METROPOLITAN ATLANTA
HIV HEALTH SERVICES PLANNING COUNCIL

NOTICE OF PUBLIC REVIEW PERIOD

May 19 – June 19, 2016

Notice is hereby given of the availability for public review of the draft Integrated HIV Prevention and Care Plan, for the Metropolitan Atlanta HIV Health Services Planning Council and the Ryan White Part A Program. This draft is the joint product of the Metropolitan Atlanta HIV Health Services Planning Council (MAHHSPC), Ryan White Part A Program, Ryan White Part B Program, Georgia HIV Prevention Program, and the Fulton High Impact Prevention Program (HIPP).

Review and comment is sought during the period of May 19 – June 19, 2016. The draft document can be retrieved at:
(URL: *http://www.fultoncountyga.gov/ryan-white-home*).

A printed copy may also be obtained by contacting the Metropolitan Atlanta HIV Health Services Planning Council, 137 Peachtree Street SW, Atlanta GA, 30303; (404) 612-0791 or by emailing; mahhspc@fultoncountyga.gov .

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The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) support the submission of an Integrated HIV Prevention and Care Plan, including A Statewide Coordinated Statement of Need (SCSN), a legislative requirement for Ryan White HIV/AIDS Program (RWHAP) Part A and B Grantees. This document serves as first draft of this plan. Your comments and feedback is appreciated. Please send comments to mahhspc@fultoncountyga.gov ; or by mail at Ryan White Program, 137 Peachtree St. S.W., Atlanta GA, 30303.

Integrated HIV Prevention and Care Plan

Georgia: CY2017 - CY2021

DRAFT

INTEGRATED HIV PREVENTION AND CARE PLAN

GEORGIA

CY 2017-2021

Section 1: Statewide Coordinated Statement of Need/Needs Assessment

A. Epidemiologic Overview

According to the 2014 estimated for the federal census population, Georgia ranked eighth among states in population size, with a total population of 10,097,343. Females comprise 51.2% of the population while males are 48.8% of the population. Among Georgians reporting one race, 62.1% were white, 31.5% were African American and 9.3% were Hispanic. About one-half of the population, 52% of the state's African American population, 66% of the Hispanic population 29% of the poor, live in the 20-county Atlanta EMA. The other half of the state's population is widely dispersed among the remaining 139 counties which has historically presented challenges in healthcare resources and service.

a. Description of the geographical region of the jurisdiction:

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

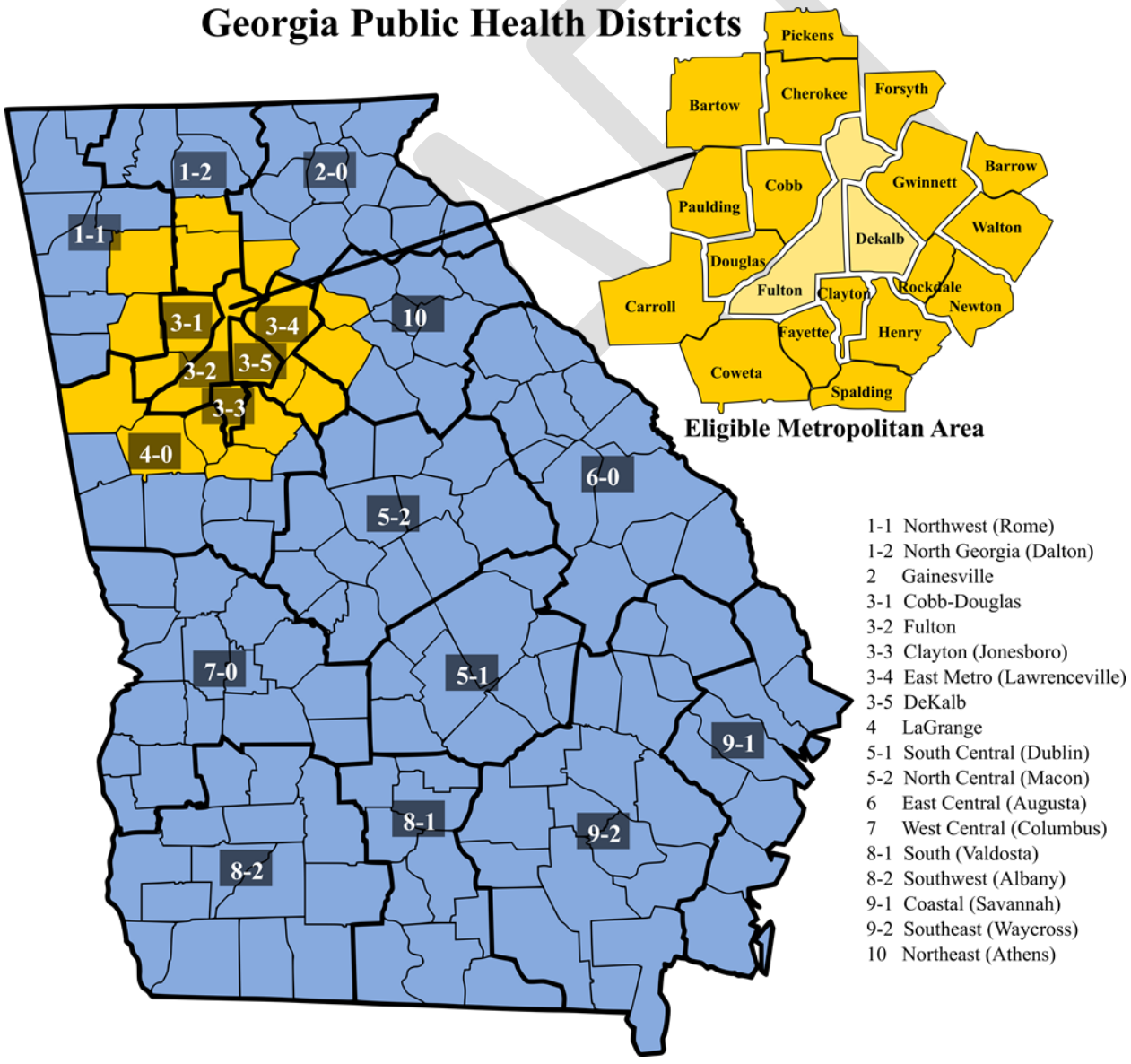
At the state level, DPH functions through numerous divisions, sections, programs and offices to fund and collaborate with Georgia's 159 county health departments and 18 public health districts. As is pertains to HIV, the Georgia Ryan White Part B Program and the HIV Prevention Programs are responsible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

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

The Georgia HIV Prevention Program develops and implements the state HIV Prevention Plan, coordinates the HIV testing program and data reporting for the state, and provides capacity building and training for community partners and public health staff. The HIV Prevention Program also provides funding to community based organizations and public health districts throughout the same 16 health districts as the Ryan White Part B Program.

Georgia has one 20 county eligible metropolitan area (EMA), and no transitional grant areas. The Fulton County Ryan White Part A Program is responsible for providing essential medical and supportive services for persons with HIV/AIDS within the EMA. The 20 counties served are: Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding and Walton (see yellow area in map below).

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



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

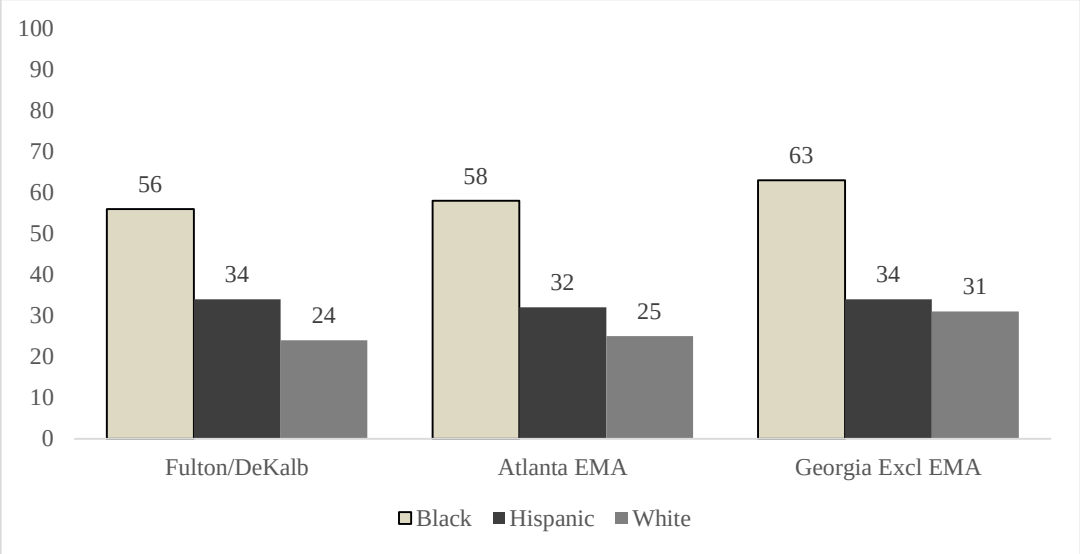
i. Demographic data including race, age, sex, transmission category, gender identity:

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

Overall, approximately 80% of new diagnoses and of PLWH were among males, and approximately two thirds were among Blacks (Tables 1 and 3). Among men, over 80% of new diagnoses were attributed to male-male sex; among women the great majority of new diagnoses and PLWH were attributed to heterosexual contacts (Table 2 and 4). A higher percent of new diagnoses White women were attributed to injection drug use than among Black or Hispanic women. Almost two thirds of new diagnoses in 2014 were among persons less than 40 years of age; almost two thirds of PLWH were 40 years of age and older (Tables 1 and 3).

Overall patterns were similar in the EMA and outside the EMA, however women accounted for a higher proportion of new diagnoses and of PLWH outside of the EMA than in the EMA (Tables 1 and 3). Among males, heterosexual contacts accounted for a higher percent of new diagnoses and of PLWH outside the EMA than in the EMA, particularly among Black and Hispanic men (Tables 2 and 4). Marked differences in age at diagnosis were observed among MSM by race/ethnicity. Almost 60% of Black MSM were less than 30 years of age at diagnosis, compared with 25-35% of Hispanic and White men. This pattern was observed both in the EMA and outside of it (Figure 1).

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



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

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

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

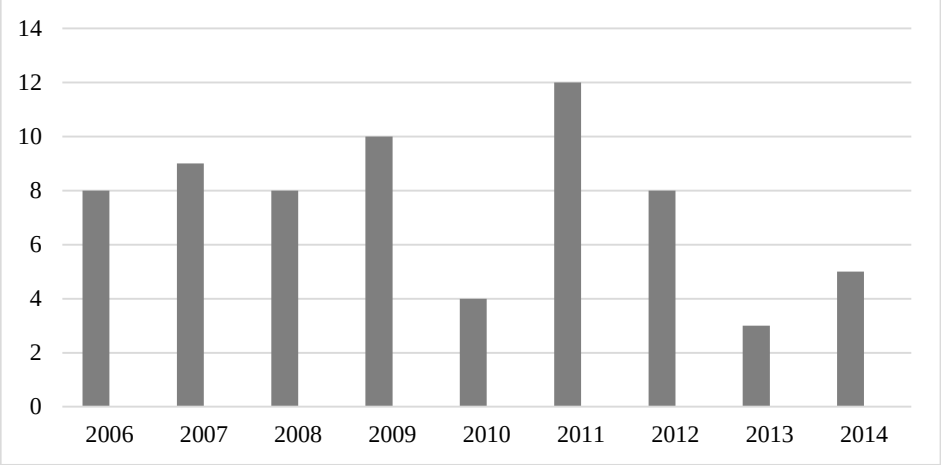


Table 1. New HIV Diagnoses by Selected Characteristics, 2014						
	Fulton/DeKalb (1,096)		**Atlanta EMA** (1,738)		**Georgia excl. EMA** (902)	
	N	(%)	N	(%)	N	(%)
Male	925	(84)	1410	(81)	701	(77)
Female	169	(15)	322	(19)	199	(22)
White	113	(10)	216	(12)	140	(16)
Black	759	(69)	1119	(64)	600	(67)
Hispanic	60	(5)	107	(6)	33	(4)
Asian	9	(<1)	11	(<1)	6	(<1)
AI/AN	<5		<5		<5	
API	19	(2)	29	(2)	16	(2)
Unknown	135	(12)	253	(15)	107	(10)
MSM	714	(65)	1070	(62)	516	(57)
IDU	26	(2)	51	(3)	39	(4)
MSM/IDU	20	(2)	29	(2)	14	(2)
Het	198	(18)	329	(19)	226	(27)
13-19	36	(3)	64	(4)	37	(4)
20-29	407	(37)	637	(37)	331	(37)
30-39	281	(26)	439	(25)	197	(22)
40-49	213	(19)	310	(18)	159	(18)
50-59	128	(12)	215	(12)	120	(13)
60+	29	(3)	66	(4)	56	(6)

Table 2. New HIV Diagnoses, Transmission Category by Race/Ethnicity and Sex, 2014						
	Fulton/DeKalb		**Atlanta EMA**		**Georgia excl. EMA**	
White Male						
MSM	98	(92)	175	(92)	98	(88)
IDU	<5		<5		5	(5)
MSM/IDU	5	(5)	8	(4)	<5	
Het	<5		<5		<5	
Black Male						
MSM	543	(87)	783	(87)	380	(84)
IDU	14	(3)	26	(3)	18	(4)
MSM/IDU	13	(2)	17	(2)	8	(2)
Het	53	(8)	75	(8)	47	(10)
Hispanic Male						
MSM	53	(94)	78	(83)	20	(76)
IDU	<5		<5		<5	
MSM/IDU	<5		<5		<5	
Het	<5		10	(11)	<5	
White Female						
IDU	<5		5	(17)	5	(15)
Het	6	(80)	21	(82)	23	(83)
Black female						
IDU	6	(5)	11	(5)	7	(5)
Het	128	(95)	200	(93)	138	(94)
Hispanic female						
IDU	<5		<5		<5	
Het	<5		11	(85)	5	(90)

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

Table 4. Transmission Category by Race/Ethnicity and Sex for Persons living with HIV, 2014

	Fulton/DeKalb		Atlanta EMA		Georgia excl. EMA	
White Male						
MSM	3,858	(90)	5,686	(88)	2,065	(82)
IDU	58	(1)	142	(2)	126	(5)
MSM/IDU	309	(7)	482	(8)	201	(8)
Het	38	(<1)	88	(1)	102	(4)
Black Male						
MSM	11,101	(82)	15,111	(82)	4,725	(69)
IDU	825	(6)	1,121	(6)	645	(9)
MSM/IDU	820	(6)	1,036	(6)	337	(5)
Het	742	(5)	1,107	(6)	1,061	(15)
Hispanic Male						
MSM	904	(86)	1,503	(83)	410	(68)
IDU	34	(3)	70	(4)	49	(8)
MSM/IDU	61	(6)	110	(6)	27	(4)
Het	46	(4)	121	(7)	113	(19)
White Female						
IDU	65	(30)	152	(25)	187	(23)
Het	147	(68)	433	(72)	613	(75)
Black female						
IDU	476	(13)	709	(12)	541	(14)
Het	3,101	(85)	5,045	(85)	3,330	(84)
Hispanic female						
IDU	25	(15)	53	(13)	25	(12)
Het	140	(82)	355	(85)	175	(86)

Table 5. Proportion diagnosed as stage 3 (AIDS) within 3 months of HIV diagnosis			
	Fulton/DeKalb %	**Atlanta EMA** %	**Georgia excl. EMA** %
Male	21	23	23
Female	18	21	25
White	18	20	20
Black	21	22	25
Hispanic	32	34	25
Asian	--*	--	--
AI/AN	--	--	--
Multiracial	--	--	--
MSM	21	22	22
IDU	27	27	33
MSM/IDU	--	19	--
Het	21	25	28
13-19	--	11	--
20-29	14	14	14
30-39	27	27	28
40-49	23	29	31
50-59	26	27	35
60+	24	33	30

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

Federal Poverty Level: Approximately 37% (3,611,500) of all Georgia residents were living at or below 200% of the federal poverty level in 2014 according to a U.S. Census Bureau poverty status report. African-Americans and Hispanics continue to be disproportionately affected, with 26% and 32% of each population living below 100% FPL. Based on RDR data available for 2014, 64% (9,170) of clients who received services at Part B sites lived at or below 200% FPL. Put in Part A info

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

416 of which have Affordable Care Act (ACA) health insurance marketplace plans. Put in Part A info

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

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

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

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

*number too small to provide estimate

Rates of new diagnosis and prevalence rates also vary substantially by region of the state. For men, rates are highest in Atlanta, followed by the southern part of the state and are lowest in the northern part of the state (Figures 3a and 3b); the difference in rates between Atlanta and other areas is greatest for Whites, followed by Blacks, and smallest for Hispanics. For women, rates are highest in the southern part of the state, followed by Atlanta (Figure Figures 4a and 4b).

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

Rates per 100,000

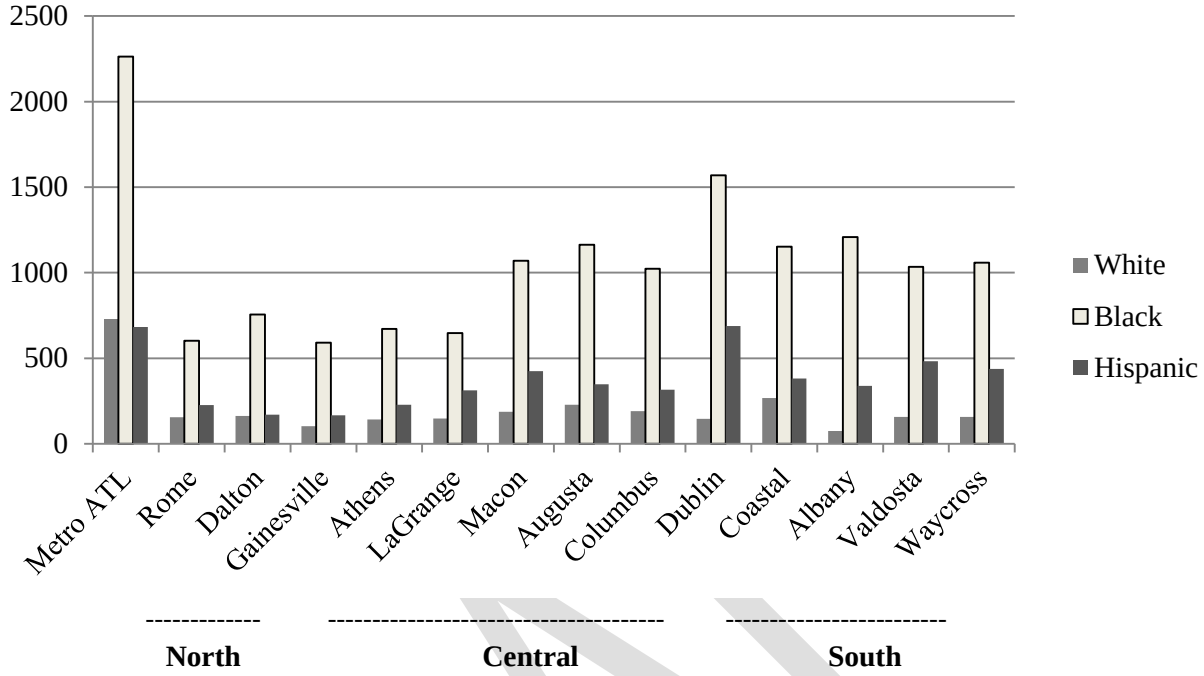


Figure 3b. New HIV diagnosis Rate among Men by Race/Ethnicity and the Health District per 100,000 Population

Rates per 100,000

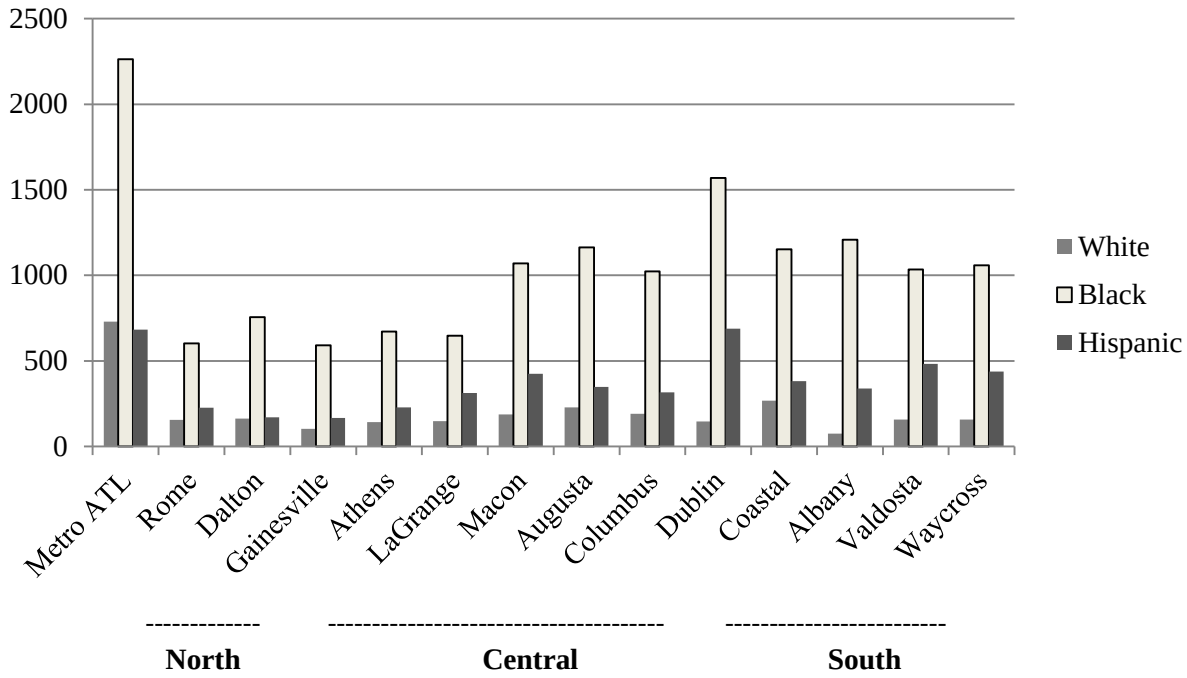


Figure 4a. HIV Prevalence Rate among Women by Race/Ethnicity and Health District per 100,000 Population

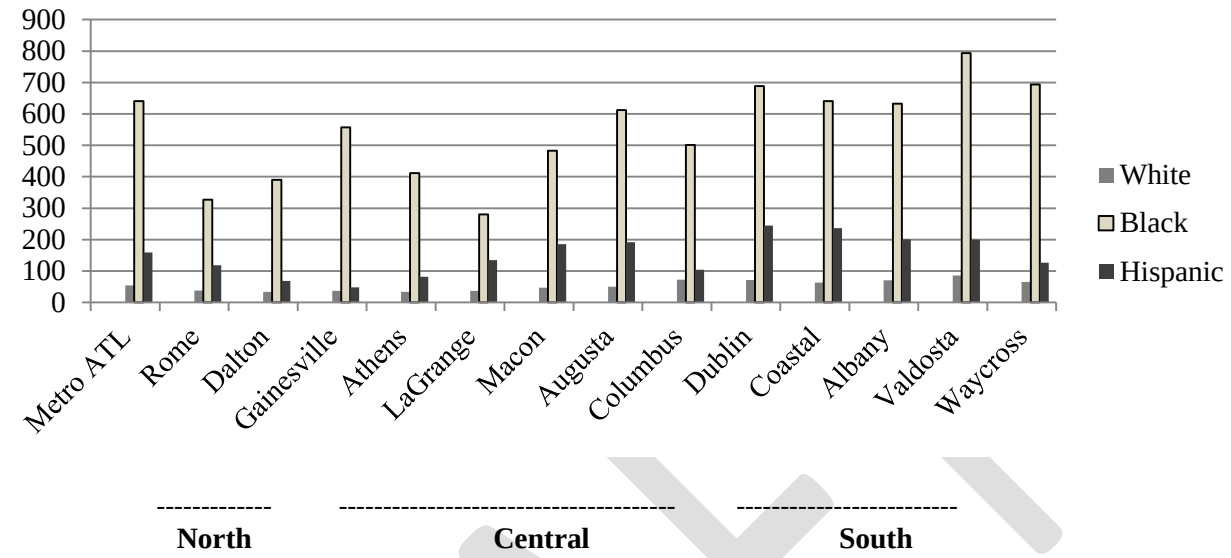
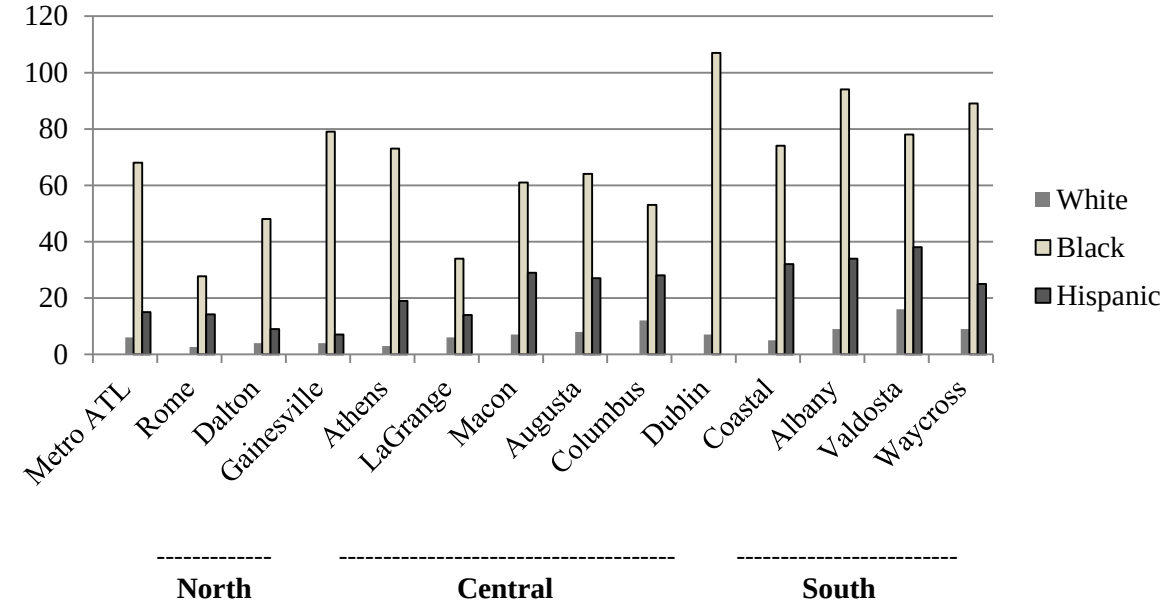


Figure 4b. New HIV Diagnosis Rate among Women by Race/Ethnicity and Health District per 100,000 Population



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

New diagnoses, overall

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

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

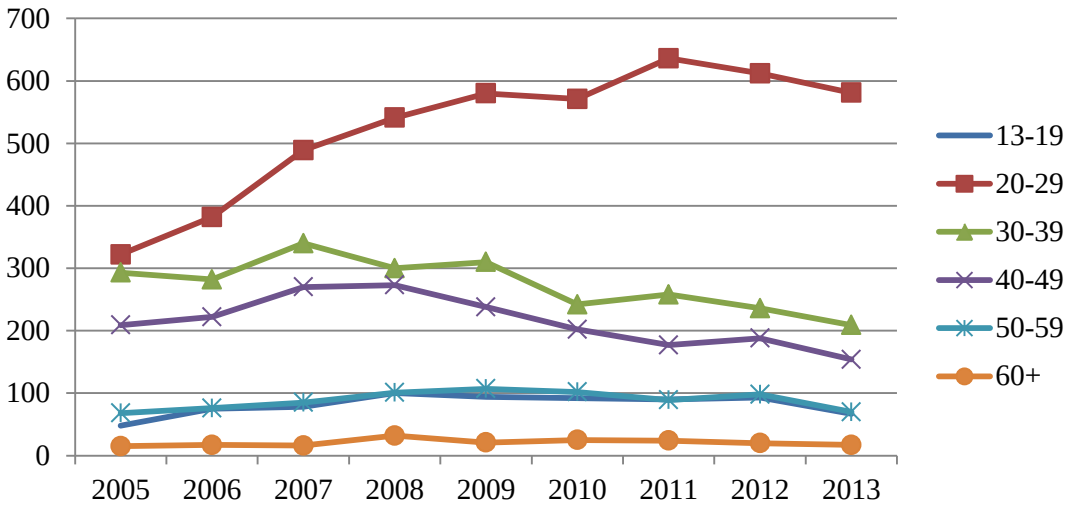


Figure 5b. New HIV diagnoses among White MSM, Georgia 2005-2013

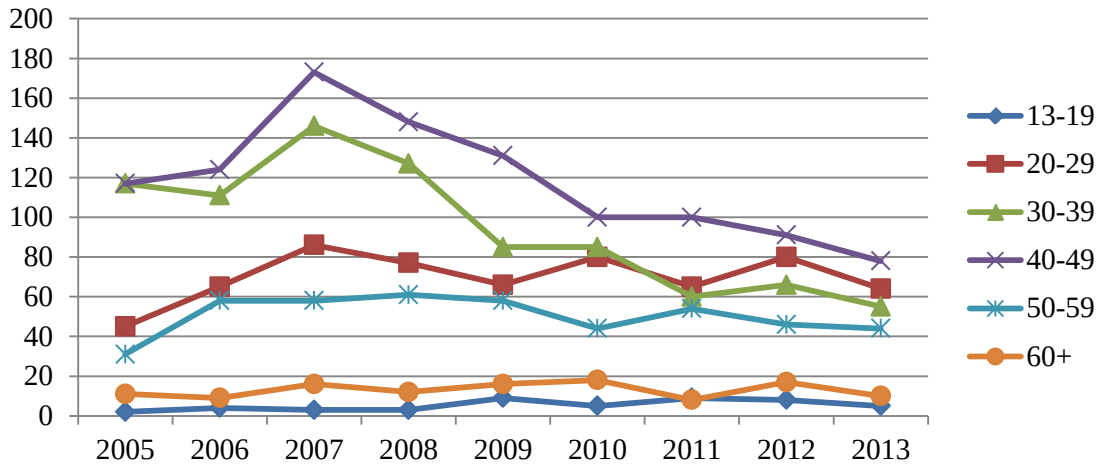
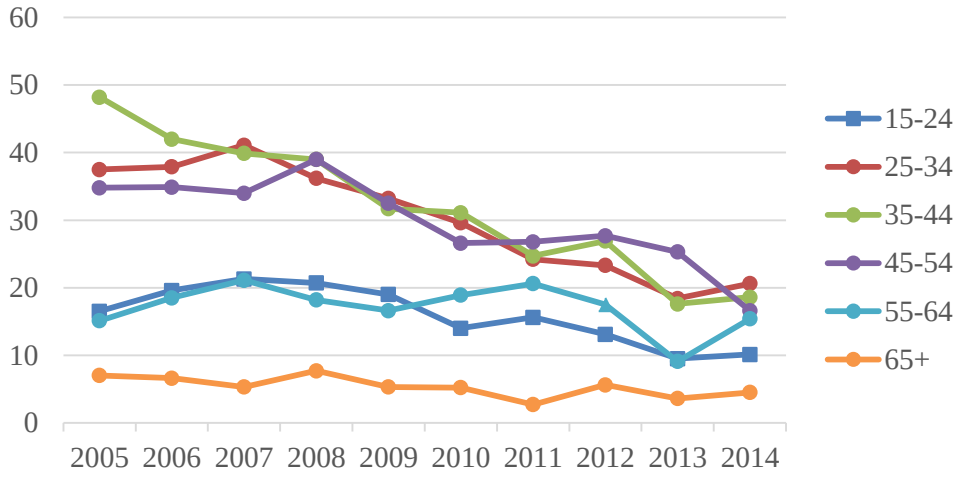


Figure 6. New HIV diagnoses among Women by Age at Diagnosis, Georgia 2005-2014



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

<u>New diagnoses, in the EMA and outside the EMA</u>

Among Black men, new diagnoses among men less than 30 years of age outnumbered those among men 30 and older starting 2010 in the Atlanta EMA and starting 2011 outside of the EMA. Both in the EMA and outside new diagnoses have declined in men 30 and older (Figures 7a and 7b). Among White men, the number of new diagnoses declined in men 30 and older and remained stable in men under 30 in the EMA; outside

of the EMA new diagnoses were stable in both groups (Figures 8a and 8b). Among Hispanics new diagnoses were fairly stable in men under and over 30, both in the EMA and outside of it (Figures 9a and 9b).

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

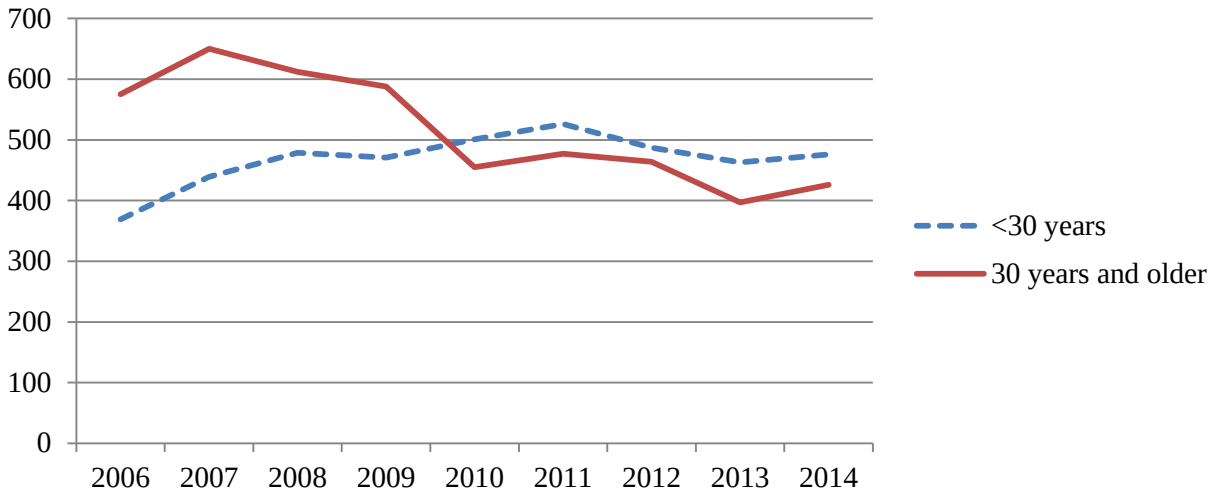


Figure 7b. New HIV diagnoses among Black Men by Age at Diagnosis, Georgia outside the EMA, 2006-2014

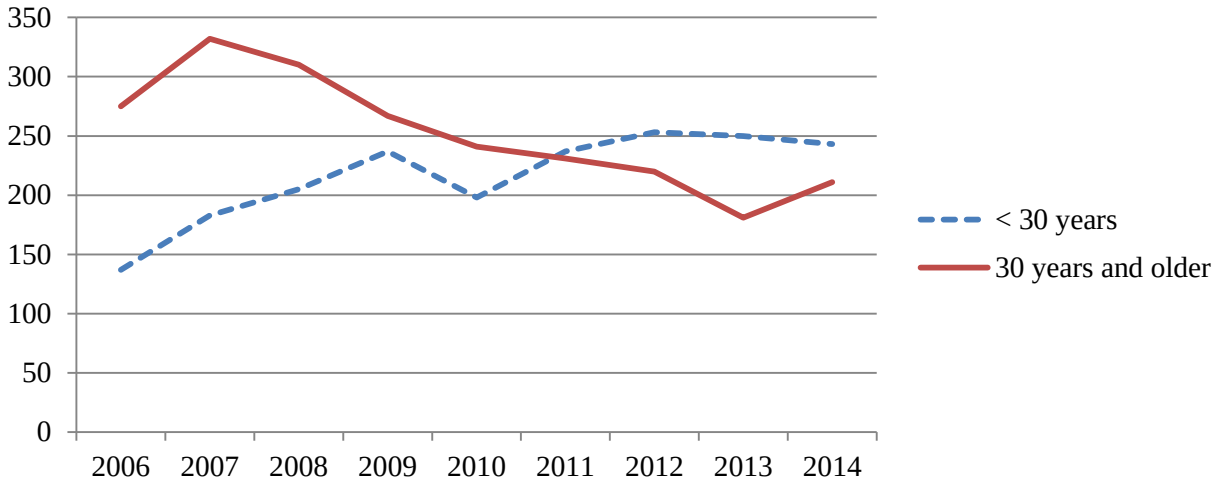
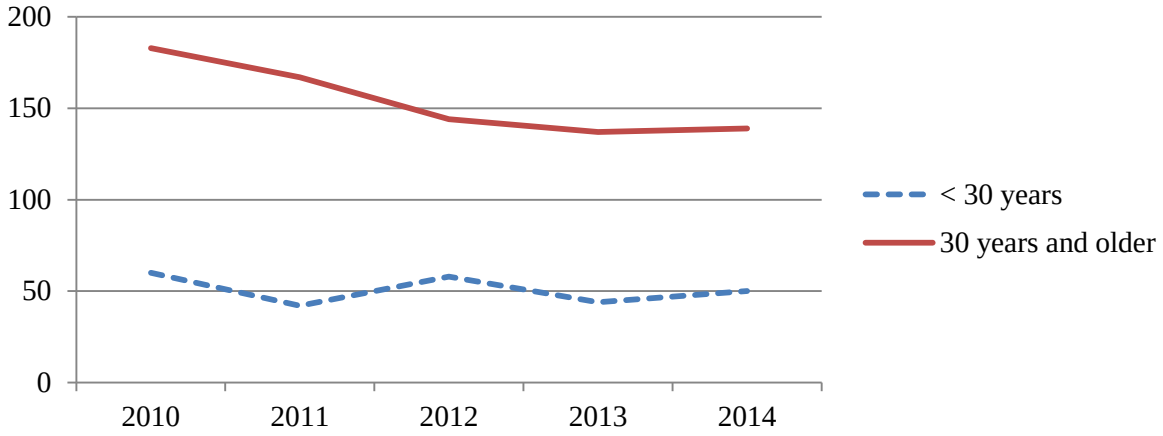


Figure 8a. New HIV Diagnoses among White Men by Age at Diagnosis, Atlanta EMA, 2010-2014



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

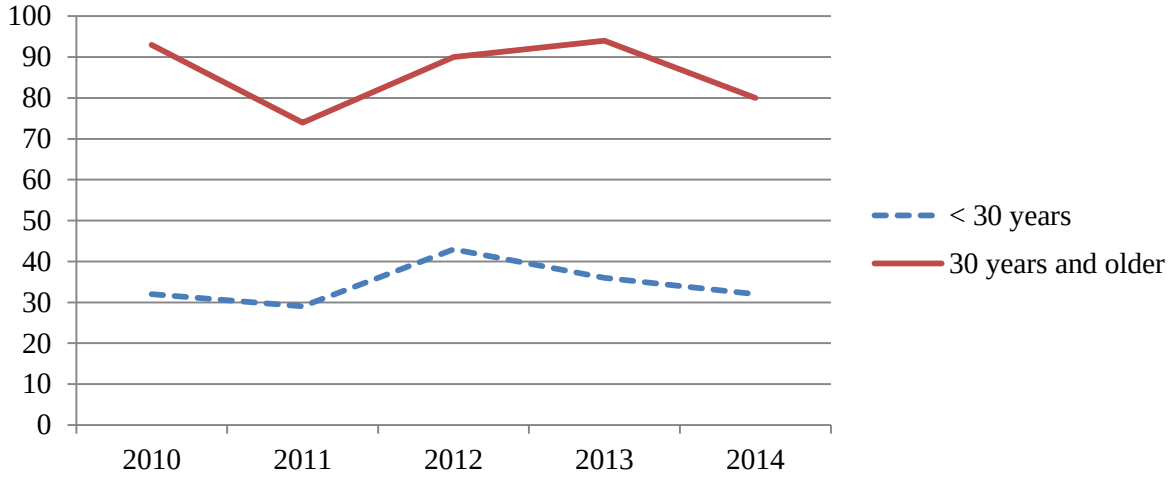


Figure 9a. New HIV Diagnoses among Hispanic Men by Age at Diagnosis, Atlanta EMA, 2010-2014

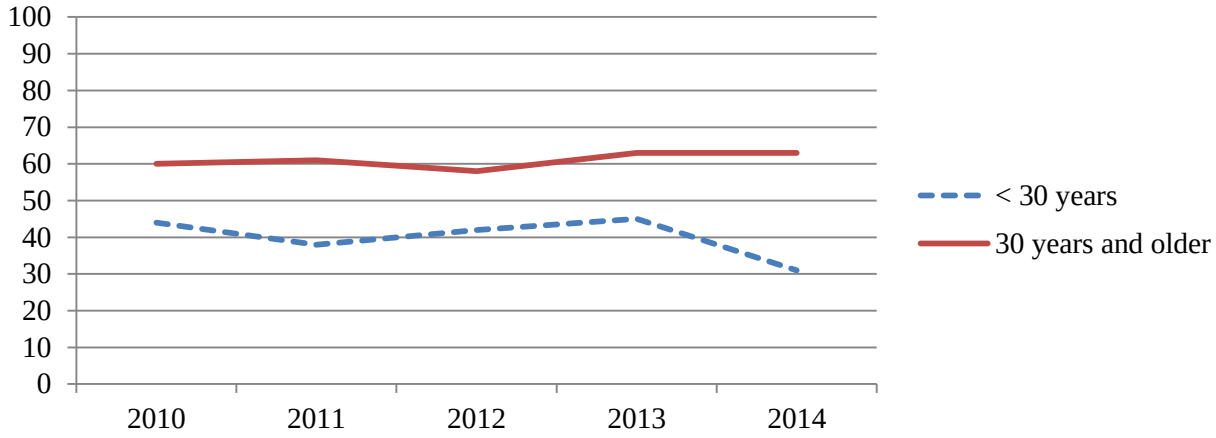
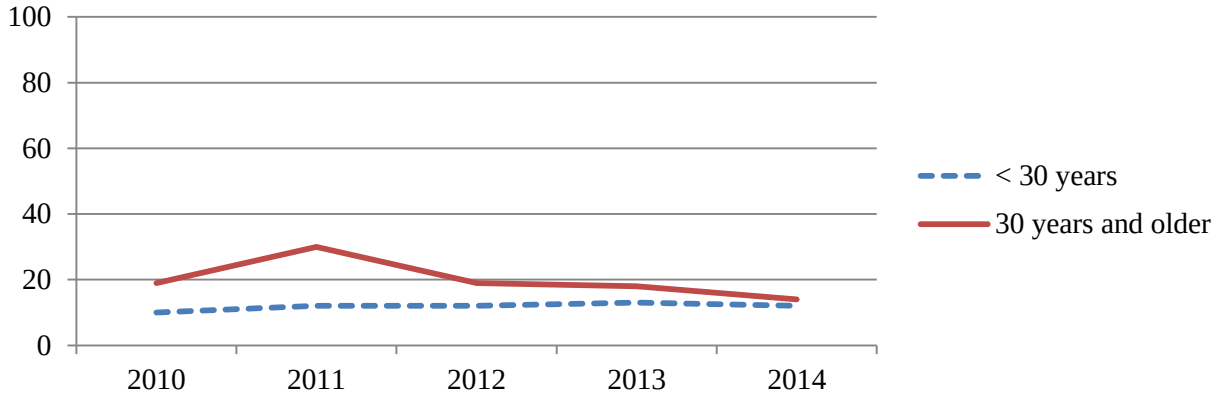


Figure 9b. New HIV Diagnoses among Hispanic Men by Age at Diagnosis, Georgia outside of the EMA, 2010-2014



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

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

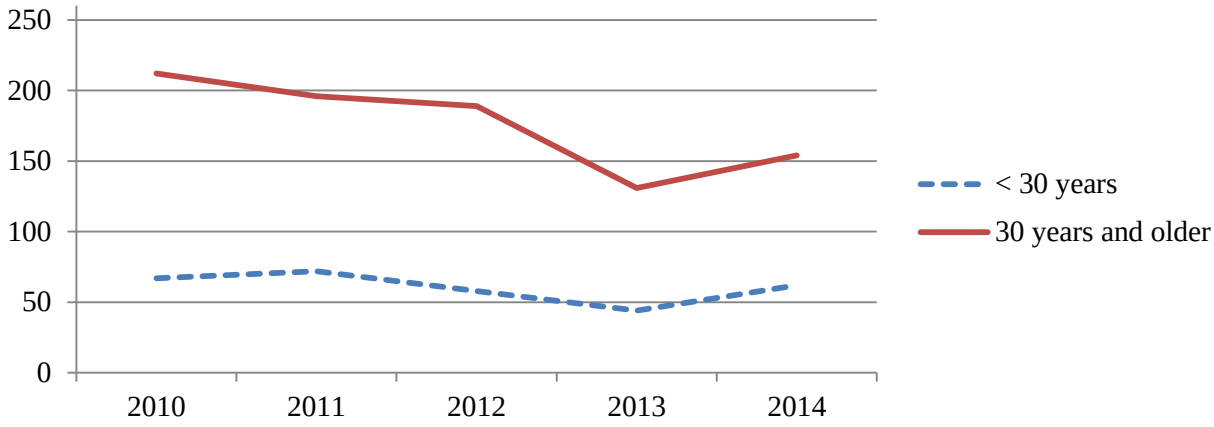
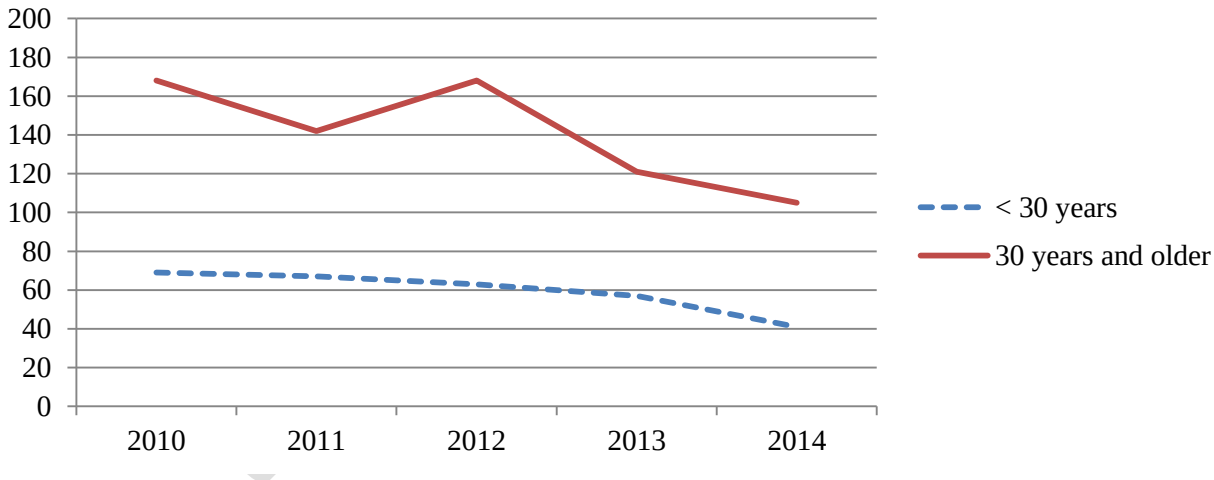


Figure 10b. New HIV Diagnoses among Black Women by Age at Diagnosis, Georgia outside of the EMA, 2010-2014



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

HIV prevalence

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

Should we include unmet need data for EMA or is GA data sufficient?

Table 4: Quantified Estimate of Unmet Need for HIV Primary Care, Georgia (GA) 01/01/2014 - 12/31/2014

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

Row H.	Number of PLWH/not AIDS who did not receive the specified HIV primary medical care during the 12-month period, 01/01/2014 to 12/31/2014	11,081	43%	B-E
Row I.	Total number of persons living with HIV Disease who did not receive the specified HIV primary medical care during the 12-month period, 01/01/2014 to 12/31/2014.	21,295	39%	C-F

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

Table 5: Unmet Need by HIV Status, Demographic Group and Transmission Category, GA 01/01/2014 -12/31/2014

	HIV (not AIDS)		**AIDS**		**Total**	
Gender	**Count**	**Percent[1]**	**Count**	**Percent**	**Count**	**Percent**
Male	8,141	42%	8,001	37%	16,142	40%
Female	2,866	45%	2,196	32%	5,062	38%
Subtotal[2]	**11,007**		**10,197**		**21,204**	
Age in years	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
<2	<5	-	<5	-	<5	-
2-12	69	46%	5	28%	74	44%
13-17	27	26%	<5	-	-	-
18-24	643	36%	116	22%	759	32%
25-29	1,458	44%	366	26%	1,824	38%
30-34	1,530	47%	595	29%	2,125	40%
35-39	1,380	46%	853	31%	2,233	39%
40-44	1,392	44%	1,302	35%	2,694	39%
45-49	1,464	42%	1,843	36%	3,307	38%

50-54	1,350	42%	2,089	39%	3,439	40%
55-59	890	41%	1,462	40%	2,352	40%
60-64	465	40%	832	41%	1,297	40%
65+	402	44%	743	47%	1,145	46%
Subtotal	**11,070**		**10,206**		**21,249**	
Race/Ethnicity	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Black/Non-Hispanic	7,282	45%	6,736	35%	14,018	40%
White/Non-Hispanic	1,768	37%	2,237	40%	4,005	39%
Hispanic/Latino, Any Race	563	44%	716	43%	1,279	43%
Other[3]	237	30%	297	25%	528	27%
Unknown	1,231	47%	234	32%	1,465	44%
Subtotal	**11,081**		**10,220**		**21,295**	
Transmission Category	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
MSM	3,698	39%	4,468	37%	8,166	37%
IDU	344	48%	906	49%	1,250	49%
MSM&IDU	237	42%	570	46%	807	45%
Heterosexual	1,037	37%	1,447	33%	2,484	35%
Other[4]	80	33%	85	33%	165	33%
NIR/NRR[5]	5,685	48%	2,738	33%	8,423	42%
Subtotal	**11,081**		**10,214**		**21,295**	

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

Table 6. Narrative of Trends or Changes

Indicator	1/1/2012-12/31/2013	1/1/2013-12/31/2014	Percent change	Trend
Newly Diagnosed, HIV (non-AIDS);	3,923	3,697	6%	Decrease
Newly Diagnosed, AIDS	2,409	1,783	26%	Decrease
Indicator	**As of 12/31/13**	**As of 12/31/14**	**Percent change**	**Trend**
AIDS Prevalence	27,502	25,397	8%	Decrease
HIV(non-AIDS) Prevalence	24,110	28,353	18%	Increase

Note: Numbers are for data entered through June 30, 2014 and are not adjusted for reporting delays.

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

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

The HIV/AIDS epidemic in Georgia continues to affect a significant number of women. From 1984 to 2014, the cumulative proportion of AIDS cases among women increased

from 4% to 24%. Heterosexual contact remains the primary mode of transmission among women in Georgia. As of December 2014, 78% of cases among women living with HIV (non-AIDS) and 79% of cases among women living with AIDS in Georgia were attributed to the heterosexual transmission category.

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

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

i. Behavioral surveillance data:

Data are available from the Georgia NHBS to describe socio-economic status and risk behaviors of populations at high risk of HIV: MSM, PWID, and high risk heterosexuals.

<u>MSM</u>

MSM were recruited and interviewed in fall 2014 from venues frequented by MSM. Demographic characteristics of the respondents are shown in Table 7. Characteristics of Black and White MSM are shown separately given the large age difference between the two (46% of Black MSM vs 27% of White MSM were under 30). A lower proportion of Black MSM had completed college, and a high proportion had an annual income of less than $20,000.

Table 7. Socio-demographic characteristics of persons at risk for HIV--Georgia NHBS

	IDU (2012)[1] (n=561)	High risk hetero-sexual [1,2] (2010 and 2013) (n=840)	MSM (2014)[3] Black (n= 198)	White (n=132)
Age				
18-29	2	33	46	27
30-39	11	19		

40-49	30	24	54
50+	57	23	73
Race/ethnicity			
White	11	1	NA
Black	87	97	
Hispanic	1	2	
Education			
BA or more	2	2	42 64
2 yr college	25	18	32 22
HS/GED	40	45	27
<HS	34	35	14
Income			
<$20,000	85	84	<20,000 30 13
$20,000-49,999	11	13	20,000-39,000 32 19
4 50,000-74,000	3	2	40,000-74,000 26 36
			75,000+ 13 33
Homeless	45	29	

[1]Respondent driven sampling

[2]Recruited from low income census tracts

[3]Venue-based sampling with effort to recruit young black 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 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 MSM and 23% of White MSM responded very 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 and Whites (33% and 36% respectively), while there was a marked difference among Black and White men 30 and older (33% and 17%, respectively). Awareness of PrEP was substantially lower among Black MSM than White MSM (43% and 66%, respectively). Overall 66% of MSM had an HIV test in the last 12 months; 9% of Black MSM and 3% of White MSM reported never having had an HIV test.

Persons who inject drugs

A total of 561 persons who inject drugs were interviewed in fall 2012. More than half of the respondents were 50 and older, and the great majority were Black. Only 2% had completed college, 34% had not completed high school, and 85% reported annual income under $20,000.

Heroin was the most commonly reported often used drug (60%), followed by speedball (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.

In fall 2015, PWID were interviewed again with an emphasis on reaching young PWID. Compared with persons older than 35, a higher proportion of persons under 30 was White, and a higher proportion was previously addicted to prescription painkillers. Additionally, __% reported being HCV-positive and __% had never been tested for HCV. _____percent of those under age 30, compared with ___% of those 35 and older reported using a needle after someone else half of the time or more. A higher proportion of young compared with older PWID reported sharing needles and equipment *(data pending, to be added later).*

High risk heterosexuals

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

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

Demographic characteristics and risk behaviors among HIV-infected persons in care

MMP data for Georgia aggregated from 2009 to 2013 provide information on risk behaviors of HIV-infected persons in care. Overall, the sample was fairly representative in terms of distribution by sex, race, and transmission category (Table 8). Forty four percent of the sample had a high school education or less, and 57% reported annual income under $20,000. For 38% SSI or SSDI was the primary source of financial support and 42% were below the poverty line. Thirty nine percent

reported Ryan White support for ART and Medicare, Medicaid and private insurance were each reported by 27 to 30%

Table 8. Socio-demographic characteristics of persons in HIV care--Georgia MMP 2009-2013 (n=795)	
	%
Gender	
Male	71
Female	28
Transgender	1
Age	9
18-29	19
30-39	35
40-49	35
50+	
Race/ethnicity	
White	21
Black	69
Hispanic	5
Education	
>HS	56
HS/GED	28
<HS	16
Income	
<$20,000	57
$20,000-49,999	20
4 50,000-74,000	11
Homeless at some point in last 12 m	9
Incarcerated >24 hrs last 12 m	6
Insurance for antiretroviral medicine*	
Medicaid	27
Ryan White	39
Private	30
Medicare	27
Primary source of financial support past 12 m	
SSI or SSDI	38
Salary or wages	41
Family, partner or friends	12
Other	8
Poverty Guidelines	
Above	58
Below	42

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

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

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

ii. **HIV surveillance data:** **Combined testing data to be presented here from the State and Fulton County**

iii. **Ryan White HIV/AIDS Program data:** **Need Ryan White RSR and ADAP Data Report.**

People Served by Ryan White Part A Program in FY 2014	
Core Medical Services	
Service	***Number Served***
Outpatient/Ambulatory Medical Care	11,170
Oral Health Services	3,174
Mental Health	2,487
Medical Nutrition Therapy	1,120
Medical Case Management	7,540
Substance Abuse – Outpatient	984
Support Services	
Service	***Number Served***
Child Care Services	126
Emergency Financial Assistance – Utilities	162
Food Bank/Home Delivered Meals	962
Housing	12
Legal Services	113
Linguistics Services	299
Medical Transportation	2,858
Psychosocial Support Services	2,283

Case Management Non-medical	12,207

iv. **Other relevant demographic data including Hepatitis, STD, TB and Substance use data: Additional data are being provided by Surveillance for TB and Hep C**

STDs

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

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

Tuberculosis

Hepatitis C

Poverty

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

v. **Qualitative data: Need information from all writing team members.**

vi. **Vital statistics data: How do we access this data? Is there any information from National Death Index that the State has that we can utilize?**

vii. Other relevant program data including Community Health Center data: Did we receive Community Health Center data? Is there any data from Family Planning Clinics that we might be able to use?

B. HIV Care Continuum

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

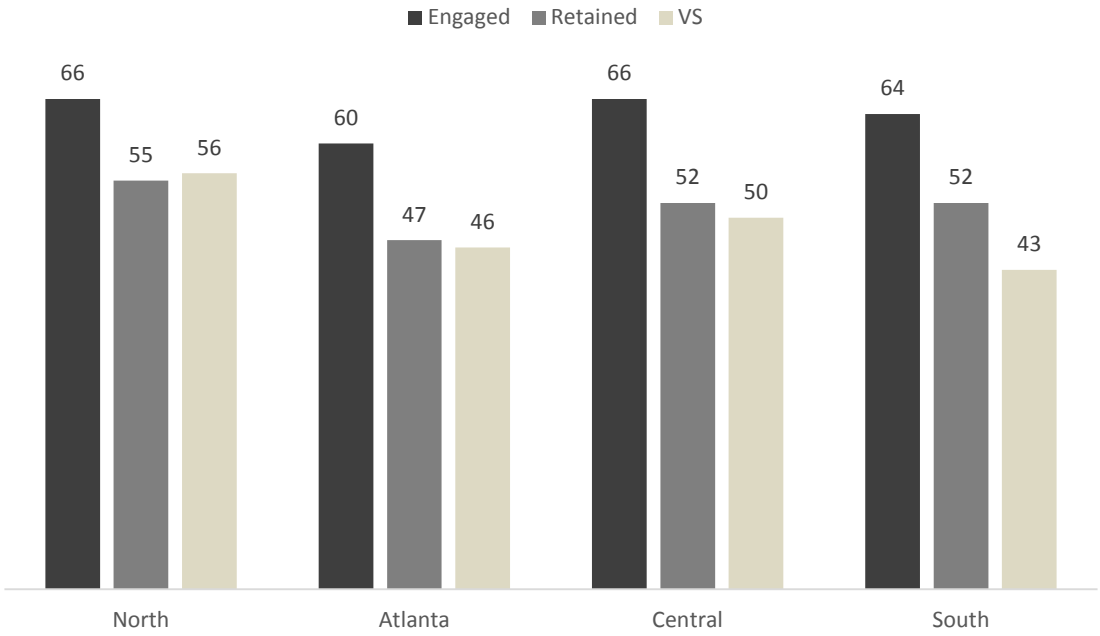
The 2014 HIV Care continuum is calculated for persons diagnosed as of the end of 2013 and living (i.e. not known to be dead) as of the end of 2014. Persons are considered to be engaged in care if they have at least one CD4 or VL during 2014; they are considered retained if they had 2 or more CD4/VL at least 3 months apart in 2014; and virally suppressed in the last viral load test in 2014 was <200 copies/ml. Timely linkage to care is assessed among persons diagnosed in 2014, with a CD4 or VL within one month of diagnosis.

Overall, in 2014 60% of PLWH in Georgia were engaged, 48% were retained, 46% were virally suppressed and among those retained in care, 81% were virally suppressed. Retention was lower among Blacks than among Whites and Hispanics, and viral suppression was lower among both Blacks and Hispanics than Whites. Retention and viral suppression were lower among persons 20-39 than among older persons, and retention and suppression were lower among IDU and MSM/IDU than MSM and high risk heterosexuals.

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

Care continuum outcomes varied by geographic region, with the proportion engaged, retained and virally suppressed highest in northern Georgia, and lowest in southern Georgia. Although engagement and retention were slightly lower in the southern health districts, viral suppression was markedly lower, with a 13 percentage point gap between viral suppression in the health districts in the north and the south of Georgia (Figure 11).

Figure 11. HIV Care Continuum by Region, Georgia, 2014



Within the EMA, the proportion linked to care within 30 days was lower for Blacks, for persons 20-29, and for IDU and MSM/IDU; outside of the EMA the proportion linked in a timely was lower for males and for Blacks.

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

b. Disparities in engagement among key populations: Need narrative to explain Tables 9-13 below.

Table 9. HIV Care Continuum, Fulton/DeKalb, 2014

	Engaged %	Retained %	Virally suppressed %	VS among retained %
Males (19,382)	59	46	45	83
Females (4,103)	61	48	43	78
White (4,322)	60	49	52	91

Black	(16,238)	59	45	42	78
Hispanic	(1,142)	58	48	44	82
Asian	(84)	76	62	65	94
AI/AN	(<5)	--	--	--	--
Multiracial	(842)	75	62	58	83
13-19	(88)	72	58	55	82
20-29	(2,622)	62	43	35	66
30-39	(5,029)	60	45	41	76
40-49	(6,966)	60	47	47	84
50-59	(6,460)	58	48	47	86
60+	(2,333)	55	46	47	89
MSM	(15,640)	61	47	46	82
IDU	(797)	49	39	36	81
IDU/MSM	(1,237)	54	44	39	79
Het	(4,102)	62	49	44	78

Table 10. HIV Care Continuum, Atlanta EMA, 2014

		Engaged %	Retained %	Virally suppressed %	VS among retained %
Males	(27,375)	60	47	47	84
Females	(7,145)	62	49	47	81
White	(6,729)	63	51	54	91
Black	(22,966)	60	46	44	80
Hispanic	(2,095)	58	49	47	85
Asian	(157)	69	55	59	92
AI/AN	(13)	--	--	--	--
Multiracial	(1,255)	77	63	60	83
13-19	(171)	75	61	57	81
20-29	(3,951)	62	43	37	68
30-39	(17,427)	61	45	43	78
40-49	(10,423)	62	48	49	85
50-59	(9,279)	57	49	50	88
60+	(3,342)	57	48	49	90
MSM	(21,930)	62	48	48	84
IDU	(2,277)	52	41	40	82
IDU/MSM	(1,698)	56	45	42	80
Het	(7,014)	63	49	47	81

Table 11. HIV Care Continuum, Georgia excl. EMA, 2014				
	Engaged	Retained	Virally suppressed	VS among retained
Males (10,160)	61	48	42	77
Females (5,148)	63	51	43	74
White (3,171)	61	49	47	82
Black (10,222)	64	51	42	73
Hispanic (764)	55	46	42	82
Asian (26)	--	--	--	--
AI/AN (10)	--	--	--	--
Multiracial (484)	80	66	58	78
13-19 (72)	64	53	39	71
20-29 (1,749)	60	44	34	66
30-39 (2,785)	58	45	38	74
40-49 (4,258)	63	50	43	74
50-59 (4,517)	63	52	46	79
60+ (1,948)	62	51	47	80
MSM (6,933)	63	50	44	77
IDU (1,595)	59	47	40	75
IDU/MSM (582)	61	47	41	74
Het (5,324)	65	53	44	74

Table 12. HIV Care Continuum among MSM, by Race/Ethnicity, 2014									
	Fulton/DeKalb			Atlanta EMA			Georgia excl. EMA		
	W (3,719) %	B (10,379) %	H (839) %	W (5,449) %	B (14,087) %	H (1,405) %	W (1,959) %	B (4,379) %	H (388) %
Engaged	62	60	60	64	51	59	63	63	53
Retained	50	45	49	52	45	49	51	49	43
Virally Suppressed	54	42	46	56	43	48	49	41	41
Suppressed among Retained	92	78	82	92	79	85	83	74	82

Table 13. Proportion linked to care within 30 days of HIV diagnosis			
	Fulton/DeKalb %	Atlanta EMA %	Georgia excl. EMA %
Male	55	54	47
Female	63	56	54
White	66	64	53
Black	53	52	48
Hispanic	69	60	59
Asian	78	82	--
AI/AN	--	--	--
Multiracial	53	52	63
MSM	55	54	47
IDU	53	51	60
MSM/IDU	49	49	--
Het	62	57	53
13-19	64	64	43
20-29	50	49	45
30-39	58	55	54
40-49	54	57	53
50-59	72	65	43
60+	62	55	57

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

Georgia/Part B

The HIV Care Continuum is currently being utilized to plan, prioritize, target and monitor available resources in response to needs of PLWHA and in improving engagement at each stage in the HIV Care Continuum. The Georgia HIV Care Continuum was taken into consideration when developing the Integrated Plan Goals and Objectives, making sure that initiatives align with each step of the continuum. In Georgia, two of the focus areas include the promotion of HIV testing and linkage to care. By increasing HIV diagnosis, and linking PLWHA to care, the state can achieve higher rates of viral suppression overall, and eliminate disparities in HIV testing, treatment and care. Late diagnosis of HIV infection contributes to poorer outcomes for infected individuals and impedes HIV prevention efforts. Earlier diagnosis provides opportunity for interventions for viral suppression for the benefit of the individual and for reduced HIV transmission for the benefit of the community.

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

Underscoring MSM's disproportionate impact are several key structural factors. The HIV Office has identified three structural areas for targeted interventions, including stigma, education and job training, as well as geographical location. The following describes the planned initiatives to address these factors. The HIV Office's Coordinators for MSM/ Lesbian, Gay, Bisexual, Transgender (LGBT) Activities have several initiatives to assess and address the distinct structural barriers MSM face related to the Care Continuum. The first initiative is assessing rural MSM's HIV prevention needs as well as the barriers to accessing these services. While the majority of GA's HIV cases remain concentrated primarily in urban counties, a significant minority are spread out across rural areas. This initiative will inform the HIV Office in determining what is working and not working to ensure this underserved and high risk population's needs are met. The second initiative is a multi-tiered approach to mitigating the stigmas attached to HIV and sexuality, which hinder engagement in prevention and care services. This initiative mobilizes a community-based advisory group to develop actionable steps to reduce stigmas. In addition, the Coordinators for MSM/LGBT Activities have developed a continuing education unit-based program to work with medical and social service providers on reducing perceived, as well as actual stigma. To complement these efforts, empowerment trainings are planned for MSM living with HIV to boost their self-efficacy related to managing their care and treatment. The third initiative offers free job training, General Educational Development (GED) classes and exams, as well as health literacy training for MSM who lack a high school diploma. Improving educational attainment has shown to be effective in assisting PLWH to achieve optimal health and well-being.

<u>Atlanta EMA/Part A</u>

- On June 17, 2015 the Director of the DPH's HIV/AIDS Epidemiology Section briefed the Priorities Committee of the Metropolitan Atlanta HIV Health Services Planning Council (Planning Council) on the HIV Care Continuum for the State of Georgia and the 20-county EMA. Data for 2014 were presented for adults and adolescents living with HIV and the stages of the HIV Care Continuum broken-down by sex, age, and race/ethnicity. Data were also provided to compare viral suppression among those retained in care by race/ethnicity. These data, among others, were used to inform decisions on the rankings and funding allocations among priority service categories. For example, $1,275,184 was allocated within the OAMC category to initiate ART while working to have coverage picked up by AIDS Drug Assistance Program (ADAP) or Patient Assistance Programs. This led to

increases in the case management non-medical category from FY14 to FY15 and again for FY16 to support ADAP coordinators to assist clients with accessing coverage for medications.

- HIV/AIDS Bureau (HAB) performance measures 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. As further indicated in section iii, African Americans have lower levels of linkage, retention and viral suppression. In addition to targeting Minority AIDS Initiative (MAI) funds to OAMC, funds were allocated to support a HIV clinic in a targeted underserved area with high morbidity levels. Additionally, funds were allocated to expand evening clinic hours at another site to allow clients more options for accessing care.
- To improve antiretroviral use and viral load suppression, new options for providing medications have been implemented at several sites which allow clients to continue to receive medication at the agency, through home delivery, or through contracted pharmacies.
- Part A quality management staff and data staff assist each primary care provider in developing an agency continuum to evaluate performance and success in meeting quality standards.
- The needs of persons **not in care** were considered**.** During the priority setting process, the Priorities Committee used numerous data sources including the 2011 Atlanta EMA HIV/AIDS Consumer Survey which included service gap information for persons who know their HIV status but were not in care. In addition to allocating funds for mental health and substance abuse service to support individuals in preparing to enter care, the Committee recommended continued funding the Atlanta Area Outreach Initiative (AAOI – a community education program described more thoroughly in section *ii*. below), patient navigation, and psychosocial support (peer counselors and support groups). It is also important to note that there is a higher percentage of persons virally suppressed than the percentage in care – due to the fact that many clients who are virally suppressed and generally healthy have medical visits less frequently than two times a year at least three months apart. Funds were allocated to support these clients in maintaining their health through such services as case management non-medical to assist clients with ADAP recertification, and medical case management.

C. Financial and Human Resources Inventory

a. See Jurisdictional HIV Resources Table included as Attachment I.

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

The distribution of providers across the state continues to impact access to care, creating a service gap among PLWHA, particularly for residents of rural areas and especially for those who require specialty care. There are many providers in urban areas and not enough in rural parts of the state. According to the Health and Human Resources Administration

(HRSA), as of March 2015, 141 of the 159 counties in Georgia were designated Medically Underserved Areas, and 7 counties were designated as having Medically Underserved Populations. Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population. Specialty care is more limited, and generally located in areas with academic medical centers (i.e., Atlanta, Augusta, Macon, and Savannah) leaving large portions of the state with very limited access to this care.

Georgia also has several Health Professional Shortage Areas (HPSAs), which are designated by HRSA as having shortages of primary medical care, dental or mental health providers. Of the 159 Georgia counties, 137 have mental health professional shortages, 54 have primary health care professional shortages, and 46 have dental health professional shortages.

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

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

There is a high incidence of oral health problems among PLWHA. According to HRSA Ryan White Program estimates that "between 32 and 46 percent of PLWHA will have at least one major HIV-related oral health problem— bacterial, viral, and fungal infections as well as cancer and ulcers—in the course of their disease…and 58 to 64% do not receive regular dental care".
(http://hab.hrsa.gov/abouthab/files/oral_health_fact_sheet.pdf) Although not specific to HIV, the U.S. Department of Labor, Bureau of Labor Statistics' 2015 state occupational employment statistics indicate that as of May 2015, Georgia had 2,450 general dentists, 50 oral and maxillofacial surgeons, 130 orthodontists, and 310 dentists, all other specialists. Bureau of Labor Statistics are also available for the Atlanta-Sandy Springs-Roswell, Georgia metropolitan statistical area (28 county area that includes all of the 20 counties in the Atlanta EMA served by the Ryan White Part A program). According to

the Bureau, 1,420 (57.9%) of the state's dentists are located in the 28-county Atlanta region. However, six of the EMA's 20 counties are low income (Barrow, Bartow, Clayton, Newton, Spalding, and Walton) or partial (Douglas) dental HPSAs. Barriers to dental care for PLWHA include lack of dental providers who do not accept patients with HIV infection, lack of dental insurance, limited income, and stigma.

The Bureau of Labor Statistics report also provides information on the number of other employed healthcare practitioners in Georgia. In May 2015, there were 3,170 physician assistants, 68,980 registered nurses, 3,920 advanced practice nurses, 1,810 dietitians and nutritionists, 8,850 pharmacists, 760 optometrists, 5,230 physical therapists, 2,930 occupational therapists, and 25,360 licensed practical and licensed vocational nurses. For the Atlanta-Sandy Springs-Roswell statistical area, there were 1,960 (61.8%) physician assistants, 36,200 (52.4%) registered nurses, 1,940 advanced practice nurses, 800 (44.1%) dietitians and nutritionists, 4,760 (53.7%) pharmacists, 360 (47.3%) optometrists, 2,970 (56.7%) physician therapists, 1,750 (59.7%) occupational therapists, and 10,450 (41.2%) licensed practical and licensed vocational nurses in May 2015. Both statewide as well as in the Atlanta EMA, some counties have greater health workforce coverage than others. In addition, some individuals seeking healthcare services may experience difficulties because of lack of insurance coverage and limited income. Georgia has chosen not to expand its Medicaid coverage and existing coverage. Further, some physicians do not accept or limit their number of patients with Medicaid or Medicare coverage. The Division of Medical Assistance, the Department of Community Health's largest division, administers the state's Medicaid program which provides health care for approximately 1.7 million low-income children, pregnant women and people who are aging, blind and disabled. Pregnant women and their infants with family incomes at or below 200% of the federal poverty level (FPL) are eligible for Right from the Start Medicaid for Pregnant Women and Their Infants (RSM Adults and Newborns). Pregnant women, children, aged, blind, and disabled individuals whose family income exceeds the established income limit may be eligible under the Medically Needy program. Almost six in ten births (59%) in Georgia are covered by Medicaid.

Ryan White Funded HIV Workforce Capacity: The Atlanta EMA Ryan White Part A program provides care for low-income, uninsured and underinsured individuals and families affected by HIV in the 20-county EMA. Funds support clients as they progress through the HIV care continuum and core medical and support services. The table below shows the number and types of personnel funded by provider through the Ryan White Part A Program.

Agency	Part A Funded HIV Services	Funded Personnel by Type and Number
AID Atlanta - offers HIV/AIDS prevention and care services, including (but not limited to) Primary Care, HIV/STD Screening, PrEP, Community HIV Prevention Programs,	Primary Care, Case Management, Oral Health, Mental Health, Patient Navigation, Linguistics Services, and Medical Transportation	37 Medical Case Managers; 4 Non-Medical Case Managers; 3 Mental Health Counselors; 5 Outpatient

Agency	Part A Funded HIV Services	Funded Personnel by Type and Number
Linkage Services, Case Management, and a state-wide Information Hotline.		Ambulatory Health Services (OAHS) Clinicians; and 2 Psychosocial Support (Patient Navigators)
AIDS Healthcare Foundation – provides HIV primary care, laboratory care, and an on-site pharmacy	Primary Care, Case Management, Oral Health, Patient Navigation, and Medical Transportation	10 OAHS Clinicians; 1 Non-Medical Case Managers; 1 Psychosocial Support staff (Patient Navigator); and 3 Medical Case Managers
ANIZ, Inc. – provides mental health and substance abuse counseling, support services, and sexual health education.	Mental Health, Substance Abuse, Psychosocial Support, and Medical Transportation	1 Mental Health Counselor; 3 Psychosocial Support staff (2 Peer Counselors and 1 Intake Specialist); and 1 Non-Medical Case Manager
Atlanta Legal Aid – provides free legal representation, conducts home and hospital visits, provides off site access to legal assistance, conducts community information sessions on legal issue relating to HIV, and implements legal standards of care.	Legal Services	6 Legal Services Staff (5 Attorneys and 1 Paralegal)
Clarke County Board of Health – provides HIV services for Barrow and Walton Counties. The Specialty Care Clinic provides comprehensive HIV primary health care and supportive services.	Primary Care, Oral Health, Case Management, and Medical Transportation	5 OAHS Clinicians and 1 Medical Case Manager
Clayton County Board of Health – provides comprehensive HIV primary health care and supportive services.	Primary Care, Oral Health, Psychosocial Support, Patient Navigation, and Medical Transportation	6 OAHS Clinicians; 1 Non-Medical Case Manager; 2 Psychosocial Support staff (Peer Counselor and Patient Navigator)

Agency	Part A Funded HIV Services	Funded Personnel by Type and Number
Cobb County Board of Health – through its HIV/AIDS Clinic, provides primary care to PLWHA in Cobb and Douglas Counties.	Primary Care, Oral Health, Mental Health, and Patient Navigation	4 OAHS Clinicians; 1 Mental Health Counselor; 1 Linguistic Service staff (Spanish Translator); and 1 Psychosocial Support staff (Patient Navigator)
DeKalb County Board of Health – provides clinical care, outreach, and case management at five health centers in DeKalb County. Its Ryan White Early Care Clinic provides medical services, mental health, oral health, substance abuse services, transportation services, education, and self-management training.	Primary Care, Oral Health, Mental Health, Psychosocial Support, Patient Navigation, Linguistics Services, and Medical Transportation	8 OAHS Clinicians; 4 Oral Health Clinicians; 1 Mental Health Counselor; 1 Medical Nutrition Therapist staff (Nutritionist); 2 Psychosocial Support staff (Peer Advocate and Patient Navigator)
Emory University Hospital Midtown Infectious Disease – is the outpatient Infectious Disease for Emory Healthcare. Offers HIV outpatient ambulatory medical care, specialty care, radiology and diagnostic services, phlebotomy, pharmacy, inpatient care, interdisciplinary clinical research, medical social work, non-medical case management, mental health, and nutritional counseling. Additional mental health care and oral health care are available offsite.	Primary Care, Food Vouchers, and Medical Transportation	10 OAHS Clinicians and 3 Non-Medical Case Managers
Fulton County Department of Health and Wellness – through its HIV Clinic, provides primary medical care, laboratory services, mental health and substance abuse services, dental health services, case management, and health education.	Primary Care, Oral Health, Mental Health, Substance Abuse, Medical Nutrition Therapy, Food Vouchers, Patient Navigation, Linguistics Services, and Medical Transportation	17 OAHS Clinicians; 5 Oral Health Clinicians; 4 Mental Health Counselors; 4 Substance Abuse Counselors; and 2 Non-Medical Case Managers

Agency	Part A Funded HIV Services	Funded Personnel by Type and Number
Grady Health System's Grady Infectious Disease Program (IDP) – is the outpatient HIV/AIDS facility of the Grady Memorial Hospital (GMH). Provides an array of services including primary care in four clinic areas; sub-specialty services (e.g., hepatology, neurology, ophthalmology, and hematology-oncology), onsite pharmacy, comprehensive oral health care, comprehensive mental health care, substance abuse treatment, education, onsite childcare, laboratory services, x-ray, and nutritional evaluation/ counseling. Clients have access to clinical trials and research through the onsite Clinical and Translational Research Center of the Emory Center for AIDS Research. The adult Treatment /Holding Unit provides outpatient infusions, transfusions, cancer chemotherapy, urgent medical care and direct transfer to GMH when needed. Partner agencies provide essential services onsite	Primary Care, Oral Health, Mental Health, Substance Abuse, Medical Nutrition Therapy, Child Care Services, Case Management, Psychosocial Support, Linguistics Services, and Medical Transportation	72 OAHS Clinicians; 11 Oral Health Clinicians; 10 Mental Health Counselors; 3 Medical Case Managers; 2 Medical Nutrition Therapy staff (Registered Dieticians); 1 Child Care staff; 2 Psychosocial Support staff (Peer Educators); and 1 Linguistic Service staff (Translator)
Here's To Life – provides education and support services to persons who have HIV disease and substance abuse. Provides comprehensive substance abuse treatment and counseling services.	Substance Abuse, Emergency Substance Abuse Housing, Psychosocial Support and Medical Transportation.	3 Substance Abuse Counselors; 1 Non-Medical Case Manager; and 1 Psychosocial Support staff (Intake Specialist)
National Education and Services for Minorities (NAESM) – provides behavioral health services including substance abuse treatment, HIV testing and prevention services. Additional services include food	Mental Health, Substance Abuse, Food Vouchers and Medical Transportation	1 Non-Medical Case Manager; 1 Mental Health Counselor; and 1 Substance Abuse Counselor

Agency	Part A Funded HIV Services	Funded Personnel by Type and Number
vouchers and medical transportation.		
Positive Impact Health Centers - provides HIV specialty care and support services, behavioral health including substance abuse treatment, HIV testing and prevention services.	Primary Care, Oral Health, Mental Health, Substance Abuse Services, Case Management, Emergency Substance Abuse Housing, Patient Navigation, Psychosocial Support, and Medical Transportation	11 OAHS Clinicians; 11 Mental Health Counselors; 12 Substance Abuse Counselors; 4 Medical Case Managers; 2 Psychosocial Support staff (Certified Peer Specialist and Patient Navigator); and 1 Medical Transportation Manager
Open Hand/Atlanta, Inc. – provides comprehensive nutrition care through home-delivered meals and nutrition education.	Medical Nutrition Therapy, Home Delivered Meals, Food Pantry	4 Medical Nutrition Therapy staff (Registered Dietitians)
Recovery Consultants of Atlanta – provides psychosocial support, behavioral health services including substance abuse treatment, HIV testing and prevention services.	Psychosocial Support and Medical Transportation	1 Psychosocial Support Service (Peer Counselor)
St. Joseph's Mercy Care- provides HIV/AIDS prevention and outreach services and through its Early Intervention Clinics (EIC), provides primary care, oral health care, medical nutrition therapy, health education/risk reduction, assistance with ADAP and pharmaceutical assistance programs, case management, mental health support and emergency financial assistance for food and utilities. EIC patients have access to other onsite Mercy Care services including optometry, x-ray and behavioral health.	Primary Care, Oral Health and Food Vouchers	7 OAHS Clinicians; 2 Oral Health Clinicians; and 2 Non-Medical Case Managers

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

People Served by Ryan White Part A Program in FY 2014	
Core Medical Services	
Service	***Number Served***
Outpatient/Ambulatory Medical Care	11,170
Oral Health Services	3,174
Mental Health	2,487
Medical Nutrition Therapy	1,120
Medical Case Management	7,540
Substance Abuse – Outpatient	984
Support Services	
Service	***Number Served***
Child Care Services	126
Emergency Financial Assistance – Utilities	162
Food Bank/Home Delivered Meals	962
Housing	12
Legal Services	113
Linguistics Services	299
Medical Transportation	2,858
Psychosocial Support Services	2,283
Case Management Non-medical	12,207

Ryan White Part D HIV Workforce Capacity - Mirroring the Atlanta EMA Part A Program service area, the Atlanta Family Circle Part D Network serves women, children, youth and families infected or affected by HIV/AIDS who live in the five core Metropolitan Atlanta counties (Fulton, DeKalb, Cobb, Clayton, and Gwinnett) and the surrounding 15 counties. The Grady Memorial Hospital Corporation/Grady Health System (GHS), Infectious Disease Program (Grady IDP) serves as the Part D Grantee of record. The Atlanta Family Circle Network includes: AID Atlanta, Fulton/DeKalb Hospital Authority's Grady Infectious Disease Program Ponce Family and Youth Clinic (Grady FC) and Women's Health Services (Grady WH), and SisterLove, Inc. (SLI). The primary purpose of the Atlanta Family Circle HIV/AIDS Network: Ryan White Part D Services for Women, Children, and Adolescents (Network) has been to create an integrated, coordinated system of comprehensive, culturally competent, family-centered, community-based services for HIV + women, children, adolescents and families residing in the Atlanta

EMA. The majority of the population targeted for Ryan White Part D services are low-income minorities.

Network services funded through Ryan White Part D include linkage to care services provided by SisterLove and AID Atlanta; one-on-one adherence counseling is provided by Grady WH for HIV+ pregnant women attending the Grady Hospital OB High Risk Clinic as well as assistance in management of treatment regimens, side effects, and serious adverse reactions to therapies, coordination of prenatal care and resource referrals for clients, linkage with the OB social work case manager, and linkage to available research and support groups; and primary care and specialty care are provided to children and adolescents in the Grady IDP Family and Youth Clinic as well as adherence counseling for women, children, and youth. AID Atlanta provides case management services for Part D women who are followed at the IDP.

Ryan White Part D funding is used to enhance Atlanta EMA HIV Workforce Capacity for women, infants children and youth (WICY) living with HIV. Project staffing is provided in the table below.

Agency	Part D Funded Staff
Grady IDP	2 Pediatricians (.10 FTE and .20 FTE), 1 Physician Assistant (.55 FTE), 2 Medical Case Managers (2 FTE), 1 Phlebotomist (1 FTE), 1 Nurse Educator (.50 FTE)
Grady Women's Health	1 High Risk OB Nurse (1 FTE); attending physician in High Risk OB Clinic for HIV+ pregnant is provided in-kind
AID Atlanta	1 WICY Linkage Specialist (.50 FTE), 2 WICY Case Managers (2 FTE)
SisterLove, Inc.	1 Health Educator (1 FTE), 2 HIV Outreach and Linkage Specialists (2 FTE); 3 in-kind HIV Prevention Specialists/Peer Advocates

Impact of Atlanta Family Circle Ryan White Part D Funded Workforce: In CY 2015, 1,777 women, infants, children, and youth received Part D funded services through the Atlanta Family Circle Ryan White Part D Network. Approximately two-thirds of all children, adolescents and young adults with reported HIV/AIDS in Georgia are cared for at the Grady IDP Family and Youth Clinic, which also provides the majority of care for HIV-exposed infants throughout the state. The clinic delivers community-based mother- and child-centered comprehensive care within the medical home of the IDP including HIV research, training and education. The center provides extensive support services reflected in the make-up of staff members and includes counseling and referral of family and members and exposed partners. In CY 2015, 176 HIV-indeterminant infants (0 to 2 years), 70 HIV infected infants children (0-12 years of age), and 423 youth (13-24 years of age) received primary care and treatment adherence services and 976 women (25+ years of age) received treatment adherence services. Twenty-five youth received transition to adult medical care services. In addition, 393 youth were screened for mental health problems and 376 received substance abuse screening services; 515 children and youth received medical case management services.

Grady WH-OB offers HIV counseling and testing pregnant women for women receiving prenatal services through the OB clinic system and includes HIV counseling and routine, voluntary, HIV testing as part of its reproductive health program. HIV counseling and testing, using an opt-out approach to testing is provided during the initial OB registration visit. In CY 2015, 2,460 prenatal patients were tested with 19 pregnant women identified as HIV+. Pregnant women who test positive are followed the full course of their pregnancy by the Grady Hospital Department of Gynecology and Obstetrics, Women's Health Services (Grady WH) in its high-risk clinic or by local private providers. In CY 2015, 80 women received services through the OB HIV High Risk Clinic. Clients have comprehensive prenatal services including screening for other STD's, drug screens, PPD testing, baseline viral load and lymphocyte subset testing. Treatment **a**dherence is encouraged through discussions, assessments and problems with medications therapy at each clinic visit and via telephone contact. Other services that are available to the pregnant HIV+ women include, dental care follow up, access to ultrasonographers, nutritionists, cardiologists, neonatologists, rheumatologists, pulmonologists, internists, endocrinologists, pediatric cardiologists to work closely with the maternal- fetal medicine specialists in managing fetuses diagnosed with structural heart defects, screening for genetic conditions , chromosomal abnormalities and growth restriction. Also, all HIV+ clients are scheduled for counseling if needed with the OB counseling services in the WH Department, and of course, case management is provided by the Grady IDP social worker from who attends the weekday clinic.

Three part-time SisterLove HIV Outreach and Linkage Specialists conduct health education and risk reduction workshops for HIV+ women and adolescents; conduct HIV counseling and testing drives for high-risk women and youth and arrange for referral and linkage to care for those testing positive for HIV. They also conduct outreach to recruit and retain women and youth with HIV, using counseling and testing activities to identify diagnosed and undiagnosed HIV+ individuals in the target populations and ensure they are linked into primary medical care and retained in care. In CY 2015, 742 high risk African American women and youth received HIV counseling and testing and prevention education services. Five were identified as positive and linked to care. SisterLove Part D duties also include conducting support groups for HIV+ women receiving services at the agency, treatment and adherence education and support as well as distribution of perinatal transmission information for high-risk and HIV positive women of childbearing age. Three in-kind funded peer educators recruit and retain HIV infected youth (ages 13 to 24), including horizontally infected youth, in primary medical care. They also conduct support groups for HIV+ women and adolescents (including those perinatally infected) receiving services at the agency and collaborative networks in the Atlanta EMA; treatment adherence education and support; as well as distribution of perinatal transmission information for high-risk and positive women of childbearing age.

AID Atlanta provides case management services for Part D women who are followed at the IDP. In FY 2015, 125 women ages 25 and above received case management services, including a written plan of care, from two Part D funded social workers. Both the IDP Family and Youth Clinic and AID Atlanta Part D funded Medical Case Managers (MCM) provide assistance to clients to help remove those barriers that prevent them from

accessing HIV medical care or remaining in medical care. They provide a thorough assessment through the use of the ISP to identify those barriers to care. Major barriers include lack of transportation, lack of adequate or affordable housing, substance use and/or mental health issues. The MCMs use various resources for assisting clients in obtaining financial assistance for housing (through HOPWA funds at AID Atlanta, The Living Room, Traveler's Aid, private funds, local churches, and other organizations providing such assistance). AID Atlanta MCMs also identify and link clients to other agencies and community resources for mental health care, substance abuse treatment, medical care, food, clothing etc.)

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

Georgia/Part B

The organizational structure of the Georgia Department of Public Health, Office of HIV/AIDS allows for collaboration and coordinated efforts between the Prevention and Care Programs. These efforts decrease the likelihood of duplication of efforts by streamlining the way funding is utilized in order to ensure the continuity of prevention, care and treatment services.

Examples of this interaction include linkage services to Ryan White clinics provided to newly diagnosed individuals through the Prevention program. The Ryan White Part B program incorporated language into the policies and procedures that emphasizes that clinics do not need a confirmatory test in order to begin the linkage process with an aim at shortening any wait times for clients to begin receiving care. In addition, through the Care and Prevention in the United States (CAPUS) Initiative, a statewide online Resource Hub was created to be the primary resource in Georgia for testing, prevention and care for HIV/STD/Viral Hepatitis/TB, and related psychosocial and social determinants of health. 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. This will help reduce barriers to program enrollment, and expediting clinic admission for patients. The anticipation is that linkage to care will increase, and that time to linkage will decrease. The CAPUS team has worked closely with Ryan White Part B State Office Staff and local Case Managers to make sure that the Eligibility Portal aligns with their process.

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

Need to talk about local level programs and coordination and GPACC and inclusions of other funding sources. What about roles of Parts C and D outside EMA. JPPG and other coordination.

Atlanta EMA/Part A

HIV Prevention Programs: Based on the 2010 National HIV/AIDS (NHAS), the Centers for Disease Control (CDC) revised its funding for the "Comprehensive Prevention Program for Health Departments" to ensure federal HIV prevention funding allocation to jurisdictions with the greatest need. With its 2012-2016 funding cycle, CDC expanded the number of cities to receive direct HIV Prevention funding from six to ten, including the Atlanta area. The Georgia, the Department of Public Health (DPH) is the recipient of the remainder of funding in Georgia through the CDC Prevention Program. DPH is responsible for coordinating the HIV Prevention Planning Group, developing and implementing the Georgia HIV Prevention Planning Group, and coordinating the HIV testing and data reporting for the state. The program also provides funding to community based organizations and public health districts throughout the state to conduct HIV counseling and testing.

The CDC HIV prevention funding was awarded in 2012 to the Fulton County Department of Health and Wellness (FCDHW), a Ryan White Part A subrecipient, to implement the HIV Prevention Program. Additionally, the FCDHW subcontracted with the DeKalb County Board of Health to perform HIV prevention activities to reduce the number of new HIV infections in DeKalb County. In an effort to better integrate prevention and care services and activities to support clients as they move along the continuum, Fulton County is developing an HIV Services Coordination Office that consolidates the HIV Prevention Program with the Fulton County Ryan White Part A Program under the leadership of the Part A Director. This office, which provides oversight for both programs, affords a more comprehensive view of the continuum and successes/challenges in moving clients along the continuum. It also leverages the proven record of the Ryan White grants management process and facilitates coordination of prevention and treatment services in the EMA.

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, Ryan White Part A staff 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 Atlanta Area Outreach Initiative (AAOI) which has focused on educating persons living with HIV on the need to access care, remain in care, and become virally suppressed. In 2014, the CDC-funded High Impact Prevention Program co-sponsored the AAOI and incorporated HIV and STD testing, linkage to care, and education on treatment as prevention. The AAOI is a day-long session focusing on persons who are living with HIV, are aware of their status, but are not in care or have been lost to care. This initiative seeks to facilitate access to care, and also serves as a

mechanism for evaluating barriers which have kept these individuals from care. Beginning FY14, AAOI expanded its focus to include consumer education on insurance eligibility and enrollment.

Opt-out HIV testing has been implemented in the emergency room of the largest public hospital in the EMA. Persons testing HIV positive are connected with linkage coordinators who assist in accessing care in Ryan White and non-Ryan White funded facilities.

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

Atlanta is one of 12 municipalities that are participating in the Enhanced Comprehensive HIV Prevention Plan (ECHPP). The Atlanta ECHPP focuses on developing and enhancing strategies to address HIV and AIDS in the Atlanta EMA. It incorporates a combination of initiatives related to scaling up certain activities including HIV testing in clinical and non-clinical settings, linking HIV+ individuals to care and treatment services, medical and treatment adherence interventions for persons who are HIV+. Strategies also include partner services and condom distribution. ECHPP also includes activities that address individuals who are HIV negative and at high risk of infection.

In addition, the Georgia DPH is a Care and Prevention in the United States (CAPUS) Demonstration Project grantee. The purpose of this CDC funded demonstration project is to reduce HIV and AIDS-related morbidity and mortality among racial and ethnic minorities living in the U.S. Georgia CAPUS goals include increasing HIV testing, linkage to, retention in, and re-engagement with care, treatment, and prevention; enhancing navigation services; using surveillance data and data systems to improve care and prevention; and addressing social and structural factors directly affecting HIV testing, linkage to, retention in, and re-engagement with care, treatment, and prevention. One of the key CAPUS components is the Metro Atlanta Testing and Linkage Consortium (MATLC) which was created to provide formal coordination among agencies providing HIV testing services. MATLC uses quarterly meetings, statistical data, and geospatial maps in order to strategize best practices for outreach to target populations, geographic areas served, and timing of testing events or services. The consortium also helps agencies to avoid duplication and gaps in services, as well as inefficient targeting of resources.

One significant CAPUS component is the Resource Hub, which went live in 2015. The CAPUS Care Portal has four components: 1) an eligibility portal to help determine pre-eligibility for Ryan White services; 2) mapping and testing to improve the effectiveness and efficiency of testing in Georgia; 3) an online resource directory to locate HIV testing, HIV medical services, housing assistance, and mental health services 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.

Care and Treatment: Metro Atlanta has a coordinated service HIV/AIDS service delivery system which encompasses a comprehensive range of primary care, other core services, and support services for individuals and families infected with, and affected by, HIV disease. These services are accessible to all eligible PLWHA in the EMA. Included in this delivery system are mechanisms to facilitate access and retention in primary care for: newly diagnosed; underserved; hard to reach individuals and/or disproportionately impacted communities of color; and, those who know their HIV status but are not presently in HIV primary medical care. The EMA strives for cultural competency in the provision of all services. The Atlanta EMA's system of care is consistent with HRSA and NHAS goals of increasing access to services and decreasing HIV health disparities among affected subpopulations and historically underserved communities.

There are well established relationships with the Part A, Part B, Part C, and Part D Ryan White programs in the EMA as well as in Georgia with other programs that provide prevention and care services for individuals living with HIV/AIDS. In this environment of limited funding for HIV/AIDS and the increased prevalence among emerging populations, integration and coordination of services ensures timely, uninterrupted care. Atlanta Ryan White Part A (only Part A program in Georgia) funds the majority of services in the 20-county EMA, with Parts B, C, and D contributing a small percent. The attached table highlights the coordination of services and funding in the 20-county Atlanta EMA.

The ***Atlanta EMA Part A*** Program funds 16 service providers and these providers are located throughout the EMA. 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 Part A funds, 8 of which are located in Fulton and DeKalb Counties. The 3 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. As described in HIV Workforce Capacity description above, other core and support services are provided by agencies located throughout the entire EMA. Many agencies 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 primary care, as well as client choice.

The EMA's primary care system increases access to care for all clients and targets services to women, infants, children, youth, minorities, and underserved populations by providing services that are located where the clients are, are driven by standards of care, and are complemented by a series of supportive services. Primary care sites are co-located with counseling and testing sites to promote seamless access to care. And in an effort to facilitate access to and retention in care by People of Color, all Minority AIDS Initiative (MAI) funds are allocated to the Primary Care service category.

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

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

"Client trackers" provide follow-up if clients begin to exhibit a pattern of missed appointments and/or there are problems in locating a client. Once located, the individual is referred to a case manager or other social service provider who assists with re-entry into the primary care system.

Ryan White-eligible clients often enter the continuum of care through the public health system upon notification of positive HIV test results and upon completion of the counseling process in clinics where counseling and testing and care programs are co-located. The counseling and testing staff personally escorts the client to the clinic to initiate enrollment. Medical case managers, peer counselors, and/or social service providers furnish information regarding available HIV services and refer clients to facilities for receipt of care, specialized treatment and support services. Upon referral to one of the primary care sites, a client receives immediate intake and enrollment and are screened for medical case management, mental health, and substance abuse needs. Clients receive confirmatory diagnostic testing, a TB skin test, a medical examination, and consults with the care provider regarding treatment options. In addition to a comprehensive physical examination, a variety of services are provided including viral load and CD4 testing; resistance testing if warranted; family planning services; vaccines; and, other preventive and therapeutic medical services. Women seeking prenatal care at the primary care sites are informed of the benefits of knowing their HIV status and are encouraged to have a confidential HIV antibody test as a standard of care. If a woman who is pregnant, or of childbearing age, tests positive for HIV disease, she receives counseling and information regarding the current recommendations for antiretroviral treatment to minimize perinatal transmission of the virus, provision of such medications if she consents, and referral to an HIV obstetrics specialist.

Part A funded agencies strive to provide "treatment on demand" and enroll the client in programs specifically designed for clients with active substance use or abuse histories. Via agency or self-referral, clients link with medical services, mental health services,

housing, drug treatment services, detox beds, legal services, and emergency assistance. Other services include: information on HIV/AIDS risk reduction; early intervention; disclosure; discussions on sexual behavior; and, prevention methods that promote personal responsibility. Client trackers locate individuals lost to care to return clients to care and/or case finders to facilitate treatment referrals.

The current continuum includes provisions for comprehensive mental health services (including medications) provided by certified mental health professionals to individuals, groups and families affected by HIV disease. Clients' access services directly, or through referrals by other providers. The client is broadly assessed for depression, risk of suicide, substance abuse and addiction. In addition to the psychological assessments, clients are educated about services available to them and their rights and responsibilities as clients. Services are linked to primary care, medical case management, treatment education, and support services. EMA agencies employ dual diagnosis clinicians who are trained and licensed in both fields to meet the changing needs of newly affected and underserved populations. Funds also support specific services for Communities of Color and underserved populations, including the availability of mental health counselors and bilingual professionals. Client trackers are used to locate individuals lost to care in order to return to care and/or case finders to facilitate treatment referrals.

Oral health services in the continuum of care emphasize the provision of comprehensive, high quality client-centered oral health services for HIV-infected persons in collaboration with primary care providers. Patients receive an oral health assessment (either directly or through contractual arrangement) in conjunction with the medical assessment received at primary care sites. Comprehensive oral health services include preventive, periodontal, restorative, endodontic, surgical, and prosthetic care as well as management of oral manifestations associated with HIV disease. Medications used to prevent dental decay, treat periodontal diseases and manage oral pathology are covered within this category of care.

In order to maximize the funding designated to medical case management, the EMA currently operates a centralized client-centered system1. The centralized system ensures accountability for service delivery, parity regardless of point of entry, and improves the quality of service delivery. The agency outstations medical case managers at: CT facilities; primary care clinics; AIDS Service Organizations (ASOs); community-based organizations (including minority Community Based Organizations (CBOs); local jail pre-release programs; and HIV/AIDS housing facilities. Additionally, services include bilingual case managers located in sites with concentrations of non-English speaking communities. Having medical case managers at all primary care sites serves to provide a smooth transition into the continuum of care by enabling clients to have their medical and social needs met at one location. Clients are evaluated during regularly scheduled Individualized Service Plan (ISP) assessments to determine readiness to "graduate" from medical case management to self-management. Clients not requiring medical case management at that time may be referred to peer counseling (funded under psychosocial support) for referral and information services and are provided with a resource packet

[1] The model will be modified in 2016 to allow agencies that are interested in hiring their own Case Managers to do so.

that identifies available services. Clients may be re-evaluated as conditions change. It is important to note that treatment adherence counseling is provided to all clients by registered nurses at the primary care sites as a separate component of medical case management.

On-site medical case management services for HIV patients are available at all Part A primary care sites and at the local Veterans Administration (VA) hospital. Case managers assist in coordinating other services to reduce barriers to care such as: making transportation arrangements, identifying appropriate childcare services, facilitating access to emergency financial assistance, mental health and substance abuse counseling services, and obtaining legal services.

Case manager aides assist eligible clients with enrolling in the Health Insurance Market, State ADAP, Health Insurance Continuation Program (HICP), and the Patient Assistance Programs of pharmaceutical companies (PAP). On-call case managers are available after normal business hours, at the funded case management agency to assist clients in identifying or locating care and treatment resources, including assistance with bilingual and sign language needs. These include persons who have relocated to the EMA or individuals referred by the statewide AIDS Information Line.

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

The Atlanta EMA treatment and care continuum includes essential support services that remove barriers to care for the newly affected and the underserved. In order to ensure that support services lead to improved health outcomes, the EMA has a policy, requiring clients be enrolled and receiving primary care before being eligible for such services as: food, emergency assistance, psychosocial support, legal assistance, and childcare. Translation services are available in Spanish and American Sign Language throughout the continuum in an effort to increase access to care, maintain clients in care, and reduce disparities in care.

The core of substance abuse and mental health treatment services in Georgia is funded through the Georgia Department of Behavioral Health and Developmental Disabilities (BHDD). Georgia has a set-aside for services to PLWHA in substance abuse treatment funding from the Substance Abuse Mental Health Services Administration (SAMHSA) for HIV/AIDS services through BHDD. The required 5% set-aside for HIV is $2,517,908. Part A funded outpatient and residential substance abuse treatment programs expand the capacity to address the increasing demand and facilitate access to care and treatment for the dually diagnosed.

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.

Part B Services, including the AIDS Drug Assistance Program (ADAP)*:* The Part B program, administered by Georgia DPH, provides care and treatment services. These services include those provided by ADAP and the Health Insurance Continuation Program (HICP). Grady IDP receives Part B funding to provide care for infants and children living outside the 20-county EMA. All primary care clients within the EMA are screened for ADAP eligibility. If eligible, applications are submitted to DPH to complete the enrollment process. DPH contracts with the Grady Health System, which participates in the State's ADAP Contract Pharmacy (ACP) Network. The pharmacy is co-located within the Grady IDP (Part D grantee as well as one of the Part A funded primary care providers). IDP clients within the Atlanta EMA can pick up their ADAP medications.

Part C Services: There are 17 Ryan White Part C programs in Georgia, providing outpatient HIV early intervention services and ambulatory care such as testing, counseling, partner notification and treatment. Part C programs located in the Atlanta EMA include: Positive Impact Health Centers, Cobb County Health Department, DeKalb County Health Department, Hemophilia of Georgia, Inc. Emory Midtown, and St. Joseph's Mercy Care Services, Inc. Five of the Part A primary care sites are also Ryan White Part C funded recipients. Part A and D funds do not supplant services funded by Part C, or for any other funding source.

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

IDP Family and Youth Clinic staff work closely with High Risk OB Nurse in the Grady Women's Health high risk OB Clinic for HIV+ Women to ensure pregnant women living with HIV receive coordinated services. A Grady IDP social worker provides case management services onsite at the weekly OB clinic. In addition, two of the Physician Assistants (PAs) from the Family Clinic visit the HIV OB clinic on the first and third Wednesday of the month (the clinic is held weekly on Wednesdays) so that the PAs can meet with future patients and establish a relationship with them. It also allow 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.

The Atlanta Family Circle Ryan White Part D Program aligns its service delivery with that of the Part A Program. As described above in the HIV Workforce Capacity description, Part D Program services include linkage to care services for women and adolescents who have been identified to be lost to care, health education and risk reduction workshops for HIV+ women and youth, HIV counseling and testing drives for high-risk women and youth; referral and linkage of HIV+ women and youth identified during counseling and testing drives, and peer education services to help recruit and retain HIV+ youth and women in primary medical care. One-on-one adherence counseling is provided for HIV+ pregnant women attending the Grady Hospital OB High Risk Clinic as well as assistance in management of treatment regimens, side effects, and serious adverse reactions to therapies, coordination of prenatal care and resource referrals for clients, linkage with the OB social work case manager, and linkage to available research and support groups. Primary care and specialty care are provided to children and adolescents in the Grady IDP Family and Youth Clinic as well as adherence counseling for women, children, and youth and case management services. All funded Part D agencies are required to provide representation on the Part A Planning Council and serve on assigned committees.

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

Integration of prevention and care and treatment planning at the Part A level: A number of activities have been implemented by the Atlanta EMA to integrate prevention and care planning.
Some specific activities include:

- Participation of Part A Planning Council member on the DPH Prevention and Care Community Planning Group and Fulton County prevention program's Jurisdictional Prevention Planning Group. The Director of the Ryan White Program also serves on the DPH Prevention and Care Community Planning Group.
- Part A Planning Council Members and the Director of the Ryan White Program serve on the "Fulton County HIV Task Force" which is developing a roadmap for the elimination of new cases of HIV in Fulton County.
- Cross-pollination between the Ryan White Part A Planning Council and the Fulton DeKalb Jurisdictional Prevention and Planning Group (JPPG). Six of the eight committees of the Planning Council have members who also serve on the JPPG; and four of five committees of the Prevention planning body have members who also serve on the Planning Council.
- The Department of Public Health and Fulton County Department of Health and Wellness presented information to members of the Quality Management Committee

and shared information and identified opportunities to coordinate services to avoid duplication.

- The Part A Planning Council Project Officer and Planning Council members participate on the 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.
- The EMA's annual Atlanta Area Outreach Initiative has fully integrated a prevention component in both the planning and delivery of educational sessions.
- During FY15 the Housing Committee of the Planning Council worked with the Jurisdictional Prevention and Planning Group to develop a series of two Housing Forums designed to meet the goal of the National HIV AIDS Strategy by increasing the number of Ryan White clients with permanent housing from 82% to 86%.

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

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

Georgia/Part B

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

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

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

What are resources needed in the Part A and Preventions Programs?

D. Assessing Needs, Gaps, and Barriers

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

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

The Georgia Ryan White Part B program utilizes funded agency data to update statewide activities and prioritize the key areas of focus for the funding year. In addition to working with each funded agency and consortium to develop a needs assessment, the state also collaborates with other Ryan White Program grantees and providers to ensure that identified disparities in health care infrastructure are addressed. Needs assessments conducted by the 16 funded agencies show that, in order of importance, the five most needed services are: Primary Care, Medical Case Management (CM), Oral Health, Non-Medical CM, and Medical Transportation Services. These five needs are identified across the state regardless of where HIV positive individuals reside (urban, suburban, or rural) as priorities by the consortia. Other needs identified by rank mirror the overall lack of services in the communities where PLWHA reside. Rural populations identified transportation as a higher ranked need while suburban and urban regions ranked mental health and emergency financial assistance as a greater need.

Specific to the development and implementation of the Integrated HIV Prevention and Care Plan, the program reached out to each of the 16 Consortia for feedback for the integrated plan. They were asked to provide insight as to the advantages of plan integration, areas of interest, types of guidance/tools that would be helpful, characteristics of the communities, and goals/objectives they would like to see included in the plan.

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

The Atlanta EMA held a Stakeholder's Meeting. Participation in Consumer Surveys, etc.

Utilizing community advisory groups (CAGs) assisted Fulton/DeKalb Counties with targeting, recruiting, and retaining participants in the HIV planning process. Each CAG has a work plan to ensure that deliverables are met.

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

Persons at risk for HIV are in need of HIV prevention education and the availability of resources to support the establishment of pre-exposure prophylaxis (PrEP) clinics and the provision of PrEP services (medication and clinical follow-up).

The top service needs identified for PLWH were housing and transportation. Housing options and shelters are usually scarce throughout the state posing difficulties for agencies to place clients who need housing or shelter as a basic necessity before they are able to fully engage in care.

Rural areas of the state identified several issues with transportation, including lack of public transportation, and limited transportation providers. Higher costs were also described, as clients often have to travel for longer distances in rural areas for their medical appointments.

HIV prevention and care service needs of persons at risk for HIV

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

The Fulton County HIV Task Force estimates that 18.7% of Georgians are living with HIV infection but are unaware of their HIV serostatus, and that 20.8% of men who have sex with men (MSM) in Georgia are infected but undiagnosed.

Decreasing the number of persons who have HIV but are unaware of their status will require expansion of routine opt-out testing in healthcare settings, coordinated and strategic use of non-healthcare setting testing targeted toward disproportionately affected populations, as well as expansion of partner services to provide testing and education to partners and sexual networks of persons with HIV. Increased identification of acute HIV infection will require widespread use of new "4th generation" HIV tests that are able to detect HIV infection earlier than older tests, including during the acute phase. Point-of-

care rapid 4th generation tests are available but are not widely used in Fulton County. State and County data systems must be modified to classify correctly persons identified with acute infection, and to use these data in a timely manner for maximal impact on prevention and care. While these systems are being developed, both providers and public health staff need education on the proper management of persons with acute infection, and the need to rapidly link them to medical care and other services to support retention in care.

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

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

<u>HIV prevention and care service needs of PLWH</u>

Early initiation of ART and retention in HIV care are central to achieving viral load suppression and reducing mortality and progression to AIDS [Mugavero, 2012; Mugavero, 2009]. Linkage to care is the first step in this process. Nationally and locally, there are large disparities in linkage to care by race, gender, age, and transmission risk. Understanding the relationship between local geographic factors and initial linkage to care for HIV-infected persons and

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

Among the 726 adults and adolescents diagnosed with HIV infection in 2013 in Fulton County, living as of 12/31/2014, 52% were minimally engaged in care with at least one CD4 or VL 4-15 months after diagnosis and 36% were retained in care with at least 2 CD4 or VL measures 4-15 months after diagnosis. Racial/ethnic disparities are apparent when examining these data. Only 36% of Blacks and 38% of Hispanic/Latinos were retained in care. Among Whites 40% were retained. Retention in care is also lower among young patients with only 35% of those aged 25-29 retained in care, compared with 40% of those aged 45-49. In Fulton County, 41% of persons diagnosed with HIV are virologically suppressed (note that this is among known diagnoses as opposed to among all HIV-infected. Among patients who made it to clinic (engaged in care), 73% achieved viral suppression in 2011 [Doshi, 2014]. However, even among patients who have engaged in care only a minority (39%) maintain their viral suppression for three years in a row [Colasanti, 2015].

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

Having excellent therapies for HIV is meaningless without adequate healthcare systems to deliver them. Decreased numbers of HIV-trained care providers threatens to undermine HIV care programs and add additional barriers to fulfilling care obligations for the increasing numbers of persons living with HIV. Unfortunately, even when funding is available, clinics report difficulties in

finding physicians, nurses, including advanced practice nurses, and physician assistants. Difficulty in hiring staff results in fewer patient care slots, and lower clinic and private practice capacities. Public clinic sites often cannot match salaries that can be earned in the private sector. Physician training in HIV is often suboptimal, and many infectious disease (ID) programs are unable to fill their programs.

Service needs identified by the EMA during its priority setting process included:

- **Oral Health Services**: preventative dental care service to correct dental problems, and emergency dental services either through the direct provision of services at clinical sites or through referrals to external providers.
- **Medical Nutrition Therapy:** registered dietitians to provide nutritional assessments, counseling, education, healthy eating classes, and the provision of medically-required nutritional supplements.
- **Medical Case Management**: medical case management staff to work with clients and the medical teams to develop an individualized service plan to support the client in linking to care, being retained in care, accessing retroviral therapies and becoming and remaining virally suppressed (including provision of adherence counseling). Client assistance is also needed with active referrals and advocacy to meet clients' medical and social needs. In addition, ongoing adherence assessments and counseling is needed.
- **Mental Health Services**: individual and group mental health counseling, psychiatric services as needed for therapy and medication management, and provision of mental health medications. Counseling services supporting clients with a history of intimate partner violence are also needed.
- **Substance Abuse Services**: To reduce service gaps and lay the foundation for individuals to engage in and maintain consistent relationships with physicians, case managers and other social service providers, substance abuse treatment models are needed to address all stages of addiction and recovery. Needed services include bio-psychosocial assessments, individual and group substance abuse counseling and after-care programs, and psychiatric services as needed. Needed programs include addiction and specialized sexual identification education groups; targeted programs for of both the homeless; certified treatment teams coordinate with health professionals and a broad community network of providers to ensure that individualized treatment plan addresses each client's addictive disorders, as well co-occurring disorders.
- **Health Insurance Premium Assistance**: financial assistance with annual premiums and some of out-of-pocket expenses such as Medication Co-Insurance Payments to assist low-income clients who have private insurance via the Health Insurance Marketplace or another private insurance plan.
- **Case Management Non-Medical**: client benefits specialists, ADAP enrollment specialists, and non-medical case managers who work with self-managed clients that do not require intensive medical case management, are relatively stable, but who still need help with access to medications, insurance premium assistance, and other client benefits programs or only need low intensity case management services. Needed services provided by non-medical case management include basic resource

information, one time assistance issues, self-management workshops and adherence educational programs, benefits and financial counseling, ADAP or Health Insurance Continuation Program assistance (HICP) enrollment assistance, PAP (Client Assistance Programs) or help clients to gain access to Affordable Care Act plans.

- **Food Bank/Home-Delivered Meals:** home-delivered meals, pantry meals, meal replacement snacks (for clients who miss meals during clinical appointments, mechanical soft meals (persons experiencing pain/ discomfort due to dental services) to allow for the proper absorption of medication for clients receiving oral health treatment), and grocery vouchers.
- **Psychosocial Support:** support groups, peer counselors, patient navigators, and insurance navigators.
- **Medical Transportation:** transit passes, cab fare, gas cards, and Uber services to facilitate connection to medical appointments, essential support services, and benefits enrollment sessions.
- **Legal Services:** free legal services to help clients obtain/maintain their insurance coverage; secure payment for necessary medical services; protect their jobs; access Social Security, SSI, and other income benefits; protect their confidentiality rights regarding health status; and, conduct end-of-life planning business through preparing wills and advance directives.
- **Linguistics Services**: support for language interpretive services in many languages, including American Sign Language for the hearing-impaired as well as a telephone "language line" for many other languages. Services and materials should be designed to accommodate varying literacy levels among clients in the provision of treatment and dissemination of treatment-related information.
- **Child Care Services**: onsite child care for children while the parent/caregiver attends to medical appointments or other core or support services.

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

<u>Georgia/Part B</u>

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

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

<u>Atlanta EMA/Part A</u>

- Oral Health Services - 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%), African Americans (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.

- Medical Nutrition Therapy - Needs Assessment: Ranked #5 in gaps in services with a 14% gap between those reporting a need for the service and those who received the service in the 2011 survey. Ranked #3 among males of all races with a gap of 30% and #1 among Latinos (39%). The gap increased to 26.6% in the 2014 survey and the gap for nutritional supplements was 37.6%).
- Medical Case Management - Needs Assessment: Ranked #9 in gaps in core services with a 7% gap between those reporting a need for the service and those who received the service (2011); the gap increased to 10.7% in the 2014 survey. The 2012-2015 State of Georgia Statewide Comprehensive HIV Services Plan lists Medical Case Management as the 2nd among the five most needed services.
- Mental Health - Needs Assessment: In the 2011 survey, 31% of respondents (n=223) reported having received substance abuse-outpatient services. Of those, 43% reported having multiple services, 35% received group counseling, 12% received 1-on-1 counseling, and 3% received group counseling. Ranked #10 in core services needed but not received with a gap of 7%. The gap increased to 14.8% for individual counseling and 16.7% for group counseling in the 2014 survey.
- Substance Abuse - Needs Assessment: in the 2011 survey, 31% (n=223) reported having received substance abuse services since becoming HIV-positive. Of those, 43% had received multiple services, 35% had received group counseling and 12% had received 1-on-1 counseling. The need for 1-to-1 or group substance abuse counseling ranked as the #10 highest core service needed but not received with a gap of 7%. In the 2014 survey, there was a gap of 15% between those needing individual counseling and those receiving it and a gap of 17% for group counseling.
- Health Insurance Premium Support - Needs Assessment: In the 2011 survey, 51% had some type of health insurance (of those, 60% had Medicaid). The need for pharmaceutical assistance was ranked #6 with a gap of 11%. In the 2014 survey, 54.6% had some type of insurance coverage – 15% had signed-up for insurance via the ACA. 36.7% reported having a need for Premium Assistance (n=117) with 35.9% having that need unmet. When asked of the need for Medication Co-Pay Assistance, 46.4% (n=147) indicated a need with 23.8% indicating the need was not met.
- Case Management Non-Medical - Needs Assessment: In the 2011 Consumer Survey, the need for benefits counseling (a component of case management non-medical) ranked at #6 of gaps in need for support services (15%). In the 2014 survey, 37.4% indicated need for the service with 19% indicating an inability to get the service.
- Food Bank/Home Delivered Meals - Needs Assessment: In the 2011 Consumer Survey, food vouchers was the #1 service needed but not received among support services with a gap of 40%, followed by food pantry ranked #4 with a gap of 19%, followed by home delivered meals at #7 with a gap of at 14%. The gap in need for

food vouchers was ranked #1 among males (39%) and females (44%), #1 among African Americans (39%), #2 among Latinos (38%), #1 among Whites (42%), #3 among young MSM (40%), and #1 among persons over 50 years old (34%). The gap in need for food pantry was ranked #2 among transgender (50%).

- Psychosocial Support Services - Needs Assessment: In the 2011 Consumer Survey, the need for patient navigation services (a component of psychosocial support) was the #10 support service needed but not received with a gap of 11%. In the 2014 survey, there was a gap of 29% for peer counseling/support groups and a gap of 28% for patient navigation services.
- Medical Transportation - Needs Assessment: Medical transportation was not identified as one of the top 10 gaps in service for support services in the 2011 survey. In the 2014 survey 28.8% of all respondents identified a need for the service; there was a gap of 32.6% between those identifying a need for the service and those who received the service.
- Legal Assistance Services - Needs Assessment: In the 2011 Consumer Survey, the need for legal assistance services was the #5 support service needed but not received with a gap of 19%. In the 2014 survey, there was a gap of 51%.
- Linguistic Services - Needs Assessment: In the 2011 Consumer Survey, the need for linguistics services did not rank among the top 10 gaps in services. In the 2014 survey, there was a gap of 12%.
- Child Care Services - Needs Assessment: In the 2011 Consumer Survey, the need for child care services did not rank among the top 10 gaps in services. In the 2014 survey, there was a gap of 20%.

<u>Prevention Service Gaps</u>

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

- Identifying point of entry sites to develop a network of service providers offering HIV testing
- Strategic social media messaging for HIV prevention services
- Peer navigators to link HIV infected clients to care services
- Routine HIV testing offered across populations and locations
- On-site confirmatory HIV testing
- Multi-lingual service option
- Culturally competent services for all clients

Community forum participants identified specific challenges and needs, including environmental barriers that include:

- Routine HIV testing in healthcare settings
- Additional time allotted with physicians during appointments
- Integrated community education about value of testing for HIV and other STIs
- Health literacy of client
- Client adherence to HIV treatment

- Lack of services for transgender population
- Medicaid restrictions, other treatment funding challenges
- Lack of patient navigators to guide clients through healthcare system
- At-risk individuals require more tailored prevention education
- Lack of comprehensive sexual health education
- Lack of access and availability of health care
- Knowledge of healthcare providers regarding HIV/AIDS and HIV/AIDS treatment

Additionally, gaps in HIV services identified in the 2011 Georgia Department of Public Health Enhanced Comprehensive HIV Prevention Plan (ECHPP) are as follows: Lack of established guidelines for directing resources to areas with high morbidity in the Atlanta Metropolitan Statistical Area (MSA) (Georgia of Public Health Enhanced Comprehensive HIV Prevention Plan, 2011). Reach: Lack of guidelines to follow on how interventions are selected for MSA and statewide use; Coordination: Although testing is often provided at locations requested by community groups or organizations, these efforts have been limited by a lack of monitoring, tracking and evaluation, and comprehensive, standardized and sustained HIV training and technical assistance; Services: Opt-out testing in clinical settings (public and private) is not being conducted by all service providers due to "capacity and comfort levels." Although, the Official Code of Georgia Annotated supports testing pregnant women for HIV, many providers are unaware of this regulation and do not routinely offer prenatal HIV testing. Furthermore, high risk individuals with co- morbidities (i.e., other STDs, viral and/or tuberculosis) are not consistently being offered opt- out testing in clinical settings (City of Atlanta [Fulton/DeKalb Counties] Jurisdictional HIV Prevention Plan, 2014).

d. Barriers to HIV prevention and care services:

Identified barriers to HIV prevention and care services are listed in the table below. In identifying barriers, a wide range of stakeholders were involved. However, in the Atlanta EMA domestic violence and injection drug user communities were invited, but did not participate in the process and provide input. The EMA will continue to work to engage these entities and individuals.

HIV Prevention and Care Services Barriers	
i. Social and structural barriers	<u>Social</u>: • Lack of awareness of risk for general population • Stigma related to behaviors of HIV risk for infection • Poverty • Discrimination <u>Structural</u>: • Lack of information and uniformity of HIV service provision

ii. Federal, state or local legislative/policy barriers	Federal/State: • Changing healthcare coverage landscape • Lack of funding for clean syringe exchange State: • Lack of Medicaid expansion – even after implementation of the Affordable Care Act, Georgia continues to have high rates of uninsured people due to lack of income and because Georgia has chosen not to expand Medicaid • HIV criminalization laws • Mandatory lifetime ban for Food Stamp assistance for those convicted of felony drug charges • Data sharing Local: • Testing and laboratory reporting barriers including lack of uniformity in lab work reporting, delays in lab reporting impacting monitoring, and difficulties in matching lab report data to a case in eHARS • Abstinence only education in schools • Criminal history is a housing barrier for PLWHA • Limited routine opt-out testing
iii. Health department barriers	• Effective Electronic Medical Records (EMR) systems • Staff shortage for partner services
iv. Program barriers	• Challenges in examining CAREWare data for the entire EMA and de-duplicating client services data for Part A subrecipients that are also funded by Part B. • Lack of trained HIV-care providers to address expanding caseload • Lack of centrally coordinated plan for geographic or population targeted HIV testing.
v. Service provider barriers	• Lack of resources to build provider capacity to serve more clients • Need for cultural competency training among services providers • HIV education/updates are needed for all providers • Competitive salaries for service provider staff
vi. Client barriers	• Financial barriers (co-pay and co-insurance

	assistance) • Health information privacy for adult and youth dependents utilizing private insurance for HIV services • Access to affordable housing and/or emergency/ transitional housing • Untreated mental health and substance abuse issues • Lack of/or inadequate transportation • Access to PrEP

E. Data: Access, Sources, and Systems

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

The Georgia Ryan White Part B Program utilizes CAREWare to collect client level data to complete the HIV/AIDS Programs Services Report (RSR). Information from this report was used as a mechanism to complete services provided under the financial inventory.

Primary sources of data and data systems included Ryan White HIV/AIDS Program Services Report (RSR) data, 2014 Atlanta EMA Ryan White Unit Cost Analysis; 2014 Atlanta EMA Unmet Need Analysis; 2011 Atlanta EMA HIV/AIDS Consumer Survey; 2014 Consumer Survey (Preliminary); 2013 Atlanta EMA Populations and Communities with Disparate Health Outcomes (A report of the Assessment Committee of the Metropolitan Atlanta HIV Health Services (Planning Council); 2013 Ryan White Statewide Client Satisfaction Survey; Georgia ADAP/HICP Update 2014; Georgia Ryan White Part B Update 2014; Georgia's Care and Prevention in the US (CAPUS) Update; Georgia HIV/AIDS Surveillance Data Presentation; and information on other available services in the community, including services by Ryan White Parts B and HOPWA.

b. Data policies that facilitated and/or served as barriers to the in developing the needs assessment and the HIV Care Continuum: Is there additional information for this section?

The willingness of State HIV epidemiology staff to provide needed epidemiological data facilitated the assessment process.

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

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

Data that would be beneficial to use in the future in order to continue the development of the HIV Care Continuum and the integrated plan include information from Federally Qualified Health Centers (FQHCs), Medicaid, Medicare, Veteran's Affairs (VA), and data from private providers. Data from these sources could help HIV programs achieve a

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

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

The Integrated HIV Prevention and Care Plan in the table below includes information requested in **a.-d.**

e. **Anticipated challenges or barriers in implementing the plan:**

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

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

B. Collaborations, Partnerships, and Stakeholder Involvement

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

Feedback for the integrated plan was gathered from the 16 regional Ryan White Part B Consortia. Each was asked to participate in an exercise to provide insight as to the advantages of plan integration, areas of interest, types of guidance/tools that would be

helpful, characteristics of the communities served, and goals/objectives to be included in the plan. Participation included medical providers, consumers, Ryan White Part A, B, C, D and F representatives, HIV/AIDS prevention representatives, community and religious leaders, community-based organizations, and AIDS service organizations, among others. Data from the 2013 Georgia Statewide Client Satisfaction Survey was also utilized. This information, along with state staff feedback laid out the foundation for the goal and objectives related to HIV care.

Collaborations, partnerships and stakeholder involvement were critical to the development and success of the Atlanta EMAs Integrated Care and Prevention Plan. The Atlanta EMA is committed to providing an integrated continuum of core and essential support services based on an assessment of the needs of the EMAs HIV population, those in care, out of care, and at high risk for HIV infection. Contributors to this plan included representation from the Metropolitan Atlanta HIV Health Services Planning Council, Ryan White Part A agencies, the Fulton/Atlanta Jurisdiction Prevention Planning Group, State of Georgia Part B Grantee, consumers, PLWHA, health departments, HOPWA grantee/agencies, youth organizations, academic institutions and other key partners along the HIV Care Continuum. Statistical data, epi analysis, needs assessments, emerging trends, agency level data, and anecdotal information were presented by participants to achieve a comprehensive strategy for addressing the needs within the EMA. The Fulton County Government Task Force on HIV/AIDS, through a series of community meetings involving stakeholders, PLWHA and high risk populations, was instrumental in providing data and objectives which proved to be an integral part in the development of this plan. Key focus areas included the following:

HIV Testing
- Knowledge of HIV Status
- Routine Opt-Out Testing in Healthcare Settings
- Targeted Testing for Disproportionately Affected Populations in Non-healthcare Settings
- Partner Services
- Program Collaboration and Service Integration: HIV, STI, Viral Hepatitis, and TB
- Systems Issues

Preventing HIV Infection
- Biomedical Prevention: PrEP, PEP, TasP
- Prevention for People Who Inject Drugs
- Condom Distribution

Care and Treatment for Persons Living with HIV
- Linkage To Care
- Retention and Reengagement in Care
- Viral Suppression
- Quality of Care

Social Determinants of Health
- Structural Issues Affection Healthcare Access and Delivery
- Structural Issues

In developing Georgia's Integrated Plan, the Metropolitan Atlanta (Part A) HIV Health Services Planning Council's Comprehensive Planning Committee began discussing the joint HRSA/CDC guidance for the Integrated Plan in July 2015. Given the size of each respective planning bodies for the various entities to be included within the Integrated Plan (Georgia Prevention and Care Coalition, the Part A Planning Council, and the Fulton and DeKalb Joint Prevention Planning Group), each planning group was charged with identifying representatives to serve as the "writing team". The Georgia Department of Public Health (DPH) took the lead in arranging for a consultant to meet with the writing teams, to guide their creation of the integrated plan and to compile one statewide plan for the state of Georgia. Agreements were reached by the various jurisdictions on the manner in which the plan would be created; assignments; and the timeline involved - including writing, compiling and drafting the total document, reviewing, receiving feedback, final editing, approval and submission.

Each team worked with their respective bodies to identify the objectives, strategies and prioritized activities/interventions, target populations, responsible parties, and resources needed to accomplish NHAS goals. For the Part A Planning Council, representatives of the following entities participated in meetings of its Comprehensive Planning Committee:

- Consumer Caucus
- Chair of the Planning Council
- AID Atlanta
- AIDS Healthcare Foundation
- Aniz, Inc.
- Atlanta Legal Aid
- Clayton County Board of Health
- Cobb-Douglas District Board of Health
- DeKalb County Board of Health
- Emory Infectious Disease Clinic (Emory University Midtown Hospital)
- Fulton County HIV/AIDS Task Force
- Fulton County Department of Health and Wellness
- Here's to Life
- HOPE Atlanta Traveler's Aid
- National AIDS Education and Services for Minorities (NAESM)
- Open Hand Atlanta
- Positive Impact Health Centers
- Poz Vets USA International
- Recovery Consultants of Atlanta, as well as
- Representatives of the Fulton County Ryan White Program office.

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

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

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

- The Atlanta Area Outreach Initiative
- Absolute Care
- Part A Planning Council Assessment Committee co-chairs
- Fulton–DeKalb Jurisdictional Prevention Planning Group
- Georgia Department of Public Health
- Georgia Equality
- Grady Infectious Disease Clinic
- The Health Initiative
- City of Atlanta Housing Opportunities for Persons With AIDS (HOPWA) program
- Part A Planning Council Housing Committee chair
- Mercy Care
- Morehouse School of Medicine

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

The Comprehensive Planning Committee held five meetings during the two months following the January 2015 Stakeholder meeting to draft measurable objectives and

strategies for each NHAS and borrowed from the 225+ ideas shared during the stakeholder table discussions to prioritize those activities with the greatest chance of yielding improved access to care and health outcomes for the EMA.

- The Fulton County HIV Task Force- The development of a local county plan to end the AIDS epidemic
- Community Based Organizations- HIV testing work plans that include priority populations and other HIV prevention services
- Atlanta Faith In Action (AFIA) Project- 2016 HIV prevention and testing plan for faith institutions in Fulton and DeKalb

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

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

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

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

C. People Living with HIV and Community Engagement

a. People involved in developing the Plan are reflective of the epidemic: Who is funded for Part F?

The people involved in developing the Integrated HIV Prevention and Care Plan included medical providers, consumers, Ryan White Part A, B, C, D and F? representatives, HIV/AIDS prevention representatives, community and religious leaders, community-based organizations, and AIDS service organizations, among others. Involvement from

these stakeholders is reflective of the epidemic because it encompasses both individuals who provide services as well as those who utilize the services

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

Consumers serve in positions of leadership including serving as co-chairs of all Council committees. The Planning Council Consumer Caucus, which meets monthly, provides the opportunity for consumers to provide valuable input to the Council and Part A Program, including Integrated Plan development. The GPACC, Consortium, JPPG, and Fulton County HIV Task Force also include consumers. In addition, in inviting participants to the January 2015 Integrated Plan Stakeholder meeting, emphasis was placed on inviting consumers that were reflective of the Atlanta EMA epidemic.
In order to ensure that The Fulton/DeKalb HIV Jurisdictional Planning group was reflective of the epidemic the Executive committee assigned the task of conducting a needs assessment to the membership committee in the spring of 2015. Over the course of 4 months the membership committee looked at the composition of the current members paying particular attention to demographics such as: age, gender, sexual orientation, race, HIV status and location of residence. Among the findings of the committee included that the planning body was composed of a majority of African Americans persons who overwhelming represented Fulton County. The report also indicated that African American males and females were overwhelming represented by the body with females representing just a slight majority participants. In terms of sexual identity a slight majority of participants identified as heterosexual. At the time of the assessment there were two persons who were identified as YMSM along with individuals who is transgendered.

The membership committee recommended that that during the next recruitment cycle that the body make an effort to recruit and retain more YMSM, transgendered persons, people who reside in DeKalb county zip codes, along with more persons who reported an HIV positive status. The recommendations were accepted and the additional task was given to the membership committee to seek out persons who could fill the reports gaps. By the fall of 2015, a recruitment effort was underway to both replace some members who dropped out and to fill in new membership slots which the body voted to bring aboard. The result of the recruitment effort was that the Fulton/DeKalb Jurisdictional planning

group was more representative of the epidemic that existed in the jurisdiction. An additional three men of color were recruited with two of these persons having disclosed a positive HIV status all residing in DeKalb county zip codes. Efforts to recruit additional M to F transgendered person to the planning body have fallen short, yet the body is finding ways to engage and solicit the feedback from this community through a small transgendered advisory group.

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

b. Inclusion of PLWH contributed to the Plan development:

Feedback from PLWH was integral in plan development, especially when assessing behavioral decisions made related to care, and the quality of health care delivery. The inclusion of PLWH helped to develop goals and objectives that can help create more stable relationships with health care providers, improved compliance with medical advice and treatment, and increased retention in care.

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

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

Of JPPG's 30 members, approximately one-third of these persons have reported that they are living with HIV. Throughout the development of the plan, both the writers of the plan as well as the program administrators, made sure that PLWH contributed to its

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

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

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

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

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

Other engagement activities include needs assessments such as the recent health disparities assessment conducted by the Planning Council Assessment Committee, client

satisfaction surveys, and stakeholder meetings (e.g., January 29, 2015 Stakeholder meeting) as well as the valuable work of the Planning Council's Consumer Caucus, Assessment Committee, Quality Management Committee, and Comprehensive Plan Committee. In addition, an annual outreach initiative offered by the Planning Council helps the EMA engage with PLWHA and those at highest risk. The Atlanta Area Outreach Initiative (AAOI), an annual care initiative of the Planning Council, has been integrated in 2015 with the Atlanta/DeKalb High Impact Prevention Program to produce what is now known as the "Atlanta Area Outreach Initiative". The AAOI seeks to improve individual and community health outcomes by facilitating access to care through HIV prevention, linkage, care and retention. This educational forum focuses on getting individuals who are not in care linked to care as well as further prevention efforts. Event attendees have access to HIV testing, screening for STDs, exhibits, workshops, information on PrEP, linkage coordination, and other activities to inform and help our community defeat this epidemic. The AAOI meeting evaluation findings provide information that helps identify needed services. The Fulton County Government was the recipient of a National Association 2015 Achievement Award in recognition of the initiative.

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

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

Another method to engage high-risk communities throughout the jurisdiction is the utilization of mass media campaigns, in partnership with the Kaiser Family Foundation, which focuses on addressing HIV stigma, HIV testing, and access to care related issues. The campaigns, "Atlanta Greater Than AIDS" and "We Are Family" can be seen on billboards and bus kiosks throughout the jurisdiction within those zip codes with high HIV prevalence. The high priority zip codes include 30032, 30034, 30083, 30308,

30309, 30310, 30311, 30312, 30313, 30314, 30315, 30318, 30324, 30331, and 30344. The campaigns show representations of the epidemic as told through the stories of local individuals who are living with an HIV diagnosis. The campaigns promote the need for social and family support of those living with HIV as well as viewers increasing HIV awareness.

In addition to partnering with ASOs and the development of mass media campaigns to engage communities in the jurisdiction another method soliciting input has been through the use of the City of Atlanta (Fulton/DeKalb Counties) HIV JPPG, which is composed of members who represent the epidemic in the jurisdiction including young men who have sex with men, HIV positive persons, women, formerly incarcerated, gay and heterosexual men. Moreover, the City of Atlanta (Fulton/DeKalb Counties) HIV JPPG has established four community advisory groups (CAGs), which meet monthly: African American, MSM, Transgender, and Young Adult (ages 17-25).

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

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

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

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

Members of impacted communities and PLWHA are welcomed and encouraged to participate in and serve on the Part A Planning Council and its committees, including the Atlanta Area Outreach Initiative, Assessment, Comprehensive Planning, Council Procedures, Evaluation, Housing, Membership, Public Policy, Quality Management

Committees and workgroups. As part of orientation for all new Planning Council members, training on planning is included and a refresher is also offered at other meetings. Several Planning Council members also participate in HOPWA Providers meetings and on the Fulton County HIV Task Force's committees.

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

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

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

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

SECTION III: Monitoring and Improvement

A. Process for regularly updating planning bodies and stakeholders on the progress, soliciting feedback, and using feedback for plan improvement: How will the feedback be used for plan improvement?

Integrated Plan activities and outcomes will be shared with Ryan White and HIV Prevention funded agencies through program web pages and email correspondence. Agencies will be encouraged to disseminate the plan to consumers and local stakeholders. In addition, the plan will be shared with the statewide integrated planning body, G-PACC. Whose responsibility is it to share with local consortia?

With the input from Part A staff and relevant Planning Council committees and workgroups, the Council's Comprehensive Planning Committee will be responsible for updating EMA progress on plan implementation. At biannual intervals, plan updates will be provided 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 GPAAC and JPPG meetings.

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

Ongoing monitoring, input, and adjustment are critical in continuing to ensure that available HIV/AIDS resources in Georgia are maximized and the use of these resources are prioritized when changes to the system are needed. Goals and Objectives will be monitored by the Part B Program staff, in collaboration with Prevention staff and colleagues across other Ryan White Programs. Progress will be evaluated based on the measures indicated in the document and periodic updates provided to colleagues throughout the state, particularly those participating in the recent meeting to establish the plan.

The Ryan White Part B Program will continue generating reports from the CAREWare database to monitor consumer level utilization of core services. By complying with the Ryan White Services Report (RSR) reporting requirement, Part B funded health districts will continue entering client level data elements into CAREWare. Performance Measure reports generated in CAREWare continue to become more accurate and useful for quality improvement activities. RSR reports as well as performance measure reports are reviewed by the Part B Program staff and the Quality Management Core Team to identify opportunities for quality improvement.

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

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

In addition, Part A will implement contracts, as needed, for the provision of quality management activities including data collection from chart reviews at primary care sites, reporting of findings to QM Committee and Planning Council, training of committee and Planning Council members, and preparation and analysis of utilization and unit of cost data for the Atlanta EMA.

The Grantee and its funded agencies are contractually required to enter data into CAREWare's centralized server within two weeks of an encounter to assist with completeness and validity of reporting. Subrecipients are required to submit Progress Reports indicating the total of unduplicated clients and service delivery units for each funded category, Ryan White Data Report (RDR), and Program Services Report (RSR) each quarter. Providers funded through multiple Ryan White Parts are able to distinguish which clients are

served by each individual funding stream to avoid duplication of service. 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 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.
Quality of service indicators are also measured through data collection from chart reviews and/or CAREWare annually. Other data that will inform monitoring of Integrated Plan progress will include HIV surveillance data as well as evaluation-web data.

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

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

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

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

TESTING

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

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

HIV Testing - Aggregate –Healthcare Setting

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

Table 2: Clinical Testing

FOCUS Project Agency	**#Target**	**#Tests**	**Balance**	**%Completed**
Emory	3,000	5,671	(2,671)	189.03%
Grady	5,000	13,032	(8,032)	260.64%
Mercy Care	2,500	1,376	1,124	55.04%
TOTALS	**10,500**	**20,079**	**(9,579)**	**191.23%**

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

- **Test Atlanta**

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

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

DeKalb County Board of Health (DCBOH)

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

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

reflecting HIV testing beyond directly funded CBO's; to illustrate testing more broadly in the jurisdiction.

The Use of NAAT or Fourth Generation Testing in the Early Identification of HIV in Persons with Sexually Transmitted Infections (STIs) as a Means of Reducing HIV Transmission. Testing for acute HIV infection in persons from areas of high HIV prevalence who seeks STIs services will be performed because it has been shown that concurrent STI increases the susceptibility and transmissibility of HIV. FCDHW seeks to augment the existing HIV screening algorithm with enhanced testing to identify and treat highly-infective persons with acute HIV who would otherwise not be detected due to the "window period" of standard HIV testing, followed by partner notification and directed community outreach to prevent other new infections in high prevalence areas. FCDHW will implement new specimen pooling strategies to reduce the cost of NAAT without compromising capacity to detect acute HIV infection.

CONDOM DISTRIBUTION

Total number of condoms distributed overall (to HIV-positive individuals and high-risk HIV-negative individuals) during the reporting period: 2,327,774. HIPP exceeded the 2015 condom distribution goal of 2,170,068 by distributing 2,327,774 condoms within the jurisdiction. Approximately 549,000 (24%) of all condoms distributed went to individuals and to organizations that serve HIV Positive clients only.

Community sites distributing condoms request their customized condom packets and other materials via an email to the appropriate HIPP Condom Coordinator; at either FCDHW or DCBOH. In 2015, the FCDHW HIPP program upgraded its inventory control / distribution practices and moved HIV test kits, Condom, CTL test forms, and other related program materials off-site. This off-site warehouse is managed by a contractor who performs the fulfillment process for the program. Once the order has been submitted by the FCDHW Condom Coordinator, the requested items are shipped directly from the warehouse to the agency or organization; typically, in 3-5 business days. As the condoms are now housed offsite, FCDHW has discontinued its curbside pickup service at the health department. Preliminary feedback from the Condom distribution sites was favorable.

DCBOH also implemented an internal condom distribution tracking system. There are many successes related to the introduction of this condom distribution tracking database: (1) the uniformity of reporting across the jurisdiction; (2) condom purchases can be justified based on demand from distribution sites; (3) improved inventory control giving the DeKalb County Board of Health HIPP staff the ability to keep adequate supply to keep up with the demand; (4) the database has made for easier quarterly reporting of distribution numbers.

As a part of program collaboration and service integration within FCDHW, a public health educator attends every Ryan White new client orientation and provides condom education and demonstrations to each new client. The public health educator also discusses other risk reduction materials such as dental dams, proper lubrication, and STI prevention methods. In addition, to the Ryan White new client orientation the public health educators also provide

risk reduction materials and condom demonstrations in the Tuberculosis clinic at the Aldredge location. Also, a public health educator conducts a condom program overview and demonstration as a part of new employee orientation. The condom overview for new employee orientation is to ensure all staff in the health department are aware of the types and brands of condoms offered and where the staff person can retrieve the condoms if a client ask for a specific type or brand of condom in a clinical setting.

EBIs FOR HIGH-RISK HIV NEGATIVE INDIVIDUALS

A rotating schedule for Public Health Educators (PHEs) has been implemented. Staff rotate responsibilities for conduct educational sessions in conjunction with the EBI entitled Safe In The City (SITC) within the large clinic waiting area, TB waiting area, and the small waiting room of the Aldredge Clinic; taking advantage of the captive audience within these waiting areas as they wait to be seen by a DIS or clinician.

The PHEs conduct individual level interventions (ILI) with one-on-one conversations with clients on condom distribution and HIV prevention services.

SOCIAL MARKETING, MEDIA AND MOBILIZATION

Since 2014, the Fulton County Department of Health and Wellness has worked with the Kaiser Family Foundation to expand public information about HIV/AIDS in Fulton County as well as neighboring counties that encompass the Atlanta metro area with Greater Than AIDS messaging. The partnership localized and placed "We Are Family" media assets for television, radio, billboards, transit, digital and community promotions, including outreach materials and events.

Ads began running in November 2015 and pre-paid placements extend through March 31, 2016.

Highlights of the project to date include:

- Produced 121 localized media assets for television, radio, billboards, transit, digital and community promotions, including outreach materials (see designs in attached Media Kit and videos at atlanta.greaterthan.org or on provided USB/DVDs);
- Developed strategic media plan prioritizing Black/African American residents of Atlanta as a community disproportionately affected by HIV/AIDS;
- Created strong visibility among National HIV Prevention Conference attendees in highly trafficked midtown areas around Peachtree Center;
- Wrote op-Ed for Leisha McKinley-Beach published on MyAJC.com, in addition to media outreach resulting in stories by WSB-TV (Channel 2), Georgia Health News, WABE-FM (NPR), POZ et al;
- Reached more than 800,000 adults with approximately 700 television ads on BET, Bravo and other cable channels via Comcast;

- Delivered 1.5 million impressions from 60 out-of-home billboard and transit placements;

- Delivered more than 1 million impressions with 354 radio spots on leading stations;

- Produced more than 36,000 complementary HIV/AIDS materials, including brochures, posters and info guides for use by FCDHW partners, including clinics and local AIDS service and other community based organizations to support outreach;

- Secured over 100,000 digital video views of We Are Family campaign profiles in Atlanta.

PRE-EXPOSURE PROPHYLAXIS (PrEP)

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

EPIDEMIOLOGIC AND SURVEILLANCE DATA

Enhanced HIV/AIDS Reporting System (eHARS): HIPP has begun using surveillance data to generate choropleth maps of high morbidity zip codes and testing "hot spots" within the jurisdiction. These maps are being discussed periodically in management and JPPG/CBO meetings in order to improve program planning and targeted testing efforts. The Community Epidemiologist has also developed several reports and PowerPoint presentations for community stakeholders that compare PS12-1201 testing numbers and positivity rates against those areas in the jurisdiction with high morbidity (as based on surveillance data). In Q2 2015, the department also began determining the accuracy of clients' self-reported HIV status on the Part One forms compared to eHARS lab data. This information is being used to update the surveillance question on the Part Two forms and will also be utilized to assess the FCDHW care continuum for both previously positive and newly positive clients. The action item moving forward into Year 5 is the formulation of a re-engagement plan for those who are identified as out-of-care using the eHARS data and to develop an internal database to track all positive clients identified through HIPP and verified through eHARS, as well as the various surveillance databases listed below. Fulton and DeKalb County staff will be granted full access to the database. Access to eHARS will allow the health departments to more accurately determine a client's HIV history in real-time and also provide the DPH surveillance team with more up-to-date residence and risk data.

EvaluationWeb: HIV counseling, testing, and referral surveillance data being captured by EvaluationWeb is routinely reported to FCDHW management staff based on the targets and measures outlined in the Comprehensive Program Plan. This allows for management staff responsible for overseeing PS12-1201 funded sites to collaboratively develop action plans to address gaps and barriers with program implementation. Those reports, along with joint

analyses of EvaluationWeb and eHARS data, are then disseminated to the external agencies in order to improve service provision within the community.

In Q3 and Q4, CBO Half-Year Evaluation Reports were also developed to provide feedback to the CBOs on their testing performance in Q1-Q2 2015, and to offer them a comparative tool to measure their performance against key program indicators. Another objective of the Evaluation Reports was to evaluate their performance as it related to testing of at-risk populations and providing the CBOs with a comprehensive assessment of each test site and the priority populations tested at those sites.

CAREWare: Full access to the CAREWare system for the Program Evaluation Specialist, Community Epidemiologist, and Testing & Linkage Program Manager is expected to occur and will provide an additional resource for assessing Data 2 Care indicators and ensuring clients are continually engaged in care and are virally suppressed.

Sexually Transmitted Disease Management Information System (STD*MIS): The data from STD*MIS is currently being used for the purposes of reporting partner services data for previous positives. However, with the integration of STD*MIS data into SendSS, as described below, it is anticipated that the data will help generate a more in-depth analyses of STI clusters and enable data-matching of all HIV cases in SendSS with both eHARS and the FCDHW electronic health record system, Mitchell & McCormick (M&M).

State Electronic Notifiable Disease Surveillance System (SendSS): The data from SendSS is currently being used for the purposes of reporting partner services data for new positives as well as previous positives who are co-infected with syphilis and do not have a previous record in SendSS. However, discussions began regarding the incorporation of STD*MIS data into SendSS and the development of additional modules regarding linkage-to-care data with partner services data for a more streamlined method of capturing Field Services in its entirety. The transition is expected to be completed by Q1 2016.

PERINATAL HIV TRANSMISSION PREVENTION

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

The core components of the new model:

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

- to expand provider reporting and expanded services collaborations

Total Number of FBI Cases (since inception)	Number of FBI Cases for 2015	Number of Cases outside of Fulton County	# of HIV + babies born	# of HIV exposures	# of Partners identified	# of HIV Positive partners identified
104	**24**	36 *14 in DeKalb	10	94	187	45

Integrated Work Plan

Integrated HIV Prevention and Care Plan

Georgia: CY2017 - CY2021

DRAFT

2015-2020 NHAS Goal 1: Reducing new HIV Infections				
2017-2021 SMART Objective 1: By December 2021, Reduce the number of new diagnosis by at least 25%.				
Strategy 1: Expand access to effective prevention services and intensify efforts, including pre-exposure prophylaxis (PrEP).				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B	Allocate state funding consistent with the geographic distribution of the epidemic for the provision of staffing for PrEP clinics.	People at high risk of HIV exposure	• Number of positions hired for clinics
By December 2016 and biannually	Statewide Integrated Planning Council	Utilize the CAPUS resource Hub to update PrEP clinical providers as well as increase the awareness of PrEP clinical providers by tasking the Statewide Integrated Planning Council to provide an updated HIV resource manual every 2 years.	Clinical Providers	• Updated HIV resource manual
By December 2016 and biannually	Statewide Integrated Planning Council	Broaden community awareness of PrEP and nPEP of prevention HIV infection among high risk populations	MSM and African American Women	• Number of media campaigns conducted

2017-2021 SMART Objective 2: By December 2021, increase the percentage of people living with HIV who know their serostatus to 90%.				
Strategy 1: Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Statewide Integrated Planning Council	Increase HIV testing in geographical areas with high burden of disease among priority populations		• Number of HIV tests performed • HIV Positivity Rate • Number linked to medical care

By December 2021:	DeKalb Board of Health (DBOH) Fulton County Department of Health and Wellness (FCDHW) Community Based Organizations (CBO) (funded)	Utilize mobile HIV testing units in zip codes with high HIV incidence and prevalence in Fulton and DeKalb counties.	Young Men who have Sex with Men (MSM) (age 13-24) Men who have Sex with Men (MSM) (age 25-60) Male-to-Female Transgender (MTF) African American women	• Number of HIV tests • Number of mobile units utilized and frequency • Positivity rates • Number of positives linked to care • Number of negatives linked/enrolled/referred for PrEP
By December 2021:	DeKalb Board of Health (DBOH) Fulton County Department of Health and Wellness (FCDHW) Community Based Organizations (CBO) (funded)	Provide free HIV testing within Fulton and DeKalb county health departments and CBO's	General population	• Number of individuals receiving services under A01 (free HIV testing indicator within clinic) • CBO monthly report (number of individuals given HIV tests)
By December 2021:	DeKalb Board of Health (DBOH) Fulton County Department of Health and Wellness (FCDHW) Community Based Organizations (CBO) (funded)	Provide population based interventions at health department and CBOs	Targeted populations	• Number of participants for each intervention • Participants that report behavioral change including risk reduction

By December 2021		Establish HIV testing centers in post-secondary institutions where individuals are burdened with increased levels of infection.		• Number of new testing sites
2017-2021 SMART Objective 2: By December 2021, increase the percentage of people living with HIV who know their serostatus to 90%.				
Strategy 2: Educate all Americans about the threat of HIV and how to prevent it.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
2017-2021	DeKalb Board of Health (DBOH) Fulton County Department of Health and Wellness (FCDHW)	Provide Comprehensive Training and Capacity Building Assistance To Fulton and DeKalb county service providers in HIV-related work/services	General population Service providers (i.e. CBO, ASO, etc.)	• Number of evaluations completed • Sign-in sheets • Pre-test/post-test
By December 2021	Statewide Integrated Planning Council	Expand marketing campaigns in health district neighbors burdened with increased levels of infection	General population	• Number of marketing campaigns conducted
By December 2017	Statewide Integrated Planning Council	Broaden community participation with Georgia's Statewide Integrated Planning group activities.		• Number of new participants
Strategy 3: Ensure that opt-out HIV screening is provided as a standard of care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Statewide Integrated Planning Group	Increase HIV testing in Federally Qualified Health Centers.	Federally Qualified Health Centers.	• Number of FQHCs providing opt-out HIV testing

Each year from 2017 - 2021, increasing the number of agreements in 17% increments	FCDHW and DeKalb County High Impact Program Administrators Hospital Administrators Hospital staff	Enter into agreements with Fulton and DeKalb County hospitals and outpatient clinics	Young Black gay and bisexual men (13-24) Gay and bisexual men regardless of race/ethnicity (13-60) Transgender women (13-60) African American women (13-60) General Population (13-60)	• Number of HIV tests performed • HIV Positivity Rate • Number linked to medical care • Number of agreements in place
2017-2021 SMART Objective 3: By December 2021, reduce the number of perinatal transmissions by 50%.				
Strategy: Provide HIV Perinatal services to reduce seroconversion.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:		Promote mental health and substance abuse services to mothers after delivery.	HIV positive mothers	• Number of HIV positive mothers offered services
By December 2021:		Strengthen and expand the linkage process for HIV positive mothers who are in need of postpartum care for babies.	HIV positive mothers	• Number of HIV positive mothers linked
By December 2021:		Collaborate with the Statewide Integrated Planning group to improve prevention activities in Georgia.		• Identify new activities

By December 2012:		Collaborate with providers visiting delivery hospitals to link newly diagnosed women into care	HIV positive mothers	• Number of HIV positive mothers linked to care
Strategy 4: Present perinatal cases to a case review team to identify gaps and missed opportunities to develop recommendations for improvements.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:		Ensure HIV positive mothers receive training to increase medical adherence.	HIV positive mothers	• Number of HIV positive mothers trained
By December 2021:		Review no shows and appointment processes in local Ryan White clinics and strengthen processes to include follow-up with clients to assure linkage.	HIV positive mothers	• Number of HIV positive mothers linked to care

2015-2020 NHAS Goal 2: Improve Access to Care and health outcomes.				
2017-2021 SMART Objective 1: By December 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 90%.				
Strategy 1: Establish seamless systems to link people to care immediately after diagnosis.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017	Ryan White Administration/Staff FCHD Administration/ HIPP Staff DKBOH Administration/HIPP Staff	Enhanced administrative process and remove duplicative paper work for rapid entry into Ryan White Program	Young black gay and bisexual men 13-24 Gay and bisexual men regardless of race/ethnicity 13-60 Transgender African American women 18-45	• Number of days for patients to see a medical provider • Number of patients seen by medical provider within 72 hours of diagnosis
Yearly increase by 20%	Ryan White Administration/Staff FCHD Administration/ HIPP Staff DKBOH Administration/HIPP Staff CBO's Staff Hospital Administration/Staff	Implement rapid entry program ARTAS	Young black gay and bisexual men 13-24 Gay and bisexual men regardless of race/ethnicity 13-60 Transgender African American women 18-45	• Number of patients linked to HIV care within 72 hours of diagnosis • The number of rapid entry clinics in operation

Strategy 2: Reduce barriers for clients accessing care				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017	Ryan White Administration/Staff FCHD Administration/ HIPP Staff DKBOH Administration/HIPP Staff CBO's Staff Hospital Administration/Staff	Utilize case management services to remove barriers Implement ARTAS	Young black gay and bisexual men 13-24 Gay and bisexual men regardless of race/ethnicity 13-60 Transgender African American women 18-45	• Number of clients who received housing • Number of patients advocates • Number of barriers removed
Strategy 3: Incorporate opportunities for engagement into all aspects of service delivery				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017	Ryan White Administration/Staff FCHD Administration/ HIPP Staff DKBOH Administration/HIPP Staff CBO's Staff Hospital Administration/Staff	Support the utilization of navigators to reengage individuals who are "out of care"	Young black gay and bisexual men 13-24 Gay and bisexual men regardless of race/ethnicity 13-60 Transgender African American women 18-45	• Number of trained navigators • Number of CBO's utilizing navigators • Average number of days new clients are linked to care

Strategy 4: Strengthen linkage to care systems to link newly diagnosed persons to care within 30 days.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
		Strengthen the use of Public Health strategies and Best Practices to link HIV positive persons to care and sustain them in care. Increase capacity for linkage coordinators to improve the quality of linkage services. Improve partner services and linkage services to better locate and link them to care.		
Strategy 5: Expand linkage processes in correctional facilities to ensure newly released persons are linked to a medical appointment with medical records within 30 days.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017	Ryan White Administration/Staff FCHD Administration/ HIPP Staff DKBOH Administration/HIPP Staff CBO's Staff Hospital Administration/Staff	Support the utilization of navigators to reengage individuals who are "out of care"	Young black gay and bisexual men 13-24 Gay and bisexual men regardless of race/ethnicity 13-60 Transgender African American women 18-45	• Number of trained navigators • Number of CBO's utilizing navigators • Average number of days new clients are linked to care

Strategy 6: Provide rapid enrollment into Outpatient Ambulatory Health Services (OAHS).				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Establish rapid entry clinic system by February 28, 2017; provide ongoing service delivery through December 2021.	Part A Grantee, Case Managers (Non-Medical), Nurse Educators, Medical Case Managers, and Part A Providers	Implement and maintain rapid entry clinic system that includes establishment of at least two rapid entry clinics by February 28, 2017. Evaluate processes to remove barriers to rapid entry care by February 28, 2018 and ongoing.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number of HIV Tests performed overall and for each targeted population • Number of persons testing positive overall and for each targeted population • Number/percent of newly diagnosed persons (overall and for each targeted population) linked to medical care within 30 days

Strategy 7: Allocate funding for rapid initiation of antiretroviral medications.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Part A Case Managers (Non-Medical), Nurse Educators, Medical Case Managers, and Part A Providers	Administer rapid initiation of ART for 100% of newly enrolled clients and continue provision until ADAP or Patient Assistance Program coverage begins. Provide intensive treatment adherence counseling for 100% of newly enrolled clients receiving ART.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number/percent of newly enrolled clients that received ART prescriptions within 30 days
Strategy 8: Collaboration between HIV testing and care sites to facilitate identification of individuals unaware of their status and link them to care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Standardize linkage protocols across programs to ensure clients have one provider appointment within 30 days of contact.	PLWHA not in care	• Linkage rate within 30 days

Strategy 9: Provide funding for initiatives to improve linkages between HIV testing and HIV				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Linkage to Care Coordinators (CDC, Part B), Part A Patient Navigators, Case Managers (Non-Medical), Part A Planning Council, CDC-funded High Impact Prevention Program, DPH Prevention Program, and Fulton County Department of Health and Wellness CDC funded sites	Establish partnership with Prevention to add medical provider to treat newly diagnosed after testing on mobile units. Collaborate with HIV testing teams to connect newly diagnosed and previously diagnosed positive persons to care. Allocate funding for Insurance Navigators to enroll HIV positive individuals in Georgia Health Insurance Marketplace. Continue funding for Psychosocial Support Services (Patient Navigation) in seven primary care sites to assist Linkage to Care Coordinators with enrollment and retention in care of newly diagnosed persons. Provide funding support for the annual Atlanta Area Outreach Initiative (AAOI) event which incorporates HIV and STD testing, linkage to care, and education on treatment as prevention Provide funding support for the annual Atlanta Area Outreach Initiative (AAOI) event which incorporates HIV and STD testing, linkage to care, and education on treatment as prevention.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number of people tested • Number /percent of people testing HIV positive • Number/percent of people linked to care • Number of people enrolled in Georgia Health Insurance Marketplace • Number of newly diagnosed persons receiving Psychosocial Support Services that are enrolled in care • Number of persons attending AAOI

2017-2021 SMART Objective 2: By 2021, increase the percentage of people living with HIV/AIDS (PLWHA) from 85% to at least 90% that have access to regular care and are started on and adhere to antiretroviral medications				
Strategy 1: Prescribe antiretroviral medications for at least 90% of clients enrolled in medical care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Providers, Health Care Team Medical Case Managers, and Discharge Linkage Teams (hospitals/jails)	Offer 100% of patients ART. Provide intensive treatment adherence counseling for 100% of clients prescribed ART. Ensure effective transition via hospital and jail discharge linkage teams to ensure continuity of medical therapies for discharged persons who are HIV positive within 30 days.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number/ percent of clients prescribed ART • Number/percent of clients on ART that receive intensive treatment adherence counseling • Number/percent of clients who are virally suppressed • Number/percent of persons living with HIV discharged from hospitals linked to medical care • Number/percent of persons living with HIV discharged from jail system linked to medical care

Strategy 2: Deliver intensive treatment adherence counseling.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Part A Grantee, Part A Subrecipients for OAHS and Medical Case Management, Training Consultants, and, Evaluation Consultants	Through training and chart documentation, ensure 100 % of clinicians follow published Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents and Guidelines for the Prevention and Treatment of Opportunistic Infections. During each clinic visit, provide 100% of clients with counseling by Medical Clinicians and Medical Case Managers on the importance of treatment adherence. Identify clients with highest risk of non-treatment adherence, (e.g., detectable viral load, missed appointments, substance use and/or mental health disorders, etc.) and provide 100% of identified clients with intensive treatment adherence counseling and support.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Clinical chart reviews of documentation • Number/percent of clients receiving counseling • Number of clients identified at risk by risk type • Number/percent of clients identified at risk that receive intensive treatment adherence counseling and support • Number/percent of clients that are virally suppressed after receiving counseling and support

Strategy 3: Implement systematic approaches to address gaps in antiretroviral use.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Implement systematic approaches to address gaps in antiretroviral use.	Part A Subrecipients and Medical Case Managers	Provide rapid initiation of ART for 100 % of newly enrolled (or returning to care) clients and continue provision until ADAP or Patient Assistance Program coverage begins. Fund Medical Case Managers at primary care sites to provide treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatment. Through Case Managers (Non-Medical), enroll clients in ADAP or Patient Assistance Programs Complete ADAP electronic enrollment applications for 100% of eligible clients during medical appointments at care sites and Medical Case Managers office. Establish ADAP policy to allow presumptive enrollment with awaiting client documentation. Through ADAP Specialist, assist 100 % of clients on ADAP with re-certification to prevent interruption in medications. Identify and implement new options for providing medications (e.g., agency, home delivery or through contracted pharmacies).	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number/percent of clients prescribed ART at first medical visit • Number of electronic ADAP applications completed • Number/percent of clients enrolled in ADAP • Number/percent of clients enrolled in Patient Assistance Programs. • Number/percent of clients re-certified without an interruption in medications. • Number/type of new options identified for providing medications • Number/percent of clients receiving medications support from new options

2017-2021 SMART Objective 3: By 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of HIV diagnosis to at least 90% and engage individuals identified as out of care.				
Strategy 1: Establish rapid entry clinics to link clients to care and medications within 72 hours for newly diagnosed persons and seven days for identified as out of HIV care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Establish rapid entry clinic system by February 28, 2017; ongoing service delivery through December 2021.	Part A Grantee and Part A Subrecipients	Link 90% of newly diagnosed persons to care within 72 hours through rapid entry care clinics and co-location of services to ensure the client is served until a slot opens at RW clinic of patient choice for on-going care and treatment. Enroll clients with preliminary HIV diagnosis in care within 72 hours to lessen the time between diagnosis and entry in care. Through the Health Information Exchange (HIE), identify those out of HIV care persons accessing health care for reasons unrelated to HIV. Link identified out of care individuals living in the Atlanta EMA to HIV care within seven days. Use other "Data to Care" models such as the Care and Prevention in the United States (CAPUS)	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number of people who tested positive • Number/percent of people linked to care within 72 hours • Number of people lost to care who were linked to care within seven days

Strategy 2: Provide HIV resources in zip codes with the highest concentration of health disparities.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Establish mobile clinics by February 28, 2017; ongoing service delivery through December 2021.	Part A Subrecipients and Medical Case Managers	Identify zip codes with highest concentration of health disparities. Assess disparities in communities/zip codes where HIV is most heavily concentrated to identify existing HIV service provider locations and services as well a HIV resource gaps and barriers. Based on assessment, establish the health resources to be provided through mobile clinic system. Develop partnerships with existing HIV service providers in targeted zip code areas. Develop and implement communications plan to educate community and existing providers about the availability of mobile clinic HIV services and how to access these services. Implement system of at least two mobile clinics to serve identified zip codes with highest concentrations of health disparities and improve access to care. Integrate HIV services in existing clinical practices.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number of clients served in identified zip codes by mobile clinics • Number/percent of clients served in mobile clinics that are retained in care (two or more medical visits performed at least three months apart)

Strategy 3: Identify and address service gaps that hinder client access and retention in care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Part A Grantee, Part A Planning Council, and Part A Subrecipients	Conduct Client Needs Assessment to identify gaps in and barriers to services and inform priority setting and resource allocation planning teams. Develop strategic plan and timeline to reduce identified gaps and barriers. Implement strategies to reduce barriers to care and increase linkage to core medical and support services to address HIV-related co-occurring conditions and identified client challenges. Increase client awareness of available HIV services and how to access them via Part A Planning Council Atlanta Area Outreach Initiative (AAOI) Resource guide, CAPUS resource hub, Part A Website, etc. Ensure resource allocation and standardized for Case-Management (Non-Medical), Medical Case Management, Peer Counseling and Patient Navigation services. Implement annual Client Satisfaction Survey and a Consumer Survey every third year to assist with service delivery monitoring and Continuous Quality Improvement.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Needs Assessment report identifying gaps and barriers • Type/number of services clients receive • Strategic plan/timeline updates • Client satisfaction and consumer update findings

Strategy 4: Ensure linkage to HIV medical care for people living with HIV.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Ryan White Part B Clinics should ensure that all persons with HIV (with a focus on high risk populations) have access to medical and support services.	PLWHA	• Linkage rates
By December 2021:	Ryan White Part B Grantee and sub-recipients	Review no shows and appointment processes in local Ryan White clinics and strengthen processes to follow-up with clients to assure linkage.	PLWHA who are no shows to medical appointments	• Rate of no shows
Strategy 5: Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-morbidities and challenges in meeting basic needs.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Leverage available resources for primary care and support services.	PLWHA	• Number of medical providers • Number of support services provided
Strategy 6: Prioritize and evaluate gaps in knowledge and services along the care continuum.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Conduct surveys at local Ryan White clinics to identify areas of need and/or improvement.	PLWHA	• Number of surveys completed
By December 2021:	Ryan White Part B	Provide information, resources, and technical assistance to service providers to strengthen the delivery of services along the care continuum.	Ryan White clinics and providers	• Number of technical assistance sessions provided

2017-2021 SMART Objective 4: By 2021, increase the number of PLWHA retained in care to 90%.				
Strategy 1: Expand resources and clinic hours in underserved geographic areas to provide PLWHA with more access to care options.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Part A Grantee, Part A Subrecipients (Providers), and Local Clinics or Federally Qualified Health Centers (FQHC)	Implement system of mobile "health" units, satellite clinics, and expanded clinic hours (evening and Saturdays). Establish relationships with non-traditional partners for service expansion.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number of clients served by mobile "health" units and satellite clinics • Number of clients served during expanded clinic hours • Number of non-traditional partnerships established
Strategy 2: Improve retention in care for people living with HIV.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Ryan White Part B Clinics should ensure that all persons with HIV (with a focus on high risk populations) have access to medical and support services.	PLWHA	• Retention rate
By December 2021:	Ryan White Part B Grantee and sub-recipients	Ryan White Part B Clinics should ensure that all persons with HIV (with a focus on high risk populations) have access to antiretroviral therapy (ART).	PLWHA	• Number of people on ART
By December 2021:	Ryan White Part B Grantee and sub-recipients	Review no shows and appointment processes in local Ryan White clinics and strengthen processes to follow-up with clients to reduce gaps in the delivery of services along the care continuum.	PLWHA who are no shows to medical appointments	• Rate of no shows

By December 2021:	Ryan White Part B Grantee and sub-recipients	Identify clients that have fallen out of care and attempt to re-engage them in care using the Data to Care model.	PLWHA out of care	• Number of out-of-care persons linked
By December 2021:	Ryan White Part B	Provide information, resources, and technical assistance to service providers to strengthen the delivery of services along the care continuum.	Ryan White clinics and providers	• Number of technical assistance sessions provided
Strategy 3: Increase the number of available providers of clinical care and related services for people living with HIV.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Increase the number of available providers of HIV care.	Ryan White clinics, PLWHA	• Number of providers
By December 2021:	Ryan White Part B Grantee and sub-recipients	Strengthen the current provider workforce to ensure the delivery of quality care.	Ryan White clinics, PLWHA	• Number of new medical and non-medical providers
Strategy 4: Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-morbidities and challenges in meeting basic needs.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Leverage available resources for primary care and support services.	PLWHA	• Number of medical providers • Number of support services provided
Strategy 5: Prioritize and evaluate gaps in knowledge and services along the care continuum.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Conduct surveys at local Ryan White clinics to identify areas of need and/or improvement.	PLWHA	• Number of surveys completed

By December 2021:	Ryan White Part B	Provide information, resources, and technical assistance to service providers to strengthen the delivery of services along the care continuum.	Ryan White clinics and providers	• Number of technical assistance sessions provided

Strategy 6: Reengage individuals identified as out of HIV care through the Health Information Exchange (HIE) provider sites within seven days of identification.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017, ongoing	By December 31, 2017, ongoing	Through HIE, identify those out of HIV care persons accessing health care for reasons unrelated to HIV. Link 90% of individuals identified as out of care to HIV medical care within seven (7) days of identification. Use other "Data to Care" models such as the Care and Prevention in the United States (CAPUS)	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Through HIE, identify those out of HIV care persons accessing health care for reasons unrelated to HIV. • Link 90% of individuals identified as out of care to HIV medical care within seven (7) days of identification. • Use other "Data to Care" models such as the Care and Prevention in the United States (CAPUS)

Strategy 7: Provide Health Insurance Premium Support				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017, ongoing	Part A Subrecipients and Georgia DPH Part B	Identify Ryan White (RW) eligible clients who are eligible for Affordable Care Act (ACA) enrollment and vigorously pursue enrollment through Georgia Health Insurance Exchange/Marketplace. Partner with enrollment agencies to help RW-Eligible clients who are 100% of federal poverty level or above to enroll in ACA through Georgia Health Insurance Exchange/Marketplace. Fund medication co-insurance payments for antiretroviral medications for clients enrolled in Health Insurance Exchange/Marketplace. Enroll eligible clients in Health Insurance Continuation Program (HICP) and Health Insurance Premium (HIP) program. Utilize Part A funding to assist with ACA enrolled clients' out of pocket costs such as deductible and co- insurance of outpatient medical care.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Chart Reviews (Eligibility and Enrollment Files) • Number of clients uninsured versus insured • Number/percent of eligible clients enrolled in Health Insurance Exchange • Number/percent of clients enrolled in HICP/HIP

Strategy 8: Ensure availability of core and other support services to improve access to and retention in care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017, ongoing	Part A Subrecipients (Providers) and Ryan White Planning Council	Utilize Ryan White and other funding sources to provide core and support services for Ryan White eligible clients.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Type/number of services • Number/percent of clients receiving core services • Number/percent of clients receiving support services • Number/percent of PLWHA linked to care • Number/percent of clients retained in care

2015-2020 NHAS Goal 3: Reduce HIV related health disparities and health inequities.				
2017-2021 SMART Objective 1: By December 2021, increase the percentage of persons diagnosed with HIV infection who are virally suppressed to at least 80%.				
Strategy 1: Support retention in care to achieve viral suppression and reduce transmission risk.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Ryan White Part B Clinics should ensure that all persons with HIV (with a focus on high risk populations) are retained in care and are receiving medical and support services.	PLWHA	• Retention rate
By December 2021:	Ryan White Part B Grantee and sub-recipients	Ryan White Part B Clinics should ensure that all persons with HIV (with a focus on high risk populations) have access to antiretroviral therapy.	PLWHA	• Number of people on ART
By December 2021:	Ryan White Part B Grantee and sub-recipients	Review no shows and appointment processes in local Ryan White clinics and strengthen processes to follow-up with clients to reduce gaps in the delivery of services along the care continuum.	PLWHA who are no shows to medical appointments	• Rate of no shows
By December 2021:	Ryan White Part B Grantee and sub-recipients	Identify clients that have fallen out of care and attempt to re-engage them in care using the Data to Care model.	PLWHA out of care	• Number of out-of-care persons linked
By December 2021:	Ryan White Part B	Provide information, resources, and technical assistance to service providers to strengthen the delivery of services along the care continuum.	Ryan White clinics and providers	• Number of technical assistance sessions provided
Strategy 2: Increase the number of available providers of clinical care and related services for people living with HIV.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Increase the number of available providers of HIV care.	Ryan White clinics, PLWHA	• Number of providers

By December 2021:	Ryan White Part B Grantee and sub-recipients	Strengthen the current provider workforce to ensure the delivery of quality care.	Ryan White clinics, PLWHA	• Number of new medical and non-medical providers
Strategy 3: Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-morbidities and challenges in meeting basic needs.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Leverage available resources for primary care and support services.	PLWHA	• Number of medical providers • Number of support services provided
Strategy 4: Prioritize and evaluate gaps in knowledge and services along the care continuum.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Part B Grantee and sub-recipients	Conduct surveys at local Ryan White clinics to identify areas of need and/or improvement.	PLWHA	• Number of surveys completed
By December 2021:	Ryan White Part B Grantee and sub-recipients	Provide information, resources, and technical assistance to strengthen the delivery of services along the care continuum.	Ryan White clinics and providers	• Number of technical assistance sessions provided

2017-2021 SMART Objective 2: By 2021, reduce disparities related to race, sexual orientation, gender, gender identity, and age to improve retention in care of targeted populations to 50%.				
Strategy 1: By 2021, reduce disparities related to race, sexual orientation, gender, gender identity, and age to improve retention in care of targeted populations to 50%.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Establish mobile clinics by February 28, 2017; ongoing service delivery through December 2021.	Part A Grantee and Part A Subrecipients	Implement system of at least two mobile clinics to serve identified zip codes and improve access to care. Identify potential community clinic partners to provide HIV services collaboratively. Partner with existing community clinics to provide HIV services in the targeted areas. Expand evening and weekend clinic hours to allow more options for accessing care. Establish new options for providing medications (i.e., agency, home delivery & contracted pharmacies) Develop and implement awareness communications plan to inform PLWHA in targeted communities about available HIV services. Explore innovative treatment options such as Telemedicine for clients.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number/percent of clients receiving mobile clinic services • Number/percent of clients receiving HIV services through partnerships with community clinics • Number/percent of clients accessing care through evening clinic hours • Number/percent of clients accessing care through weekend clinic hours • Number/percent of clients receiving medications through new options.

Strategy 2: Support access to continuous comprehensive care along the continuum to reduce disparities.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Establish mobile clinics by February 28, 2017; ongoing service delivery through December 2021.	Part A Grantee and Part A Subrecipients	With additional funding to expand Psychosocial Support services by increasing the number of Patient Navigators from seven to ten and maintain funding levels to provide Peer Counselors at five sites. Conduct ongoing awareness campaigns targeted at communities with greatest health disparities. Implement and maintain system of at least 2 mobile care units in communities with greatest health disparities. Conduct outreach to Spanish speaking communities. Provide linguistic services to 100 % of Spanish speaking clients, including use of patient education materials in Spanish. Provide assistance for 100% of clients with vision and/or hearing impairments. Provide support services to decrease barriers to care, including medical transportation and translation assistance. Increase OAHS and HIP support to offset 80% of Part A clients who do not qualify for insurance coverage under ACA and are not eligible for	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number of Patient Navigators • Number of Peer Counselors • Number/percent of clients in communities with greatest health disparities that receive peer support services • Number/percent of clients in communities with greatest health disparities that receive mobile care health services • Number of Spanish speaking individuals receiving outreach services

				• Number of Spanish speaking individuals identified through outreach as HIV positive • Number/percent of Spanish speaking individuals newly diagnosed that are linked to care • Number/percent of Spanish speaking individuals retained in care. • Number/percent of clients with vision and/or hearing impairments receiving assistance • Number/percent of clients receiving support services

				• Number/percent of clients not eligible for ACA or Medicaid that are enrolled in OAHSs • Number/percent of clients in not eligible for ACA or Medicaid that are enrolled in HIP

Strategy 3: Increase the provision of integrated services to reduce social determinants of health and reduce HIV-related health disparities.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Part A Grantee and Part A Subrecipients	Co-locate Mental Health services on site in at least six clinic sites. Review and revise EMA screening/assessment tool annually and provide training on revised tool as needed. Assess 100% of new clients for behavioral health needs. Based on client assessment, schedule 100% of clients with identified behavioral health needs for same day behavioral health appointment as HIV primary care visit for clinics with co-located services. Based on client assessment, implement same day behavioral health referral for 100% of clients with behavioral health needs when behavioral health services are not available onsite. Assess 100% of new clients for co-morbid conditions and other health related needs. Refer clients with identified co-morbidities to resources such as Open Hand to provide education on healthy lifestyles. Resource provisions to treat clients with high rates of serious medical co-morbidities, significant oral disease, severe	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number/percent of clients screened/assessed • Number/percent of clients identified with mental health needs • Number/percent of clients identified with substance use disorders • Number/percent of clients with identified behavioral health needs that are linked to onsite co-located mental health and/or substance use services • Number/percent of clients with identified behavioral health needs referred same day for offsite mental health and/or substance use services

				• Number/percent of clients assessed for co-morbid conditions and other health related needs • Number of clients referred to community resources and specialty clinics

Strategy 4: Reduce stigma and discrimination based on gender identity and expression, sexual identity and expression, race/ethnicity, and socioeconomic status among PLWHA.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Part A Grantee, Part A Subrecipients, and Part A Planning Council	Address stigma and discrimination in the following institutions: Healthcare, educational, criminal justice systems, faith-based and government. Conduct annual training for Part A provider staff and partner agencies (i.e., pharmacies, specialty vendors, etc.) on: Office of Minority Health's National Culturally and Linguistically Appropriate Standards (CLAS); providing culturally and linguistically appropriate care for LGBT, gender identity and sexual identity and expression, non-English speaking populations, African American and Hispanic, precariously housed and homeless, formerly incarcerated, substance users, individuals with mental health problems, and lower socioeconomic populations; health disparities and impact of social determinants of health; the impact of stigma and discrimination; and state and federal laws on stigma, discrimination and criminalization of HIV Require that 100% of funded Part A providers implement at least one strategy annually in each of the three CLAS component categories (i.e., 1)	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number of trainings • Number/percent of Part A funded agencies with staff participating in training • Number/percent of partner agencies with staff participating in training • Number of provider staff trained with training documented in personnel records • Pre/posttest training results • Number/percent of funded agencies that have implemented at least one strategy in each of the three CLAS categories

		Implement speakers' bureau to provide education on HIV stigma and discrimination for state and local institutions including healthcare facilities, educational systems, correctional systems, faith-based institutions, and state and local governments.		• Number/type of stigma and discrimination awareness campaign activities implemented • Number of speakers bureau engagements

2017-2021 SMART Objective 3: By 2021, 75% of clients among minority populations engaging in HIV care will achieve a viral load of less than 200 copies/mL.				
Strategy 1: Direct Minority AIDS Initiative (MAI) funds to providers possessing HIV treatment expertise and experience in addressing treatment barriers experienced among socially				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Ryan White Part A MAI Providers, Nurse Educators, Clinical Pharmacists, and Medical Case Managers	Establish partnerships with MAI providers equipped with resources to treat patients with high rates of serious medical co-morbidities, significant oral disease, severe mental illness, neuropsychiatric conditions, chronic substance dependence and multiple psychological challenges	African American (AA); AA-MSM; Hispanic; and women, infants, children, and youth	• Number of Subrecipients/ Providers funded
Strategy 2: Increase efforts to improve HIV care access, retention and treatment adherence among underserved individuals.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**

By December 31, 2017; ongoing through December 2021.	Ryan White Part A MAI Providers, Nurse Educators, Clinical Pharmacists, and Medical Case Managers	Increase the service provision by expanding Ryan White Clinic operating hours (i.e., evening hours and/or weekends) in at least three of five targeted zip codes. Support walk-in clinics. Implement increased appointment scheduling flexibility in at least one specialized clinic targeted toward the needs of "hard-to-reach" populations.	African American (AA); AA-MSM; Hispanic; and women, infants, children, and youth	• Number of service locations • Number of clients served clients at each service location • Number of service locations with expanded operating hours • Number of clients accessing services during expanded operating hours • Number of walk-in clinics • Number of clients using walk-in clinic services • Number of specialized clinics offering appointment scheduling flexibility

Strategy 3: Provide enhanced treatment adherence support and education for populations at higher risk to achieve viral suppression.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Ryan White Part A MAI Providers, Nurse Educators, Clinical Pharmacists, and Medical Case Managers	Provide 100% of clients with HIV educational information on enrollment at HIV service delivery sites. Ensure educational materials are culturally and linguistically appropriate. Provide 100% of enrolled clients with annual education opportunities including presentations lunch and learns, webinar, etc. Provide 100% of clients with treatment adherence support at initiation of ART. Identify clients who are not virally suppressed and provide enhanced treatment adherence support for 90% of these clients. Implement innovative youth-oriented initiatives to assist youth with treatment adherence and engagement in care (e.g., use of social marketing, youth transition to adult care activities). Provide comprehensive outpatient health services to include resistance testing, diagnostic procedures, general lab, radiology, treatment, adherence counseling and support.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number/percent of clients receiving educational information at enrollment • Number/type of educational offerings for clients • Number/percent of clients provided with treatment adherence support at ART initiation • Number/percent of clients not virally suppressed prior to receiving treatment adherence support • Number/percent of clients virally suppressed after receiving enhanced treatment adherence support

		Integrate gynecological screening and diagnostic services into HIV/AIDS care treatment plan for Women. Refer enrolled clients as appropriate for specialty medical services (e.g., dermatology, urology, oncology, neurology etc.). Provide innovative youth-oriented initiatives to assist with the transition into adult care. Establish additional initiatives: -Linguistic services (bi-lingual providers) -Cultural competency -Bi-lingual materials -Hearing impaired initiatives		• Number/type of youth-oriented initiatives implemented • Number/percent of youth receiving social marketing messages that are virally suppressed • Number/percent of youth receiving transition to adult care at age 25

2017-2021 SMART Objective 4: By 2021, reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, Black women.				
Strategy 1: By 2021, reduce HIV-related disparities in communities at high risk.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Between 2017 and 2021	FCDHW (HIPP Program Staff) DKBOH (HIPP Program Staffs)	Utilize PrEP clinic at the local health department to reduce new HIV infections and provide high risk negatives (HRN) access to HIV prevention education and services.	Young black gay and bisexual men 13-24 Gay and bisexual men regardless of race/ethnicity 13-60 Transgender women 13-60 African American women 18-45	• Number of HRNs enrolled in PrEP services • Number of HIV Tests performed • Number of persons retained in PrEP services • Number of HRNs that are newly diagnosed HIV positive • Number of PrEP counseling/ health education sessions provided • Number of condoms distributed to HRNs via PrEP clinic

Between 2017 and 2021	FCDHW mobile unit staff DCBOH mobile unit staff	Utilize the mobile units to conduct HIV testing, outreach, and recruitment in high incidence and prevalence neighborhoods throughout Fulton and DeKalb Counties	Young black gay and bisexual men 13-24 Gay and bisexual men regardless of race/ethnicity 13-60 Transgender women 13-60 African American women 18-45	• Number of HIV tests performed • HIV positivity rate • Number linked to medical care • Number of outreach events conducted

Strategy 2: Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Between 2017 and 2021	FCDHW staff DCBOH staff	Routinize the screening of sexually transmitted infections/diseases, viral hepatitis, and tuberculosis in Fulton and DeKalb Counties in the health department within communities disproportionately impacted by HIV	Young black gay and bisexual men 13-24 Gay and bisexual men regardless of race/ethnicity 13-60 Transgender women 13-60 African American women 18-45	• Number of STI, VH, and TB tests performed among persons with HIV • Number of STI test performed in conjunction with HIV tests • virally suppressed after receiving enhanced treatment adherence support

Between 2017 and 2021	FCDHW staff DCBOH staff	Build partnerships with youth leaders, adult allies, and youth-serving organizations to advocate for policies and champion programs that recognize young people's rights to honest sexual health information; accessible, confidential, and affordable sexual health services; and the resources and opportunities necessary to advocate for comprehensive sex education and create sexual health equity for all youth.	Youth and young adults 13-24	• Number of CBA requests • Number of trainings provided • Number of partnerships developed • Number of Atlanta Public Schools, Fulton County Schools, Decatur City Schools, DeKalb County Schools implementing compre-hensive sex education

Strategy 3: Reduce stigma and eliminate discrimination associated with HIV status.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017	DBOH staff FCDHW CBO	Provide "Safe and the City" intervention on facility monitors	General population	• Number of individuals receiving service tickets • Number of participants in "Safe in the City"among persons with HIV
By the end of 2017	DBOH FCDHW CBO	Provide CBO/ASO technical assistance for "Healthy Relationships"	HIV positive individuals	• Number of participants in "Healthy Relationships"

By the end of 2017	FCDHW staff	Implement anti-stigma campaign inclusive of print and digital media and marketing	Young black gay and bisexual men 13-24 Gay and bisexual men regardless of race/ethnicity 13-60 Transgender women 13-60 African American women 18-45 Youth and young adults 13-24	• Key Performance Indicators: reach, demographics and location, and amplification
By the end of 2017	FCDHW CBO	Promote the involvement of businesses in HIV and AIDS awareness, prevention, education, and mobilization through the Business Responds to AIDS (BRTA) program.	African Americans 13-60	• Pre- and post-surveys of attitudes, beliefs and knowledge

2015-2020 NHAS Goal 4: Achieve a more coordinated response to the HIV epidemic in				
2017-2021 SMART Objective 1: By 2021, increase coordination of HIV programs across the state of Georgia				
Strategy 1: Institute integrated planning processes for the delivery of HIV prevention and treatment services in Georgia.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Georgia DPH, Ryan White Part A, Integrated Planning Group, and Ryan White Planning Council	Develop and implement mechanisms to share and match prevention and treatment data. Hold annual meetings with (CDC & HRSA) funded parts, agencies, administration, HOPWA, Veterans Administration (VA), SAMHSA, PLWHA, other providers, and AIDS Service Organizations (ASOs)/Community-Based Organizations (CBOs) to share information and obtain input to support integrated planning. Establish Integrated (Comprehensive Plan work groups) to monitor and share progress towards NHAS goals and Integrated Plan objectives. Plan and implement annual Atlanta Area Outreach Initiative (AAOI) event which incorporates HIV and STD testing, linkage to care, and education on treatment as prevention.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Number of meetings held • Types of information shared • Record of input received • Number/type of strategies implemented to support integrated planning • Work plan and integrated plan updates

Strategy 2: Coordinate monitoring, tracking (trending data analysis), and progress reporting toward achievement of NHAS goals in Georgia**.**				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	DPH, RW All Parts, and JPPG	Establish a subcommittee of Integrated Planning body to monitor and share data. Develop and implement monitoring, tracking and progress report work plan that identifies activities, timelines, responsibility parties, and data indicators. Conduct ongoing HIV prevention and treatment monitoring and tracking, including tracking progress toward NHAS goals and Integrated Plan objectives annually. Review monitoring and tracking findings annually and identify areas needing improvements. Implement continuous quality improvements (CQIs), as needed, based on ongoing monitoring and tracking. Based on monitoring and tracking, complete and submit all required progress reports by established deadlines.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Prevention and treatment numbers/percent served • Work plan updates • Integrated plan updates • Number/type of Continuous Quality Improvement (CQI) projects implemented • Number/type of progress reports

Strategy 3: Share information within planning bodies, jurisdictions and consumers				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021.	Part A Database Manager and DPH	Establish a mechanism and team to create annual progress reports and achievements towards NHAS goals. Collect and disseminate monitoring, tracking, and progress report information annually to Planning Council (Assessment, Comprehensive Plan, Consumer Caucus, Priorities). Obtain input from Planning Council membership on successes and areas for improvement. Prepare and submit progress reports by established deadlines. Disseminate progress reports to prevention and treatment partners and stakeholders.	African American (AA)-MSM, ages 15-29, AA-MSM, ages 30-45; AA heterosexuals; and transgender females	• Program and goal/objective data collected and trends identified • Number/type of reports developed

Strategy 4: Promote public leadership of people living with HIV.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
		Collaborate with planning bodies including the Georgia Prevention and Care Council, the Ryan White Part A Planning Council, and the Jurisdictional Prevention Planning Group to actively promote public leadership by people living with HIV, including women, gay and bisexual men, racial/ethnic minorities, transgender people and youth.		• Inclusion of additional populations
Strategy 5: Increase coordination of HIV programs between federal, state and local governments				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017	FCDHW Staff CDC HHS HUD HRSA Ryan White VA	Establish a Local Interagency Working Group on HIV comprised of representatives from multiple Departments and many agencies that will share best practices, strategies and the progress being made on a local, state and federal level.	General Population	• Number of agencies at the table. • Consistency of attendance at meetings/conference calls • Visible collaborative events, programs and initiatives that are implemented

By the end of 2017	FCDHW Staff	Coordinate with federally funded programs including SAMHSA, HRSA, CDC, VA, to identify jurisdictional resources for HIV testing and linkage to care	General Population	• Number of persons tested and linked as a result of more coordinated federal efforts • Number of agencies in solidified partnership with FCDHW
By the end of 2017	Ryan White Administra-tion/Staff FCHD Administra-tion/ HIPP Staff /STD Administra-tion/Staff	Develop and execute an integrated service protocol for FC. The protocol will clearly spell out the roles and responsibilities of both prevention and care and define "in-kind" integrated services.	HD Administra-tion Management Staff	• Data-sharing amongst departments to include STD; Ryan White; TB; etc. • Proficiency in sharing of client information and human resources

Strategy 6: Develop improved mechanisms to monitor and report on progress toward achieving national goals				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2018	FCDHW Epidemiology and Evaluation staff	Use Microsoft project to track and monitor the progress of the HIV Prevention Program	Staff JPPG	• Up-to-date status reports for the progress of HIV Prevention Programs • Clear scopes of works developed at least yearly for program staff based on the key indicators and benchmarks

Strategy 7: Measure the results of efforts to reduce new infections and improve health outcomes to chart progress nationally, and refine the response to this public health problem over time.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2018	FCDHW Epidemiology and Evaluation staff JPPG Monitoring and Evaluation Committee	Use Microsoft project to track and monitor the progress of the HIV Prevention Program Use data to redefine target populations, high risk zip codes, evidence based interventions, social marketing campaigns, etc.	Staff JPPG Media Sub-contractors Community Advisory Groups	• Up-to-date status reports for the progress of HIV Prevention Programs • Conduct Community Health Assessments at least bi-annually to document and address changes the cultural make up, technology, etc.

Statewide Coordinated Statement of Need

Integrated HIV Prevention and Care Plan

Georgia: CY2017 - CY2021

DRAFT

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

Part B	**$54,216,225**			X				X																														II-V
Chatham County – Health District			X			X						X	X	X		X		X		X				X													
Clarke County - Health District			X			X		X					X	X		X		X	X					X													
Clayton County – Health District			X			X										X		X						X		X											
Cobb County – Health District			X			X								X		X																					
Columbus County – Health District			X			X								X		X		X					X														
Dalton County – Health District			X													X		X																			
Dougherty County – Health District			X			X		X						X	X	X		X	X	X				X		X						X					
Floyd County – Health District			X			X						X	X	X		X								X													
Positive Impact – Duluth			X			X								X		X		X																			
Hall County – Health District			X										X	X		X		X	X				X	X													
Laurens County – Health District			X			X		X	X				X	X		X		X	X		X			X													
Lowndes County – Health District			X			X								X		X		X	X	X						X											
Macon County – Health District			X									X		X		X		X						X													
Richmond County – Health District			X			X						X		X		X		X		X	X			X		X											
AID Atlanta – LaGrange			X			X								X		X		X						X													
Ware County – Health District			X			X		X					X	X		X		X		X				X													
Georgia Department of Corrections														X																							
Fulton/DeKalb Hospital Authority			X																																		
Time Logistics			X																																		
Georgia State Laboratory			X																																		
Part C	**$10,566,756**																																				II-V

Albany Area Primary Health Care, Inc. - Albany			X																																		
Specialty Care Clinic – Clarke County - Athens												X		X		X								X													
AID Atlanta, Inc. - Atlanta			X											X				X						X												
Emory University – Atlanta			X											X																							
St. Joseph's Mercy Care – Atlanta			X																																		
Georgia Regents University – Augusta			X																																		
Columbus Department of Public Health			X			X							X											X													
North GA Health District – Dalton			X			X						X	X		X																						
DeKalb County Board of Health – Decatur			X																																		
Laurens County Public Health – Dublin			X																																		
Positive Impact Health Centers – Duluth			X										X	X		X																					
Hall County Public Health – Gainesville			X									X	X	X				X																			
Clayton County Public Health – Jonesboro													X			X																					
Houston County Board of Health – Macon			X									X		X				X																			
Cobb County Board of Health – Marietta			X			X							X	X																							
Floyd County Health Department – Rome			X									X	X												X												
Chatham County Board of Health – Savannah												X			X	X																					
Lowndes County Health Department – Valdosta			X											X		X			X																		
Ware County Board of Health – Waycross			X									X		X	X	X		X	X	X					X												
Part D	**$1,560,039**																																				**II-V**

Chatham County Health Department - Savannah			X			X						X	X	X	X	X							X																		
Ware County Health Department -Waycross			X			X								X						X			X	X																
Grady Infectious Disease Program - Atlanta			X																					X																
Part F	**-0-**																																								
MAI	**$2,317,249**																																								
Part B MAI	**$557,798**																																								**II-V**
Chatham County – Health District																				X					X																
Clayton County – Health District																				X					X																
Columbus County – Health District																				X					X																
Dougherty County – Health District																				X					X																
Richmond County – Health District																				X					X																
Ware County – Health District																				X					X																
Part A MAI	**$1,759,451**																																								**II-V**
Grady Infectious Disease Program			X																																					
CDC																																								
Directly Funded	**$3,902,274**																																								
Georgia Dept. of Public Health – Surveillance																																							X	
Georgia Dept. of Public Health - MMP																																							X	
St. Joseph's Mercy Care																																					X			
AID Atlanta, Inc.																																					X			
Positive Impact Health Centers																																					X			
Georgia Dept. of Public Health – NHBSS																																							X	

Emory University																																				X	
Georgia Department of Public Health	**$7,717,403**																																				
Fulton County Dept. of Health and Wellness	**$8,032,822**																																				
AID Atlanta, Inc.																																					
AIDS Research Consortium																																					
Aniz, Inc.																																					
Atlanta Harm Reduction																																					
Center for Black Women																																					
NAESM, Inc.																																					
Positive Impact Health Centers																																					
Recovery Consultants																																					
St. Joseph Mercy Care																																					
Grady IDP																																					
Emory Fulton and DeKalb County Jail Project																																					
SAMHSA	**$6,618,139**																																				
Albany State University – Albany																																					
Savannah State University – Savannah																																					
Morehouse School of Medicine, Inc. – Atlanta																																					
Spelman College - Atlanta																																					
Georgia State University – Atlanta																																					
Morris Brown College -																																					

Atlanta																																								
Recovery Consultants of Atlanta, Inc. – Atlanta																																								
Positive Impact Health Centers – Duluth																																								
Paine College – Augusta																																								
West Care Georgia, Inc. – Atlanta																																								
St. Joseph's Mercy Care Services, Inc. – Atlanta																																								
HIV/AIDS Empowerment Resource Center – Atlanta																																								
Georgia Regents Research Institute, Inc. – Augusta																																								
Cobb County Community Services Board – Marietta																																								
HUD/HOPWA																																								
Department of Community Affairs	**$2,256,003**																					**X**																		
Augusta - Richmond County	**$1,072,089**																					**X**																		
City of Atlanta - HOPWA	**$18,078,087**																					**X**																		
AIDS Athens																																								
AIDS Legal Project																																								
Covenant House																																								
Furniture Bank																																								
Jerusalem House																																								
Legacy House																																								
Legacy Village																																								

Making a Way Housing																																						
Project Open Hand																																						
Positive Impact																																						
The Edgewood Center																																						
Bureau of Primary Health																																						
Albany Area Primary Health Care – Albany																																						
Athens Neighborhood Health Center																																						
Center for PanAsian Community Services – Atlanta																																						
Christ Community Health Centers – Augusta																																						
Coastal Health Services – Brunswick																																						
Community Health Center – Wrightsville																																						
Diversity Health Center – Ludowice																																						
East Georgia Healthcare – Swainsboro																																						
Family Health Centers of GA – Atlanta																																						
First Choice Primary Care, Inc. – Macon																																						
Georgia Highlands Medical – Cumming																																						
Good Samaritan Health Center – Marietta																																						
J.C. Lewis Health Center – Savannah																																						
McKinney Community Health Center – Waycross																																						
Oakhurst Medical Centers, Inc. – Stone																																						

Mountain																																					
Palmetto Health Council – Atlanta																																					
Primary Care of South-West GA - Blakely																																					
Primary Care Center of Dade – Trenton																																					
St. Joseph's Mercy Care Services – Atlanta																																					
South Central Primary Care Center – Ocilla																																					
Southside Medical Center – Atlanta																																					
Southwest Georgia Healthcare - Richland																																					
Tender Care Clinic – Greensboro																																					
Valley Healthcare System - Columbus																																					
Office of Rural Health																																					
Office of Women's Health																																					
Office of Minority Health	**$415,000**																																				
Wholistic Stress Control Institute – Atlanta																																				**X**	
Recovery Consultants of Atlanta - Atlanta																																				**X**	
Office of Population Affairs																																					
State Funds																																					
Part B Match	**$16,652183**		**X**		**X**																																
County Funds																																					
Fulton County	**$629,811**																																				
Private Funds																																					

Medicaid	**$85,669,910**		**X**		**X**																																		
TOTAL FUNDING																																						