the elements and expenditures related to HIV/AIDS core medical and support services for FY14 and FY15.

b) MOE will be maintained in the current fiscal year. See Attachment 12: Maintenance of Effort Documentation.

A description of the process used to determine the amount of expenditures is included in **Attachment 12: Maintenance of Effort Documentation.**