State of Georgia
Comprehensive HIV Services Plan
2009 - 2012

Division of Public Health
Office of Essential Preventive Clinical Services
HIV Unit

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January 30, 2009

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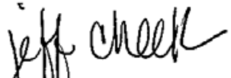
Dear Dr. Barclift:

As a participant and contributor to the State of Georgia's 2009-2012 Statewide Comprehensive Plan, the Atlanta EMA Ryan White Part A Program submits this letter of concurrence with the goals, objectives, and strategies of the Plan which will guide the development and monitoring of the state's HIV/AIDS health care delivery system. The Plan includes discussions of the fundamental goals of HIV/AIDS care in the EMA, which include improving access to HIV-related core services, improving the quality of health care and health outcomes, eliminating health disparities and barriers to care, and enhancing collaboration and communication with partners statewide.

The Atlanta EMA is pleased to have been a part of the network that provided input to ensure that the needs of individuals and families affected by HIV/AIDS in the Metropolitan Atlanta EMA were considered in this regional and statewide process. This kind of coordination is very timely, particularly in light of the limited resources available to meet the needs of Georgians living with HIV/AIDS.

Sincerely,



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January 26, 2009

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Dear Dr. Barclift:

On behalf of the Atlanta Family Circle Ryan White Part D Project, we are confirming our concurrence with the State of Georgia's 2009-2012 Statewide Comprehensive Plan to the Health Resources and Services Administration (HRSA) for the HIV/AIDS funds under Section 2617 (b)(6) of the Ryan White HIV/AIDS Treatment Modernization Act of 2006. We believe that the document addresses the patient care planning needs priority populations that are being supported through the funding commitments of the Georgia Department of Human Resources as well as other Ryan White program funding sources, including Part D.

In developing the plan, Georgia has updated the process for conducting or utilizing needs assessments, in concurrence with the legislative requirements. Atlanta Family Circle Ryan White Part D project contributed to the development of the state's 2009-2012 statewide comprehensive plan and reached consensus that the priorities and strategies proposed in the statewide comprehensive plan reflected the priorities expressed by Atlanta Family Circle Ryan White Part D Project. During the October 1 and 2, 2008 SCSN meeting, Atlanta Family Circle Ryan White Part D project staff, sub-recipients and consumers provided the state with substantial feedback on the development of the 2006-2009 statewide comprehensive plan.

Sincerely,

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Southeast AIDS Training and Education Center
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January 28, 2009

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Dear Dr. Barclift:

On behalf of the Southeast AIDS Training and Education Center (SEATEC), we are confirming our concurrence with the State of Georgia's 2009-2012 Statewide Comprehensive Plan to the Health Resources and Services Administration (HRSA) for the HIV/AIDS funds under Section 2617 (b)(6) of the Ryan White HIV/AIDS Treatment Modernization Act of 2006. We believe the document addresses the patient care planning needs and priority populations that are being supported through the funding commitments of the Georgia Department of Human Resources as well as other Ryan White program funding sources, including Part F.

In developing the plan, Georgia has updated the process for conducting or utilizing needs assessments, in concurrence with the legislative requirements. SEATEC contributed to the development of the state's 2009-2012 statewide comprehensive plan and reached consensus that the priorities and strategies proposed in the statewide comprehensive plan reflected the priorities expressed by SEATEC. During the October 1 and 2, 2008 SCSN meeting, SEATEC project staff provided the state with substantial feedback on the development of the 2009-2012 statewide comprehensive plan.

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B. J. Walker, Commissioner

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Georgia Department of Human Resources – Division of Public Health
HIV Prevention Program: Letter of Concurrence

January 26, 2009

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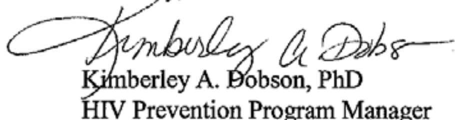
Dear Dr. Barclift:

On behalf of the HIV Prevention Program, we are confirming our concurrence with the State of Georgia's 2009-2012 Statewide Comprehensive Plan to the Health Resources and Services Administration (HRSA) for the HIV/AIDS funds under Section 2617 (b)(6) of the Ryan White HIV/AIDS Treatment Modernization Act of 2006. We believe that the document addresses the patient care planning needs priority populations that are being supported through the funding commitments of the Georgia Department of Human Resources.

In developing the plan, Georgia has updated the process for conducting or utilizing needs assessments, in concurrence with the legislative requirements. Key staff from the HIV Prevention Program as well as members of the Georgia Community Planning Group (GCPG) provided input and feedback towards the development of the state's 2009-2012 statewide comprehensive plan and reached consensus that the priorities and strategies proposed in the statewide comprehensive plan reflected the priorities expressed by Georgia's HIV Prevention Comprehensive Plan during the October 1 and 2, 2008 SCSN Planning Meeting.

The HIV Unit values the opportunity to foster collaboration with all HIV/AIDS programs statewide to enhance community planning and develop an effective and comprehensive approach in Georgia.

Sincerely,



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Introduction

Comprehensive HIV/AIDS services' planning is a central focus of the Ryan White HIV/AIDS Treatment Modernization legislation and an essential component of the Ryan White programs. Comprehensive planning is necessary to achieve the goals of the Ryan White HIV/AIDS Treatment Modernization: to develop, organize, coordinate, and implement more effective and cost-efficient systems of essential services to individuals and families with HIV disease.

Comprehensive planning guides decisions about services for people living with HIV disease and AIDS. Planning activities undertaken by the Georgia Department of Human Resources Division of Public Health Ryan White Part B state and local programs, the Metropolitan Atlanta Part A Planning Council, and Ryan White Part C and D programs across the state assist the decision-making process in the development and maintenance of a system of care and support for persons living with HIV and AIDS (PLWHA) in Georgia. This is especially important in light of the changing and increasingly complex health care environment.

The comprehensive HIV services planning process undertaken in Georgia required Ryan White providers, other HIV/AIDS providers, other public agency representatives, and PLWHA to ask four questions related to the state's HIV health service delivery system and to engage in a planning process that resulted in this written Comprehensive HIV Health Services Plan. The four questions addressed in the Plan are:

- ► Where Are We Now: What is Our Current System of Care?
- ► Where Do We Need To Go: What System of Care Do We Want?
- ► How Will We Get There: How Does Our System Need to Change to Assure Availability Of And Accessibility to Core Services?
- ► How Will We Monitor Our Progress: How Will We Evaluate Our Progress In Meeting Our Short-and-Long-term Goals?

Executive Summary

The Georgia Department of Human Resources/Division of Public Health, HIV Unit is the lead agency responsible for planning, coordinating and developing a comprehensive service delivery network of health care and supportive services for people living with HIV/AIDS. The HIV Unit program areas include both HIV prevention services and HIV/AIDS care services. The Ryan White Part B program consist of several network of providers, including sixteen (16) public health districts and several community-based organizations to deliver HIV/AIDS services throughout the state. Each funded public health district is served by a Ryan White Part B HIV Care Consortium that serves as an advisory body and is charged with the responsibility to conduct regional needs assessments, gap analysis, and make recommendations on how to prioritize Ryan White Part B funds in their respective districts. The HIV Section collaborates with Parts A, C, D and key stakeholders throughout Georgia to develop a statewide comprehensive plan. Comprehensive planning activities assist the decision-making process in the development and maintenance of a system of care and support for persons living with HIV and AIDS (PLWHA) in Georgia. This is especially important in light of the changing and increasingly complex health care environment.

The comprehensive HIV services planning process undertaken in Georgia required Ryan White providers, other HIV/AIDS providers, other public agency representatives, and PLWHA ask four questions related to the state's HIV health service delivery system and to engage in a planning process that resulted in this written Comprehensive HIV Health Services Plan. The four questions addressed in the Plan are:

- ► Where Are We Now: What is Our Current System of Care?
- ► Where Do We Need To Go: What System of Care Do We Want?
- ► How Will We Get There: How Does Our System Need to Change to Assure Availability Of And Accessibility to Core Services?
- ► How Will We Monitor Our Progress: How Will We Evaluate Our Progress In Meeting Our Short-and-Long-term Goals?

Georgia's FY 2009-2012 Comprehensive HIV Services Plan provides the goals, objectives, and strategies that will be used to guide the further development and monitoring of the state's HIV/AIDS health care delivery system. The 2009 SCSN identified needs and barriers have been incorporated into the goals and objectives. Many of the needs and barriers identified during the 2006 SCSN meeting continue to exits in Georgia for PLWHA. The goals and objectives were aligned with HRSA long range strategies. The Georgia Comprehensive Plan includes four overarching goals:

Goal 1: Improve access to HIV-related core services.
Goal 2: Improve the quality of health care and health outcomes.
Goal 3: Eliminate health disparities and barriers to care.
Goal 4: Enhance collaboration and communication with partners statewide.

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. The Ryan White Part B staff will ensure the

implementation of the FY 2009-2012 Comprehensive HIV Services Plan in collaboration with 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.

Section 1: Where Are We now: What is Our Current System of Care?

Description of the State

Population in Georgia: According to the 2007 federal census, Georgia ranked 9th among the states in population size, with a total population of 9,544,750. This represented an increase in total population of 47.3% over the 1990 census of 6,478,216. The largest state east of the Mississippi River, Georgia now has the country's ninth largest population and is the fifth fastest growing state nationally, both numerically and percentage-wise. In 2005, the U.S. Census Bureau estimated that the state's population was 9,072,576, an increase of 886,123 (9%) since 2000. By 2010, Georgia's population is projected to grow to 9.6 million persons.

Georgia's population is not evenly distributed. About one-half of the population, 51% of the state's African American population, 62% of the Hispanic population, and 38% of the poor, live in the 20-county Atlanta Eligible Metropolitan Area (EMA). Within the EMA, 65% of the total population lives in the four most urbanized counties: Fulton, DeKalb, Cobb, and Gwinnett. The other half of the state's population is widely dispersed throughout the state, largely in rural areas and small cities. This uneven distribution has historically presented challenges in healthcare resources and service delivery.

Population Characteristics:
Population, Georgia Compared to US (2007 Census)

Characteristic	Georgia	US
Persons under 5 years old	7.7%	6.9%
Georgia persons 18 years and over	73.5%	75.3%
White persons	62.3%	74.1%
Black or African American persons	29.6%	12.4%
Asian	2.7%	4.3%
Other race	3.8%	6.2%
Hispanic/Latino origin	7.4%	14.7%
Foreign born persons	9.0%	12.5%
Language other than English	11.8%	19.5%
High school graduation	82.2%	84.0%
Bachelor's degree or higher	26.6%	27.0%

Source: U.S. 2007 Census Bureau

Data from the 2007 Census, the latest available data, highlights the exceptional growth and increasing diversity of Georgia. This growth is driven by natural increase (i.e., births versus deaths), domestic migration and international migration. About one in four of the state's current residents did not live here ten years ago. Georgia is now the thirteenth top destination for international immigrants and second for domestic migrants. Much of this escalation is concentrated in the 20-county Atlanta EMA, which drew two-thirds of the overall state increase over the past ten years.

Race/Ethnicity: An increasing number of African Americans have been moving to the South. Georgia is the most popular choice for African Americans moving from other states. It ranks 3rd nationally, behind New York and Texas, in the number of African Americans and 4th in the

percentage of African Americans in the overall population of the state, behind the District of Columbia, Mississippi, and Louisiana.

Reflecting national trends, the number of Asians and Hispanics in Georgia have shown dramatic increases, which are projected to continue. Prior to the 1990's, almost all of the foreign born people living in Georgia were either migrant agricultural workers or a small nucleus of Southeast Asians and Mexicans in the core Atlanta area. With the booming economy in the early 1990s, these already settled residents, mostly men, formed the foundation for supportive communities that brought relatives, friends and neighbors to the state. Hispanic or Latinos (of any race), are the most rapidly growing minority group and now reside throughout Georgia. About 7.4% of all Georgians are Hispanic.

Asians have a long immigration history which until recently consisted of small numbers of Koreans and Chinese settling in the metro Atlanta area. Over the past 15 years, the number of Asians has increased along with significant diversification. Large numbers have arrived from Southeast Asia – Vietnam, Philippines, Laos, Thailand, Cambodia – and from the Indian subcontinent – India, Pakistan – and have settled in the state's metro areas. Asians comprised 23.8% of foreign-born Georgians in 2007. Driven by upheavals in their countries of origin, recent waves of eastern Europeans and Africans have also migrated to Georgia. Immigrants have arrived from the former Soviet republics and Soviet block nations, including war-ravaged former Yugoslavia. Similarly, Africans displaced by famine and war have arrived as refugees from Ethiopia, Somalia, Eritrea, and Africans from other nations have arrived seeking economic opportunities. While Arabs have a long history of immigration to the U.S., their experience settling in Georgia is relatively new. This new group of immigrants consists of both Muslims from Africa and the Middle East.

Age: Georgia's population continues to grow younger compared to the U.S. as a whole, ranking 6th in terms of the lowest median age. In 1990, Georgia was not even the youngest state in the south; by 2000 the only states in the country with a younger population were all in the west. This trend represents a combination of a baby boom and huge numbers of young professionals from other parts of the country and working age immigrants moving to Georgia. The state ranks 7th nationally in the percent of its population who are of working age.

Poverty: A total of 1,709,826, individuals in Georgia had incomes below the poverty level in 2007. There were 655,191 (25%) children under the age of 18 living in poverty; 927,747 adults living below the poverty level of which 17% were females and 14% males. Of the state's poor households, 46.4% were female headed households with children under the age of five years.

Health Delivery System Environment: While most of the reported cases of HIV/AIDS are from large metropolitan cities or EMAs, more cases are being reported in rural communities. Many rural communities have unique needs and service challenges that limit their ability to meet the growing needs of persons living with HIV/AIDS. Many service delivery systems are facing profound shortages in providers and community based organizations offering HIV/AIDS related services.

The 2004 Health Resources and Services Administration (HRSA) report, "State Health Workforce Profiles," shows Georgia's workforce status across a large range of professions. Nearly 299,000 workers, 7.7% of Georgia's total workforce, were employed in the health sector in 2000. This ranks Georgia 37th among states in per capital health services employment. The demand for health professionals in the state is projected to grow by 37% by 2010. The Georgia

Department of Labor predicts a need for more than 140,000 new and replacement health care professionals, including about 30,000 additional RNs, 9,000 LPNs, 3,700 pharmacists, and thousands of allied health and behavioral health professionals.

The state's physician supply has remained stagnant despite the rapid growth of Georgia's population. This trend may be come even more pronounced as Georgia's physician workforce is aging. Baby boomers now comprise 75% of the workforce, and a significant portion of the state's physicians could retire in the next ten years. Georgia has experienced considerable growth in most primary care specialties over the last decade; however, challenges related to the geographic distribution of physicians remain.

A more profound shortage has been experienced in relation to public health nursing. The total number of public health nurses (LPNs, RNs, Nurse Practitioners) in Georgia has declined each year since 2002, FY 2002 there were 1816 to FY 2008 1526. The overall turnover rate for 2008 was 18.7% with 17 Districts reporting turnover rates in the double digits. The overall vacancy rate for 2008 was 19.9% with 16 Districts reporting vacancy rates in the double digits.

Georgia's shortage of dentists is exacerbated by its maldistribution of dentists. Almost half of the dentists in Georgia practice in an eight-county metro Atlanta area that is home to one-third of the state's population. About 70% of all dentists practice in the northern part of the state, leaving many residents in the rest of Georgia having to travel great distances for dental care. A survey of practicing dentists in Georgia indicated that over 45% said they planned to retire within ten years. In the public health sector, recruitment and retention of oral health providers has been impacted by low salaries compared to salaries offered by the private sector.

Georgia's problem with maldistribution of providers continues to impact access to care, particularly for uninsured and underinsured persons and residents of rural areas, especially those requiring specialty care. There are too many providers in urban areas and not enough in rural parts of the state. Specialty care is more limited, generally located in areas with academic medical centers (i.e., Atlanta, Augusta, Macon and Savannah), leaving large portions of the state without access to this care. Moreover, the availability of providers to serve these populations is becoming even scarcer which has led to the designation of an increasingly large number of population groups for Health Professional Shortage Area (HPSA) status. In 2007 there were 183 primary care, 56 mental health, and 126 dental care designated HPSAs in the state of Georgia.

Hospitals: Georgia has 149 acute care hospitals. Of these hospitals, 39 (26%) have fewer than 50 beds. In total, these small hospitals in the rural parts of the state have 7% of all Georgia hospital beds. Another 45 hospitals have 100 or fewer beds. These hospitals represent 13% of the overall total hospital beds in the state. At the other end of the spectrum, 38 acute care hospitals have greater than 200 beds. These large hospitals, which constitute just over one-third of all facilities in the state, have about two-thirds of all beds. Fourteen of these 38 hospitals are located in the core metro Atlanta counties.

Community Health Centers (CHC): Georgia's CHCs offer a comprehensive range of primary health care and other services including around the clock care, acute illness treatment, prenatal care, well-child care, physicals, preventive services, health education, nutritional counseling, laboratory, x-ray and pharmacy services. Georgia federally supported health centers including 28 organizations representing 114 delivery sites and serving approximately 225,722 patients. Georgia CHCs provide high quality care helping to reduce the health disparities and improve

patient outcomes. Among persons served at the state's 28 CHCs in 2007, approximately 46% are uninsured and 28% are Medicaid recipients. Almost three-fourths are members of a minority group: 17% are Hispanic, 54% Black, and 3% Asian/Pacific Islander.

Medicaid/PeachCare for Kids (CHIP): The Department of Community Health (DCH) administers the state's Medicaid and State Child Health Insurance Program (PeachCare for Kids) programs. About 12% of all Georgia residents are on Medicaid, 10th among all states. Georgia Division of Medical Assistance data indicates that 46% of the state's Medicaid recipients in FY 2007 were female. Due to strict eligibility guidelines, males with HIV must be come considerably ill and be disabled before being eligible for Medicaid coverage that would afford access to necessary care. In the Atlanta EMA, males represent 81% of the total HIV/AIDS prevalence, yet account for only 54% of Medicine recipients.

Public Health (PH): Service delivery in the state's public health system is carried out by 159 county boards of health, covering more than 57,000 miles. These boards of health are combined into 18 district units, ranging from one to 16 counties in size, and are overseen administratively by a district office that provides management services and programmatic support. Each district is led by a physician district health officer who reports to the state office of the Division of Public Health (DPH), Department of Human Resources (DHR). The county boards of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern. All 18 health districts receive Ryan White funding, either from multiple programs or exclusively from one program, to provide services for PLWHA in Georgia.

Epidemiological Profile

The HIV/AIDS epidemic continues to grow in Georgia. Georgia has the 8th highest number of AIDS cases in the United States and the 6th highest rate of AIDS cases, 17.1 per 100,000 in 2006**.** Since the earliest days of the HIV/AIDS epidemic, Georgia has had a substantial number of reported cases of AIDS**.** During the period of 2006-2007,Georgia reported 20,508 persons living with AIDS and 13,256 persons living with HIV non-AIDS infection at the end of 2007 in Georgia During the same reporting period 1,800 AIDS cases as newly diagnosed (AIDS incidence) which reflect a decrease from the previous two year period of 2005-2006. Approximately 73% of diagnosed AIDS cases were males (1,305).

Who has HIV/AIDS in Georgia? 2006-2007 AIDS Diagnosis, AIDS Prevalence, and HIV (not AIDS) Prevalence estimates in Georgia by selected characteristics are presented in the table below.

	AIDS Diagnoses[1] 1/1/06-12/31/07		AIDS Prevalence[2] 12/31/07		HIV Prevalence[3] 12/31/07	
Race/Ethnicity	#	%	#	%	#	%
White, not Hispanic	306	17.0	5,116	24.9	2,848	21.5

[1] The number of AIDS cases diagnosed in the specified period.
[2] The number of people living with AIDS as of the specified date; persons are assumed to be alive and living in Georgia unless otherwise documented or reported.
[3] The number of people living with HIV as of the specified date; persons are assumed to be alive and living in Georgia unless otherwise documented or reported. HIV (non-AIDS) reporting was mandated in Georgia on December 31, 2003.

Black, not Hispanic	1,350	75.0	14,342	69.9	9,715	73.3
Hispanic	116	6.4	868	4.2	522	3.9
Asian/Pacific Islander	1	0.1	56	0.3	51	0.4
American Indian/Alaska Native	4	0.2	24	0.1	21	0.2
Other/Multi-race	23	1.3	99	0.5	98	0.7
Unknown	0	0.0	3	0.0	1	0.0
Total	1,800	100.0	20,508	100.0	13,256	100.0
Gender	#	%	#	%	#	%
Male	1,305	72.5	15,663	76.4	9,077	68.5
Female	495	27.5	4,845	23.6	4,179	31.5
Total	1,800	100.0	20,508	100.0	13,256	100.0
Age at Diagnosis						
<15 years	2	0.1	148	0.7	271	2.0
15-24 years	123	6.8	1,316	6.4	2,402	18.1
25-34 years	399	22.2	6,825	33.3	4,344	32.8
35-44 years	680	37.8	7,821	38.1	3,941	29.7
45-54 years	442	24.6	3,358	16.4	1,747	13.2
55-64 years	129	7.2	851	4.1	438	3.3
65+ years	25	1.4	189	0.9	113	0.9
Total	1,800	100.0	20,508	100.0	13,256	100.0
Transmission Category	#	%	#	%	#	%
Men who have Sex with Men (MSM)	566	31.4	8,104	39.5	3,974	30.0
Injection Drug Use (IDU)	63	3.5	2,234	10.9	752	5.7
MSM and IDU	31	1.7	871	4.2	302	2.3
High-Risk Heterosexual Contact	155	8.6	2,993	14.6	1,364	10.3
Other[4]	3	0.2	248	1.2	278	2.1
Risk Not Reported or Identified[5]	982	54.6	6,058	29.5	6,586	49.7
Total	1,800	100.0	20,508	100.0	13,256	100.0

Trends or Changes in Georgia’s HIV Disease Prevalence

Percent of change of AIDS Diagnoses, AIDS Prevalence and with HIV (not AIDS) Prevalence in Georgia for the past two years, 2006-2007

Indicator	2006	2007	Percent change	Trend
AIDS Diagnoses	2,765	1,800	34.9%	Decrease
AIDS Prevalence	19,453	20,508	5.4%	Increase
HIV Prevalence	-	13,256	NA**	N/A**

*Percent Change and trend for HIV prevalence is not presented because previous (2006) HIV prevalence was based on an estimate.

Men who have sex with men (MSM) still represent the largest number of people living with AIDS in Georgia. They account for approximately 44% (40% MSM and 4% MSM who inject drugs) of the Georgia cases known living with AIDS as of December 31, 2007. MSM also represent the largest number of people living with HIV. Based on HIV prevalence, MSM account for 32% of the Georgia estimated cases.

[4] “Other” includes hemophilia, blood transfusion, transplant, pediatric, perinatal risk, and cases without risk factor information.

[5] Risk was either not reported or did not fall into a CDC-defined risk transmission category.

Recent trends continue to indicate that the disease is affecting African-Americans, women, heterosexuals, and people living in rural areas at growing rates. In the United States, African American males and females, ages 18-44, are most disproportionately affected by HIV and AIDS. Although African Americans make up only 30% of Georgia's population, 75% of the new cases of AIDS in 2006-2007 and 73% of the HIV cases were among African-Americans. According to Kaiser Foundation, 2006 State Health Facts, Georgia ranked 7th nationally among all States in the cumulative proportion of AIDS cases and 5th among all States in new AIDS cases represented by African Americans. Black males and females, aged 20 – 44, are disproportionately affected by HIV. As a result, AIDS continues to be in the top four leading causes of death among Black men and women.

The disproportionate impact by the HIV/AIDS epidemic on African Americans can be further illustrated by Georgia Department of Correction (DOC) data. As of December 2007, DOC reported 420 individuals released from Georgia correctional facilities with HIV/AIDS. African American accounted for 75% (316) of those identified cases. Data from the Ryan White Part B funded HIV/AIDS Pre-Release Planning Program showed 165 inmates with HIV/AIDS enrolled in the program. African Americans account for 75% of those cases.

The HIV/AIDS epidemic in Georgia continues to affect a significant number of women. From 1984 to 2007, the cumulative proportion of AIDS cases among women increased from 4% to 24%. African-American women are disproportionately affected. Heterosexual contact remains the primary mode of transmission. Many women are sex partners of men who have used drugs or of men who have sex with men. Twenty-four percent (4,845) of the individuals living with AIDS and 32% (4,179) of the cases of HIV in Georgia at the end of 2007 were female. Black women were disproportionately affected and heterosexual sex continued to be the primary mode of transmission. As more women become infected with HIV, more children may be born with HIV. Without treatment, HIV infected mothers transmit their infection to their babies 25% – 30% of the time. Treatment with antiretroviral therapy reduces the transmission rate to 2% – 5%. In Georgia, there were 6 reported cases of AIDS in children under the age of 13 in 2006.

Georgia continues to experience a growing Hispanic population. Hispanics (All Races) account for 6% of AIDS incidence cases and 4% of the estimated HIV cases reported during 2006-2007. There were more Hispanic males than females diagnosed with AIDS (92) and living with AIDS (712) during the two year reported period. Hispanic females accounted for 5% of newly reported AIDS cases and 3% of reported cases of persons living with AIDS.

The epidemic is shifting to Georgia's rural areas and small cities and towns. In 2007, 36% of people living with HIV/AIDS were living outside the 20-county Atlanta Metropolitan Statistical Area (MSA). In rural areas of the state, resources are scarce. People and services are more dispersed and therefore harder to reach with treatment and prevention efforts. Geographic regions outside of the Atlanta MSA with a high HIV/AIDS morbidity include the North Central, East Central and Coastal regions of the state.

Response to the Epidemic

The Ryan White Part B Program continues to work collaboratively and foster new relationships with other programs, departments, agencies, and divisions that may fund HIV/AIDS services within the state of Georgia. Statewide there are 16 Ryan White Part B public health districts that serve as advisory bodies and are charged with the responsibility to conduct regional needs

assessments, gap analysis, and make recommendations on how to prioritize Ryan White Part B funds in their respective districts. Public health districts review services funded by other sources when prioritizing Ryan White Part B funds to avoid duplication of services, maximize the number and accessibility of services, and ensure continuum of care.

Assessment of Need, Unmet Needs and Barriers to Care

Georgia employs several different mechanisms to assess the need for primary medical care and other core medical services and barriers among people living with HIV/AIDS in the state. The primary method of gathering data regarding needs, unmet needs, and barriers to care has been through collaborative relationships with other entities, including the HIV/AIDS Epidemiology Surveillance Section, the Southeast AIDS Education and Training Center (SEATEC), district-level Ryan White Part B Consortia, other Ryan White programs, such as the Atlanta EMA Part A Program, and the HIV Unit Prevention Program. The process of updating the Statewide Coordinated Statement of Need (SCSN) also provides critical information regarding client needs. The Ryan White Part B Program collaborates with the following agencies and departments to assess the need and barriers for PLWHA in Georgia:

HIV/AIDS Epidemiology Section Georgia's HIV/AIDS surveillance activities monitor the HIV/AIDS epidemic in the state and provide data critical to targeting the delivery of HIV prevention, care, and treatment. The HIV/AIDS Epidemiology Section reviews and analyzes reports from providers and laboratories regarding key statistics such as HIV risk factors and demographics of those who are infected. The HIV/AIDS Epidemiology Section conducts other activities to gather more in-depth information about the HIV/AIDS epidemic in Georgia. These surveillance projects examine a variety of topics, settings, and risk behaviors. Many of these studies are conducted with community, provider, and participant input and in collaboration with the Centers for Disease Control and Prevention, local universities, and HIV care providers.

SEATEC Needs Assessment Activities Southeast AIDS Training and Education Center (SEATEC) has undertaken several projects for the Georgia Department of Human Resources, HIV Unit and the Fulton County Government (Part A) and Metropolitan Atlanta HIV Health Services Planning Council. SEATEC addresses training needs of health care providers who diagnose and manage patients with HIV, with a special focus on minority and minority-serving providers, rural providers, and providers working in Ryan White programs. Part A and B representatives worked with SEATEC in the planning of the Statewide Case Management Meeting held in June 2007, and the statewide Ryan White Program Meeting in October 2007.

Ryan White Part B Care Consortia Georgia's Ryan White Part B Care Consortia provide additional information regarding client needs through local and regional needs assessments. Part B Consortia furnish district-specific client needs information to the state HIV Unit through the annual application process for Ryan White Part B funding. In the Part BI application, districts must supply a summary of the most recent needs assessment as well as identify two or more specific subpopulations and elaborate on the specific needs of each subpopulation. The data from the districts not only provide both valuable insight into client needs, but also offer information specific to a geographic area of the state. This specificity allows comparison of client needs from district to district and statewide to identify disparities in care and gaps in the healthcare infrastructure.

The data the Consortia provide enable the HIV Unit to update statewide activities and prioritize the key areas of focus for the funding year. In addition to working with each Consortium to

develop a needs assessment, the state also works with all of the Ryan White Program providers to ensure the identified disparities in health care infrastructure are addressed. The culmination of working with the Consortia allows the state to put together an updated comprehensive statewide needs assessment.

The needs assessment done by the 16 consortia show that the five most needed services are Primary Care, HIV medications, Oral Health, Medical Case Management, and Mental Health services. These five needs are identified across the state regardless of the area that 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 that HIV positive clients reside. Rural populations identify transportation, and emergency financial assistance, as higher ranked needs while suburban and urban needs are more varied in rank with no overall trends.

Other Ryan White Programs The state also gathers additional information regarding client needs through its collaborations with other programs of the Ryan White HIV/AIDS Treatment Modernization Act. Part B work with Part C programs is facilitated by the fact that 14 of the state's public health districts are either Part C Early Intervention Services (EIS) grantees or are affiliated with an agency that is. Part B Consortia frequently utilize the comprehensive needs assessment completed as a component of the Part C EIS application process for their own planning activities and for development of their annual Part B consortium application.

The state also coordinates closely with Part A programs, including representation on the Atlanta EMA Planning Council. Each year, the Part A Planning Council assesses the needs of individuals and families affected by HIV/AIDS in the Metropolitan Atlanta EMA. To coordinate service delivery, Part A and Part B programs share needs information as well as collaborate on regional and statewide needs assessments,.

Information is also gathered from Georgia's two Part D grantees: the Metro Atlanta Family Circle Part D Network and the Waycross Part D Program. The Atlanta Part D Program is administered by the Fulton-DeKalb Hospital Authority Grady Health System, Infectious Disease Program, a key program within the Part A network of providers. The Waycross Program is also a Part B grantee. The Part D programs provide important insights into the needs of pregnant women, women of childbearing age, children, adolescents, and families.

HIV Prevention Additional needs information regarding persons with HIV/AIDS is made available to the state through other projects and service programs funded by the Centers for Disease Control and Prevention. At the state level, HIV Prevention and Ryan White Part B administrative and clinical staff work collaboratively to ensure that individuals identified as positive through HIV prevention activities are linked to local Ryan White care and treatment services. Locally, many of the public health districts and community based organizations who receive Ryan White Part B funding also receive CDC prevention funds. Local public health districts and agencies work collaboratively to coordinate resources to reduce duplication of services and ensure a continuum of care. The HIV Unit will continue to provide technical assistance for both HIV Prevention, and Ryan White Part B public health districts and sub-recipients to foster integration of HIV Prevention and Ryan White service delivery

Statewide Coordinated Statement of Need The SCSN has guided all Ryan White Programs in Georgia in planning services to address the needs of PLWHA. The October 2008, an update of the state's SCSN has provided additional insight into the multi-faceted needs of Georgia's residents living with HIV/AIDS. The periodic update of the SCSN will continue to supply

Georgia with timely and relevant data on the needs of those served by the Part B Program and other Ryan White Programs in the state. A detailed description of the SCSN process is provided in **Section 2: Where Do We Need to Go: What is Our Vision of An Ideal System?**

Unmet Need Estimate Unmet Need analysis was completed using the 2007 calendar year time period. Calculations forming the basis of the estimate were completed using the HIV/AIDS Reporting System (eHARS) developed by the Centers for Disease Control and Prevention (CDC) along with an internal Laboratory Reporting Database as a supplementary source of case data. This methodology is consistent with previous grant periods' unmeet need analyses.

HARS (HIV/AIDS Reporting System) is a computer-based system that uses uniform surveillance case definition and case report forms developed by the Centers for Disease Control and Prevention (CDC) to track diagnosed and reported AIDS cases. Unmet need is defined as people who were reported to be living with HIV/AIDS as of 12/31/07 and who did not have a CD4 or HIV viral load test done in 2007. Persons with documented HIV infection in the lab database who were not reported in eHARS and who did not receive a CD4 or VL in 2007 were also included in the unmet need estimate. For the number of people living with AIDS (PLWA) receiving HIV medical care, AIDS status was defined as diagnostic status of AIDS in eHARS or evidence of ever having a CD4 count below 200 or 14% in the laboratory database. The total number of people receiving the defined HIV primary medical care approximates previous estimates and is consistent with the 2007 estimate of persons in HIV/AIDS care as defined by the Georgia Medical Monitoring Project.

Population estimates – As of December 31, 2007 17,645 people were estimated to be living with HIV/non-AIDS who knew their status; an additional 23,436 people were reported to be living with AIDS in Georgia.

Estimates of people in care_– For the period of January 1 – December 31, 2007, 8,802 (50%) PLWH/non-AIDS/aware was receiving HIV primary care. For this same period, 9,109 (39%) PLWA were receiving HIV primary.

Estimates of unmet need – For the period of January 1 –December 31, 2007, 14,327 (61%) PLWH/non-AIDS aware did not receive HIV primary medical care. During the same period, 8,843 (50%) PLWA did not receive any primary medical care.

Table A below illustrates the approach used by the Part B program to generate the unmet need estimates.

Table A: Unmet Need Estimate, Georgia 2007

Quantified Estimate of Unmet Need for HIV Primary Care, Georgia, 2007				
Population		**Total**		**Data Source**
Row A.	Number of persons living with AIDS (PLWA) as of 12/31/2007	23,436		eHARS and Laboratory Database
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware as of 12/31/2007	17,645		C-A
Row C.	Total number of HIV+/aware as of 12/31/2007	41,081		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 as of 12/31/2007	9,109		eHARS and Laboratory Database
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period as of 12/31/2007	8,802		F-D
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period as of 12/31/2007	17,911		eHARS and Laboratory Database
Calculated Results		**Total**	**Percent**	**Calculations**
Row G.	Number of PLWA who did not receive the specified HIV primary medical care	14,327	61%	A-D
Row H.	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	8,843	50%	B-E
Row I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	23,170	56%	C-F

Assessment of Unmet Need Unmet need data indicate that there are 14,327 PLWA and 8,843 PLWH (non-AIDS) who are aware of their status but did not receive HIV related care. Combined, there are an estimated 23,170 individuals with HIV/AIDS who are in need of regular primary care Table B below reflects the results of our preliminary analysis related to demographics of subpopulations with an unmet need for HIV primary care during the 12 month reporting period of January 1, 2007 – December 31, 2007. As can be seen in the table, males account for 70% of PLWH non-AIDS, who are not in care while females account for 30% of PLWH non-AIDS, who are not in care. African Americans and Whites living with HIV non-AIDS and those living with AIDS have higher unmet need than Hispanic. African Americans still represent the largest racial group of PLWH non-AIDS at 75.8%. By exposure category, MSM risk reported as the highest unmet need for both AIDS and HIV non-AIDS of the remaining exposure categories. In reviewing age, it can be seen that the 44+ age group has the highest level of unmet need for PLWA.

Table B. Unmet Need by HIV Status, Demographic Group and Exposure Category Georgia, 1/1/2007 – 12/31/2007[6]

	Unmet Need-HIV(non-AIDS) 1/1/2007 – 12/31/2007		Unmet Need- AIDS 1/1/2007 – 12/31/2007	
Race/Ethnicity	#	%	#	%
White, not Hispanic	1,677	19.0	3,701	25.8
African American, not Hispanic	6,704	75.8	9,925	69.3
Hispanic, All Races	311	3.5	582	4.1
Other/Multi-race, not Hispanic	77	0.9	90	0.6
Unknown	74	0.8	29	0.2
Total	8,843	100.0	14,327	100.0
Gender	#	%	#	%
Male	6,201	70.1	11,173	78.0
Female	2,642	29.9	3,154	22.0
Total	8,843	100.0	14,327	100.0
Age[7]	#	%	#	%
13-19 years	155	1.7	16	0.1
20-29 years	1,926	21.8	511	3.6
30-36 years	1,636	18.5	1,436	10.0
37-44 years	2,198	24.9	4,277	29.9
45+ years	2,922	33.1	8,087	56.4
Total	8,837	100.0	14,327	100.0
Exposure Category	#	%	#	%
Men who have Sex with Men (MSM)	3,136	35.5	5,221	36.4
Injection Drug Use (IDU)	601	6.8	1,659	11.6
MSM and IDU	204	2.3	628	4.4
Heterosexual Contact	937	10.5	1,839	12.8
Other[8]	32	0.4	110	0.8
Risk Not Reported or Identified	3,933	44.5	4,870	34.0
Total	8,843	100.0	14,327	100.0

Service Needs, Gaps, and Barriers to Care for People Not in Care Ryan White Part B program staff will continue to work with local public health districts to identify and address service needs, gaps and barriers to care for people not in care. Statewide there are 16 Ryan White Part B public health districts that serve as advisory bodies and are charged with the responsibility to conduct regional needs assessments, gap analyses, and make recommendations on how to prioritize Ryan White Part B funds in their respective districts to address barriers to care. Georgia's Ryan White Part B public health districts obtain specific information regarding client needs through local and regional needs assessments. In the Part B public health districts applications, public health districts are required to describe activities and partnerships that identify individuals with HIV who are aware of their status and are not receiving services and that facilitate HIV infected persons entering into care. Local needs assessments are used in the development of priorities for resource allocations to address the needs of those not in care. Local public health districts use client surveys and consumer advisory boards to identify services needs, gaps and barriers. Included among the barriers to care identified in many local needs assessments conducted by public health districts were clients' lack of knowledge or information

[6] Source: Georgia Division of Public Health HIV/AIDS Reporting System (eHARS).
Note: Numbers are based on data reported through 12/31/2007 and are not adjusted for reporting delays

of available services, not enough services available, lack of translation services, and personal barriers.

Efforts to Find People Not in Care and Get Them into Primary Care This data will be used initially in two ways. First, the data will be shared with the 16 Ryan White public health districts that are charged with providing primary care and treatment to HIV positive consumers in their geographical area. This data can be used in conjunction with outreach activities, planning, needs assessments, and other activities and initiatives at the local level. The HIV Unit will continue to work with the public health districts to develop outreach and quality management plans to address those HIV positive clients who know their HIV status but are not in care to bring them into treatment. Secondly, the HIV Unit will use this data for planning and program evaluation at the state level by incorporating into the oversight and program monitoring process of the need for outreach and retention of these HIV positive consumers not in care.

In addition local public health districts work collaboratively with community based organizations, community health centers, health departments, colleges and universities, homeless shelters, correctional facilities, AIDS Service Organizations and local hospitals, to identify people with HIV/AIDS and get them into care. Numerous linkages and memorandum of agreements exist with service organizations and health centers to refer clients into care. Through these linkages, local public health districts are able enhance their efforts in outreach and client tracking. Newly identified HIV positive individuals are referred by local community partners to Ryan White Part B funded clinics for assessment and intake. Many of the Ryan White Part B funded clinics use communicable disease specialists to locate individuals testing positive that do not return for test results.

Use of the Results of the Unmet Need Framework in Planning and Decision Making About Priorities Resource Allocations, and the System of Care The 16 public health districts will use these results with their local needs assessments to develop priorities for resource allocations to address the needs of those not in care. The HIV Unit will use this data in conjunction with other data acquired from collaborations with the HIV/AIDS Surveillance section, Part B consortia, other Ryan White programs, consumers, and key stakeholders throughout Georgia to set statewide priorities, resource allocations, and systems of care.

Service Needs, Gaps and Barriers to Care – Given the results from the subpopulation analysis, it is clear that getting individuals in to HIV primary care who are not currently receiving care is a priority. In the most recent Consumer Survey for the Atlanta EMA (where the majority of PLWH in Georgia reside), Hispanics and individuals who were diagnosed in the previous three years were found to have higher levels of unmet need for services. Hispanics most frequently reported that they didn’t know about the service or there was no enough of it available; a lack of translation services and believed that citizenship is needed to receive services were also cited as barriers. For individuals diagnosed in the previous three years, barriers more likely to be reported included lack of information or not knowing the service existed and personal issues. Males and African Americans reported information and personal barriers most frequently; females reported not finding enough of the service and information barriers most frequently while Whites reported not enough service, information and personal barriers. Overall in the Atlanta EMA, barriers associated with unmet need were predominantly related to lack of information or not knowing about the service, the way the system of care was functioning or lack of available service.

Gaps in Care Georgia's HIV/AIDS needs assessment and planning efforts, including the findings of the October 2008 SCSN (see page 27), have identified a number of common barriers to care themes. Ryan White Programs, by definition, serve clients with low socioeconomic status. Georgia continues to provide services to PLWHA whose annual income is below 300% of the Federal Poverty Level. Annual Administrative Report (AAR) and Ryan White Data Report (RDR) data indicate that the majority of clients receiving Ryan White services in the state are minorities, who historically have lacked adequate health care resources. When resources are limited, families, particularly single parent households, tend to prioritize the needs of children usually above those of the adults, who may ignore their own needs. This situation is particularly common for women, who generally act as caretakers of the family and may deny their own care in favor of other family members. Lack of childcare can also impact a woman's access to care. Childcare resources specifically targeting women who are HIV positive and their children are extremely limited in the state. The Grady Infectious Disease Program (IDP) in the Atlanta EMA provides onsite playroom services for HIV infected and affected children of parents receiving care or accessing services at the IDP. In addition, the Grady IDP, which provides the majority of primary care for HIV positive women, children and adolescents in the EMA is delivered by the Grady IDP, which co-locates its pediatric, adolescent, women's and adult clinics on the same floor to facilitate access.

Limited resources also impact a PLWHA ability to maintain adequate housing and meet basic needs. Barriers to care also include lack of transportation (particularly in rural areas of the state), inadequate resources to culturally appropriate and language specific providers and concerns regarding cost of services covering specialty care medications as well as continuous education on HIPPA Laws.

Persons with HIV/AIDS who are from historically underserved communities have limited sources and broad needs related to healthcare, mental health/substance abuse treatment, and social support services. Medical care is need for HIV-related conditions, but also for other conditions such as hypertension and diabetes. Women with families need adequate health care for their children as well as themselves, including routine preventive care such as pap smears and breast exams. Clients need access to HIV-related medications and therapies as well as non HIV-related medications for the treatment of chronic health conditions (e.g., hypertension). They also need access to dental and vision services. Provision of healthcare services is impacted in Georgia by the maldistribution of providers, especially specialists such as infectious disease specialists, and the shortage of dentists, nurses, and other healthcare providers.

For some individuals, their HIV illness is further complicated by substance abuse and/or mental health issues. Mental health and substance abuse treatment must be available in a non-threatening environment that affords confidentiality and support for persons with families, especially single parent households. Mental health and substance abuse treatment resources are limited in Georgia and eligibility requirements as well as limits on services provided can present barriers for PLWHA who need mental health and/or substance abuse treatment.

PLWHA have complex social service needs that vary greatly depending on their situation. Significant social support is necessary, including case management to assist accessing services and navigating bureaucratic agencies. Case managers that can advocate for consumers are invaluable in assisting PLWHA in meeting diverse social service needs. Housing assistance is necessary in varying degrees from financial assistance to short-term and/or long-term housing. These resources are limited for Georgia residents living with HIV/AIDS, particularly in rural areas of the state. PLWHA may also need emergency assistance with food, including vouchers,

food banks, and home-delivery meals, depending on the health of the individual. The availability of these resources also varies across the state. Faith-based and other community organizations have been an important resource in the state in working to meet housing and food assistance needs of PLWHA but additional resources are needed.

Services must not only be available, they must be appropriate to the population to be served. Over the last 15 years, Georgia has experienced exceptional growth and increasing diversity of its population. Reflecting national trends, the number of Asians, Hispanics, and other immigrant populations have show dramatic increases that are projected to continue to grow. In overcoming barriers to care, services should be provided by culturally sensitive and language appropriate providers that are located in close proximity to clients.

HIV Prevention Needs In 2008, the Georgia Department of Human Resources, Division of Public Health, HIV Unit contracted with the Kennesaw AIDS Research and Evaluation Network team at Kennesaw State University to conduct a statewide HIV/AIDS Community Services Assessment. The CSA is comprised of three components: 1) needs assessment, 2) resource inventory, and 3) gap analysis. It is employing qualitative and quantitative data collection methods, including key informant interviews, consumer focus groups, secondary data analysis, a provider survey, and a consumer survey, to identify needs, resources, and gaps in prevention and care services. The CSA focuses primarily on prevention intervention strategies and services for HIV infected consumers and high-risk negatives. The intent was to determine the met and unmet HIV prevention and care needs across various target populations established by the Georgia Community Planning Group (GCPG) population and intervention prioritization subcommittees. It also provides baseline data to assist the state's HIV/AIDS policymakers and officials, as well as GCPG, with informed decision-making in how best to target resources throughout the state of Georgia.

The gap analysis conducted by Kennesaw AIDS Research and Evaluation Network team provides a description of gaps in knowledge, care, and prevention intervention services for all populations served (HIV positive and negative) and specific priority/special populations. A series of questions in the survey assessed providers' knowledge of HIV/AIDS services and interventions used to reduce behavioral risk. Since agencies provided various types of prevention interventions and care services, it was assumed that their knowledge may depend on the organization's primary area of focus as well as the primary client population served. Overall, 79% of the respondents were aware of the CDC's initiative to target prevention efforts at persons living with HIV/AIDS. In addition, 33% of the providers were aware of the Diffusion of Effective Behavioral Interventions (DEBIs); however, only 15% are using these interventions.

The service and intervention gap analysis shows the difference between what the overall and priority/special populations have or used *and* what is requested but not available. Gaps in the overall populations were compared with gaps identified by providers who served 50% or more of a specific priority population. **Table C.** provides a summary of the findings.

Table C. Summary of HIV Prevention Gap Analysis

Population	Gaps in Services	Gaps in Interventions
Overall	• Medical services • Substance abuse services • Mental health services • Transportation	• Community-wide events • Comprehensive risk counseling and services [CRCS] • Peer counseling
Priority Populations	**Gaps in Services**	**Gaps in Interventions**
HIV Positive Clients	• Medical services • Dental services • Primary HIV services • Substance abuse services • Housing • Transportation	• Community mobilization • Couples counseling • Electronic media • CRCS • Peer counseling and peer networks • Rapid testing • Role playing • Safer sex kits
African American (AA) MSM	Transportation services • Legal assistance • Peer counseling services • Dental services • Substance abuse services • Housing	• Electronic media • Peer counseling and peer networks • Health communication and public information
White MSM	• Legal assistance • Peer counseling services • Dental services • Substance abuse services	• Print media • Electronic media • Rapid testing • Peer networks
High-risk Heterosexual AA Women	• Substance abuse services • Dental services • Housing • ADAP • Transportation services • Mental health services • Primary HIV care	• Group level interventions • Rapid testing • CRCS
High-risk Heterosexual AA Men	• Substance abuse services • Dental services • Housing • Rapid HIV testing • ADAP • Transportation services • Mental health services • Primary HIV care	• Rapid testing • Electronic media
AA IDU	• Medical services • Substance abuse services • Mental health services • Transportation	• Rapid testing • Electronic media • Internet • Print media • Health communication •Peer networks and peer counseling • CRCS
Special Population	**Gaps in Services**	**Gaps in Interventions**
Latinos/Hispanics	• Substance abuse services • Dental services • Transportation services • Primary services	• Electronic media • Peer networks

Description of the Current Continuum of Care

Georgia's system of health care is largely dependent upon the existing public health structure of 18 health districts and 159 county health departments, with community health centers, universities, hospitals, and community organizations playing a variety of roles in different parts of the state. All levels of Ryan White funding are distributed throughout the state. These funding streams have enabled Georgia to expand the resources available to PLWHA. As resources vary in different regions of the state, so does the scope of available services. Statewide planning and involvement on different planning bodies, as well as collaboration and coordination locally and regionally have assisted in service delivery development in Georgia. The Ryan White Part B program has a service delivery system which includes a comprehensive range of core medical services and essential support services for individuals infected with and affected. The HIV Unit contracts with 16 Ryan White Part B consortia and several agencies to deliver HIV/AIDS services throughout the state. The consortia are responsible for planning and prioritizing the delivery of HIV services in their respective geographic areas. The District Health Offices administer Ryan White Part B funds and are the lead agencies in the respective consortia. All consortia provide primary care services. Support services are prioritized by the consortia, using needs assessment data, and funded based on the availability of resources. The delivery of HIV care and support services are provided either directly by Part B funded public health districts or indirectly through sub-contractual agreements with local service providers Part B funds also fund the Georgia AIDS Drug Assistance Program (ADAP) and Health Insurance Continuation Program (HICP), which provide medications and health insurance coverage.

To receive Ryan White Part B services, a client must be a Georgia resident, HIV positive or affected, have no other payer source, and an income below 300% of the Federal Poverty Level. Georgia Part B contractors screen clients for eligibility through a financial screening process that requires the client to present verification of documents. Documentation of the client's available resources is assessed at the initial clinic visit and documented in the client's record and is reviewed every six (6) months. The Ryan White HIV/AIDS Program requires that Ryan White funds are the payor of last resort.

ADAP: The HIV Unit manages the AIDS Drug Assistance Program (ADAP) to ensure low income HIV-positive Georgians have access to ADAP services. There are 25 ADAP enrollment sites, located in all 18 Public Health Districts as well as other key sites. Currently, Georgia ADAP formulary includes 71 medications used in the treatment of HIV disease and associated conditions. Georgia contracts with Fulton DeKalb Hospital Authority through the Grady Infectious Disease Program to provide medications to all ADAP consumers in the state through a statewide mail out system to health districts and approved agencies.

During the ADAP enrollment process initiated at enrollment sites, case managers employ intense screening methods, including a structured ADAP application form, to assess each applicant's eligibility. The application and accompanying documentation captures the pertinent information needed to review all payor resources inclusive of Medicaid and private health insurance available to prospective clients and to assess eligibility based on program criteria. The Georgia ADAP monitors Medicaid eligibility by checking a Medicaid database for each new applicant prior to approval for enrollment into the program. If the Medicaid database provides confirmation that the applicant is receiving Medicaid benefits, the individual is declared ineligible for the ADAP. Applicants with active comprehensive private health insurance do not meet the criteria and are therefore not enrolled into ADAP. Additionally, as a quality control mechanism, active clients

are reviewed for Medicaid eligibility on a quarterly basis to maintain compliance as the payor of the last resort.

If persons are enrolled in health insurance plans or have other third party payers with documented proof that medications are not covered, the ADAP will cover the medication gap not addressed under that plan, based on the enrollee's ability to meet the criteria for eligibility.

If a client is not eligible for ADAP, or if a client has been prescribed medication that is not available through the ADAP formulary, case managers providing services in clinics and approved agencies will enroll clients in manufacturers patient assistance programs, when appropriate (e.g., in event of a waiting list). Some clients may also benefit from clinical trials if certain medications are not available through the ADAP formulary. District clinics and approved agencies may enroll clients in the ADAP if no other resources are available when clinical trials have ended.

The Georgia ADAP is available to all eligible Ryan White Parts A, B, C and D clients. Eligible clients may enroll at local district health clinics and approved agencies throughout the state.

Health Insurance Continuation Program: The HIV Unit oversees the Health Insurance Continuation Program for Georgia. This allows HIV-positive individuals to retain their private insurance to access medications and primary care. The HIV Section uses Part B funds to pay premiums and deductibles for eligible consumers to offset the cost to other Ryan White programs and services.

Minority AIDS Initiative: The HIV Unit receives Ryan White Part B funds for the Minority AIDS Initiative (MAI) to provide education and outreach in order to increase minority participation in the AIDS Drug Assistance Program (ADAP). MAI were allocated to seven public health districts to provide peer based education and outreach services to increase minority participation and access to the Georgia ADAP.

Home and Community-Based Care: The HIV Unit contracts with the Department of Corrections to provide Transitional Case Management to pre-release HIV-positive inmates in selected prisons to ensure linkage with HIV Care providers to continue HIV care and medications upon returning to their communities. In addition, upon release, the Case Manager assists HIV-positive inmates with applying for benefits (SSI, SSDI, Medicaid, ADAP), linking with a community-based Ryan White case manager, and other supportive services as needed. The goal is to improve the health status and quality of life and reduce rates of recidivism by linking and supporting these inmates as they return to their communities.

State Direct Services (State Lab HIV Viral Load Testing): The HIV Unit and the Georgia Public Health Laboratory collaborate to offer all Part B funded primary health clinics viral load testing. This collaboration allows HIV viral loads to be processed in a State controlled lab and has proven to be the most cost effective method to date. The HIV Unit provides direct oversight through fiscal monitoring, monthly Quality Management reports and testing updates submitted from the lab.

Fulton-DeKalb Hospital Authority – Grady Pediatrics: The HIV Section contracts with Grady Pediatrics to provide specialized, comprehensive, family centered primary health care and support services to HIV-exposed and HIV- infected infants, children, adolescents, and their

families. Grady Pediatrics serves children and their families from around Georgia as well as the Atlanta metropolitan area. Funding for the Grady program comes from Parts A, B and D.

Ryan White Part B planned services are also coordinated with other programs and take into consideration other funding streams for HIV/AIDS services. The Ryan White Part B Program continues to work collaboratively and foster new relationships with other programs, departments, agencies, and divisions that may fund HIV/AIDS services within the state of Georgia. The following are examples of coordination and collaboration with others programs:

Medicaid and Medicare: Local Ryan White Part B primary care sites continuously screen patients at each visit for Medicaid and/or Medicare eligibility. If a patient has Medicaid or Medicare or is suspected of having Medicare or Medicaid, their eligibility is verified using the Medifax verification system or on-line through the Georgia Medicaid web portal. Medicaid and Medicare claims for patient clinic appointments and Medicaid Targeted Case Management for Adult with AIDS are billed at the local level. Medicaid and Medicare payments are used to supplement the clinic administrative budget patient primary care.

State Children's Health Insurance Program (SCHIP): Enrollment into the SCHIP (Peach Care for Kids) is available by referral or on-site at all Part B primary care sites. Most HIV/AIDS pediatrics services are provided at Grady Infectious Diseases Clinic in the Atlanta EMA and the Medical College of Georgia in Augusta, Georgia.

Veterans Affairs (VA): Local public health districts work collaboratively with local VA providers and agencies to ensure services for veterans. Although most veterans receive their HIV/AIDS primary care at VA facilities and hospitals, some may choose to receive services at Ryan White Clinics.

Housing Opportunities for Persons with HIV/AIDS (HOPWA): Administered by the Department of Community Affairs, the Housing Opportunities for Persons with AIDS (HOPWA) program is a federally funded HUD program that primarily provides housing assistance (emergency, shelter, transitional and/or permanent) for lower income persons with HIV/AIDS. Funds are typically sub-granted to non-profit agencies within the communities who usually make their own rules for programs and criteria for assistance, provided that such rules are within the scope of HOPWA regulations and guidance from HUD. For FY 2009, HOPWA was able to award 165 agencies totaling $6.8 million dollars throughout the State of Georgia. The Atlanta EMA is the largest recipient of HOPWA funding. Local public health districts work with local agencies awarded HOPWA funding to address local housing needs for persons living with HIV/AIDS.

CDC Prevention (HIV Prevention Activities/Providers): The HIV Unit provides oversight and management of the State's CDC Prevention Grant. At the state level, HIV Prevention and Ryan White Part B administrative and clinical staff work collaboratively to ensure that individuals identified as positive through HIV prevention activities are linked to local Ryan White care and treatment services. Locally, many of the public health districts and community based organizations who receive Ryan White Part B funding also receive CDC prevention funds. Local public health districts and agencies work collaboratively to coordinate resources to reduce duplication of services and ensure a continuum of care. The HIV Unit will continue to provide technical assistance for both HIV Prevention, and Ryan White Part B public health districts and sub-recipients to foster integration of HIV Prevention and Ryan White service delivery

Services for Women, Infants and Children (WIC): Enrollment into WIC services is available by referral or on site at all Part B primary care sites for women, infants, and children ages one through five.

Local and Federal Funds for Substance Abuse/Mental Health Treatment Service: The Substance Abuse and Mental Health Services Administration (SAMHSA) funds agencies, colleges, universities, and community based organizations to provide services such as mental health for underserved PLWHA, substance abuse and HIV prevention, and outreach. Through the Division of Mental Health, Developmental Disability, and Addictive Disease (DMHDDAD), the state receives funds through the Federal Mental Health Block Grant and the Federal Substance Abuse and Treatment Block Grant. Georgia provides a comprehensive community based system of mental health care for adults with serious mental illness who need public services. Georgia also provides addictive treatment programs and services through a regional system.

Other Ryan White HIV/AIDS Program funding (Part A, C, D and F,): Several public health districts and providers receive funding from multiple Ryan White programs (Part A, C, and D). These public health districts and providers coordinate all Ryan White HIV/AIDS program funding to avoid duplication of services, maximize the number and accessibility to services, and ensure continuum of care.

Ryan White Part A: There is one Part A funded metropolitan area in Georgia. The Atlanta EMA consists of 20 counties and represents fifty percent of the state's population. Within the Atlanta EMA, 65% of the total population resides in the four most urbanized counties (Fulton, DeKalb, Cobb, and Gwinnett). Some of the counties also receive Part B funding, but Fulton and DeKalb Counties, where the largest percentage of PLWHA lives, do not. The EMA has a coordinated 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 PLWH in the EMA. Included in this delivery system are mechanisms to address the service needs of newly infected, underserved, hard to reach individuals, and/or disproportionately impacted communities of color to access and remain in care and those who know their HIV status but are not presently in HIV primary medical care.

Ryan White Part C: There are 17 Ryan White Part C grantees operating in Georgia, providing services such as testing, counseling, partner notification and treatment. Twelve of the 17 Part C grantees are public health districts.

Ryan White Part D: Georgia has two Part D funded programs. The Fulton-DeKalb Hospital Authority Grady Health System, Infectious Disease Program, founded in 1986, serves as the grantee of record for the Atlanta Family Circle HIV/AIDS Network: Ryan White Part D Services for Women, Children, and Adolescents. The Part D Network includes six service providers: AID Atlanta, AIDS Survival Project, Fulton/DeKalb Hospital Authority's Grady Pediatric Infectious Disease Program (Grady PIDP) and Department of Gynecology and Obstetrics (Grady OB), SisterLove, Inc., and the Morehouse School of Medicine's People Advocating Disease Prevention Program (Morehouse PADP). The project serves women, children, youth and families infected or affected by HIV/AIDS who reside in the five core Metropolitan Atlanta counties (Fulton, DeKalb, Cobb, Clayton and Gwinnett) and the surrounding 15 Metro counties in the 20 county Atlanta EMA. The majority of the population targeted for Part D services are low-income

minorities. Georgia's other Part D program is located in Waycross and serves a rural area of the state.

Special Projects of National Significance (SPNS): AID Atlanta is funded under the SPNS part of the Ryan White HIV/AIDS Treatment Modernization Act to determine best practices and demonstrate effective interventions for linking HIV positive inmates transitioning to the community into HIV medical care. The evaluation center for the project is the Rollins School of Public Health, at Emory University

AIDS Education and Training Centers: Georgia is served by the Southeast AIDS Training and Education Center (SEATEC), which conducts comprehensive training for healthcare providers who work with PLWH. Instruction focuses on medical management of HIV, ensuring that PHS treatment guidelines constitute the core teaching message. SEATEC trainings frequently include Ryan White funded staff along with health care providers associated with other federal and non-federal programs.

Resource Inventory

A resource inventory describing HIV/AIDS care resources and services in Georgia is provided in **Appendix 6**. SEATEC's *Key Contacts – Metro Atlanta/Georgia Resources for HIV/AIDS* telephone list of helping agencies, organizations, and people served as the baseline for the inventory. A searchable version is available at **www.seatec.emory.edu**. *Key Contacts* includes an alphabetical listing by agency/organization as well as identification of resources by the following categories:

Assistance (advocacy, case management, clothing/furniture, financial/public assistance, food, funerals, housing, legal, practical support, spiritual support, technical assistance for agencies and organizations, transportation)

Education services (AIDS information lines, educational resources, HIV education courses, hotlines and general information – not HIV/AIDS, medical treatment information, prevention education outreach, speakers' bureaus, and street outreach)

Internet resources (AIDS service organizations, government agencies, living with AIDS, medical, miscellaneous, prevention, speakers of languages other than English, substance abuse)

Medical services (access to treatment, ambulance, clinical trials, counseling/mental health care, dental, health departments/testing/medical care, HIV antibody testing sites – anonymous/confidential, HIV antibody testing sites – anonymous, HIV antibody testing sites – confidential, home health care/hospice, medical care, nursing home/long term care, wellness)

Prevention and Care Planning Councils

Services for specific populations (adolescents, alcohol and substance abusers, children, deaf and hard of hearing, family/friends, gay/bisexual, health care providers – HIV caregivers, health care providers – HIV-infected, Hispanics, Inmates/Parolees/Probationers/Ex-Offenders, Lesbian, low income/homeless, low literacy, people living with hemophilia, people of color, speakers of languages other than English or Spanish, tuberculosis patients and caregivers, women)

Social support (buddy programs, day programs, peer counseling, socializing/networking)

Support groups (bereavement, caregivers, persons living with HIV/AIDS, substance users, other)

In addition to information compiled from *Key Contacts,* Parts A, B, C, and D programs provided information for the state's Comprehensive HIV Health Services Resource Inventory, including their service areas and services offered.

The Kennesaw Community Services Assessment (CSA) resource inventory, when completed, will serve as an additional resource. The inventory describes the current HIV/AIDS prevention and care resources and services available throughout the state. It was compiled to reflect the HIV/AIDS prevention resources and services currently used to reduce the risk of infection among people living in Georgia. It includes the following information on the characteristics of services providers that completed the 2008 CSA survey:

Agency contact information
House of operation
Public Health Districts served
Funding sources
Percent of individuals served by gender
Percent of individuals served by ethnicity/race
Percent of individuals served by mode of transmission
Percent of individuals served by risk factor.

Profile of Ryan White Program Funded Providers by Service Category

In fiscal year (FY) 2008, the HIV Unit contracted with 16 public health districts, the Georgia Department of Corrections and Fulton-DeKalb Hospital Authority to provide Ryan White Part B services.
Delivery of HIV care and support services are provided either directly by the public health districts or indirectly through sub-contractual agreements with local service providers. **Appendix 4** provides a detail list of Ryan White Part B funded providers and services provided.

Barriers to Care

Georgia has made significant progress in supporting the state's HIV infected and affected residents, but there are a number of challenges in assuring continued high quality HIV/AIDS core medical and support services that will improve the overall health of HIV positive individuals.

Proposed state budget cuts and changes in Georgia's health care system may have a significant impact on Public Health and on the delivery of health care services. A 2009 report released by the Georgia Budget and Policy Institute (GBPI), indicated that State General Fund investment in Public Health declined from FY 2003 to FY 2007, even as the state's population increased considerably and that looming revenue shortfalls will put even more pressure on the state's Public Health System.

Service gaps exist between urban, suburban, and rural regions of the state. Georgia's population is not evenly distributed. About one-half of the population, 51% of the state's African American population, 62% of the Hispanic population, and 38% of the poor, live in the 20-county Atlanta EMA. The other half of the state's population is widely dispersed throughout the state, largely in

rural areas and small cities. This uneven distribution has historically presented challenges in healthcare resources and service delivery, complicated by a maldistribution of providers and a lack of transportation resources in many areas of the state. A more profound shortage has been experienced in relation to public health nursing. The total number of public health nurses (LPNs, RNs, Nurse Practitioners) in Georgia has declined each year since 2002, FY 2002 there were 1816 to FY 2008 1526. The overall turnover rate for 2008 was 18.7% with 17 Districts reporting turnover rates in the double digits. The overall vacancy rate for 2008 was 19.9% with 16 Districts reporting vacancy rates in the double digits

Medicare's prescription drug benefit (Part D) on Medicare and Medicaid/Medicare recipients, including PLWHA, remains a barrier to care for many. Many clients may experience a significant increase in out of pocket costs after enrollment. Ryan White programs, particularly ADAP, continue to face challenges in providing premium payment and prescription copayment assistance to Medicare recipients. Some individuals have experienced problems in enrolling in a Medicare drug plan and/or obtaining coverage for needed medications. It is important that PLWHA who qualify for the new Part D benefits understand Medicare Part D and how it affects them. The establishment of written Medicare Part D policies and guidelines by Georgia's ADAP and other Ryan White programs, and the dissemination of those policies and guidelines, along with other education materials, are needed to help individuals living with HIV, and providers who assist them, make informed decisions. Changes in and difficulty understanding formularies are also of concern.

Overall, there are not enough HIV/AIDS prevention and treatment services in Georgia to meet the increasing demand for services and there are not enough financial resources to meet the costs of medical and support services. Rising health care costs, particularly for HIV-related medications, complicate the problem further. In this environment, service system planning, evaluation and collaboration between Ryan White Programs and other HIV resources, become increasingly important to ensure barriers to care are addressed and minimized.

Section 2: Where Do We Need to Go: What Is Our Vision of An Ideal System?

Since the earliest days of the HIV/AIDS epidemic, Georgia has had a substantial number of reported cases of AIDS. The epidemic continues to grow and more people are living longer with HIV/AIDS in the state. There are not enough HIV/AIDS prevention, care and treatment services in Georgia to meet the increasing demand for services, and there are not enough financial resources to meet all of the costs of medical and support service needs. The state recognizes the importance of addressing key HIV/AIDS care issues, enhancing coordination across Ryan White programs, and allocating and utilizing resources to address identified needs, especially those of traditionally underserved populations and subpopulations.

In developing a 2009-2012 Comprehensive HIV Services Plan that most effectively uses limited resources to meet the needs of Georgians living with HIV/AIDS, particularly its most vulnerable populations, Georgia utilized the following key HRSA directives and strategies:

Improve access to health care by linking newly diagnosed individuals to care and identifying *individuals who know their HIV status but are not in care*, informing them about available treatment and services, and assisting them in the use of those services;

Improve health outcomes by addressing the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system as well as through coordination of HIV prevention and treatment, including outreach and early intervention services; and,

Improve the quality of health care by ensuring the availability and adequacy of critical HIV-related local core services (primary medical care that is consistent with PHS Treatment Guidelines; HIV-related medications, mental health treatment, substance abuse treatment, oral health and case management; and

Eliminate health disparities in access to services and related support services among disproportionately affected sub-populations and historically underserved communities.

The values that guided the identification and selection of the state's strategic HIV system of care goals and objectives were derived from the Shared Vision, Mission Statement, and Shared Values listed below. The planning goals and objectives are consistent with the Healthy People 2010 goal for HIV services: *To prevent human immunodeficiency virus (HIV) infection and its related illness and death.*

Shared Vision

Excellence in Georgia's HIV/AIDS services through innovation and community partnership.

Mission Statement

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

Shared Values for System Changes

The development of Georgia's Statewide Coordinated Statement of Need and 2009-2012 Statewide Comprehensive HIV Services Plan were guided by the following shared values:

1. The quality and dignity of human life.
2. Cultural competency/appropriateness in service delivery.
3. Respect for diversity and cultural differences.
4. Effective and timely support for basic needs.
5. The involvement of HIV infected individuals in decision-making.
6. The involvement and support of each affected individual's personal support system, as well as the greater community, in caring for persons with HIV.
7. An individual's right to self-determination.
8. The health of the community.
9. Service delivery systems that promote independence and self-sufficiency.
10. The efficient use of resources.

12. Prevention, education, and early intervention.

Statewide Coordinated Statement of Need: The purpose of the Statewide Coordinated Statement of Need (SCSN) is to collaboratively identify significant issues related to the needs of people living with HIV disease (PLWH) in the State and to maximize coordination across the Ryan White Programs. Georgia developed its SCSN in 1998. In 2009, the SCSN was updated to reflect changes in the arena of HIV care for the state.

The Georgia SCSN planning meeting was the collective efforts of a steering committee consisting of fifteen (15) individuals representing Ryan White Providers, Consumers and HIV Service Providers. The steering committee began meeting in July 2008. The steering committee was dedicated to developing a SCSN process that would result in useful data and to have wide range HIV service providers and consumers participants. Each steering committee participant was asked to forward the registration for the 2009 SCSN to their HIV Service Providers. All Part B recipients were invited and were asked to bring three (3) consumers. To maintain the focus of the SCSN on overarching goals, the steering committee decided to update the 2006 SCSN Input Summary, repeat the questions asked in the 2006 SCSN and collect updated information, and maintain the types of focus groups from the 2006 SCSN.

The theme of the 2009 SCSN was "Coming Together as ONE Community". The theme represented the changing attitude in the HIV/AIDS service community. With policy and funding changes all providers have to come together to provide care.

2009 Update of Georgia's SCSN: As the Ryan White Part B grantee for the state, the Georgia Department of Human Resources, Division of Public Health, Office of Essential Preventative Clinical Services, HIV Unit convened a meeting of 134 statewide Ryan White providers, other HIV service providers, public agency representatives, and persons living with HIV/AIDS on October 1-2, 2008 in Atlanta, Georgia to update the state's SCSN. (See **Appendix 1** for participant list.)

REPRESENTATIVES PARTICIPATING IN SCSN UPDATE MEETING
Part A Grantee, Planning Council representatives
Part A Funded Agencies
Part B Grantee, District Representatives, and Subcontractors
Part C Grantees
Part D Grantee, Part D Director and Project Coordinator, Subcontractors
Part F –Dental Providers
Persons Living with HIV/AIDS
Community Based Organizations
HIV Prevention Community Planning Co-Chair
HIV/AIDS Surveillance
Housing, HOPWA Grantee
Georgia Department of Community Health
Georgia Department of Corrections
HIV Prevention Providers

Meeting participants received a meeting agenda, a copy of the 2006 SCSN Input Summary Tables; a definition of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 Parts and breakout group assignments. On day one (1), Raphael Holloway, Director of HIV Services

with the Department of Human Resources, Division of Public Health., Office of Essential Clinical Preventative Clinical Services and Jeff Cheek, Director of the Metro Atlanta EMA Ryan White Part A Program, provided the welcome and purpose of the SCSN process. John Blevins, the facilitator of the day presented the overview of the day. Deanna Campbell, Epidemiologist with Epidemiology Branch of the Division of Public Health presented an epidemiologic profile of HIV/AIDS in Georgia. Representatives from all Ryan White Part's represented in the State of Georgia gave presentations. An update of emerging issues/trends were presented by Dr. David Reznik, DDS, Mac Coker, Georgia Department of Human Resources, Rebecca Culyba, SEATEC, Derek Stokes, Chairperson of the Macon Consortia and Kevin Ramos, Emory University. John Blevins, conducted the wrap-up of the day and overview of the next day. Each participant was asked to review the 2006 SCSN Input Summary Tables and to be prepared to discuss them in the next day's breakout groups.

On day two (2) Jim Sacco presented the overview of the day and a brief review of day one (1). Meeting participants were divided into six groups: administrators, healthcare providers, support services providers, a woman's consumer group, and a men's consumer groups. The 2006 SCSN consisted of two (2) male consumer groups. The facilitator's and focus group members of the 2009 decided to combine the two (2) male consumer groups due to the number of male participants.

The groups were asked to brainstorm responses to four questions:
1) What is working well?
2) What are the gaps in the provision of services for persons living with HIV/AIDS in Georgia?
3) Why are these gaps occurring?
4) What are the top issues on the horizon that will significantly impact both the provision of services and the level of need for persons living with HIV/AIDS in Georgia?

See the following tables for a compilation of the comments that resulted from the provider groups and the consumer focus groups discussions. It is important to note that the need statements and gaps and barriers are not presented as, nor intended to be, a comprehensive listing of these issues nor do they necessarily represent a consensus. Instead, the SCSN seeks to highlight the most common perceived issues in providing HIV related services to consumers. Rather than an exhaustive list of specific needs, this document includes generalized descriptions that encompass many client needs. Additionally, the needs are not prioritized due to greatly varying geographic differences in intrinsic level of need. Finally, not all of the needs listed are, or can be, addressed by Ryan White programs.

Ryan White Statewide Consumer Satisfaction Survey Results: The Ryan White Statewide Client Satisfaction Survey was collaboratively implemented across all parts of the Ryan White HIV/AIDS Treatment Modernization Act in Georgia from July 14 – August 22, 2008. Eight separate surveys were developed: Ambulatory/Outpatient Care, Case Management, Food/Nutrition Services, Outpatient Mental Health Services, Oral Health care, Outpatient Substance Use Treatment, Peer Counseling and in the EMA only, a Self Management Survey. Surveys were available in English and Spanish. A total of 4,193 surveys were completed.

Overall satisfaction rates for services are listed below.

Service	Overall Satisfaction Percentage
Ambulatory/Outpatient (n=1726)	84%
Case Management (n=1109)	75%

Food and Nutrition (n=308)	95%
Oral Health (n=377)	63%
Outpatient Mental Health (n=276)	80%
Outpatient Substance Use Treatment (n=87)	62%
Peer Counseling (n=186)	85%
Self Management (n=124)	N/A

Using the eight separate surveys that are based on services provided to clients, information was extracted to identify areas that were working well and areas where additional improvement is needed to adequately address the needs of the clients.

One common area of improvement that was expressed throughout each area of service was "how to contact someone regarding questions or concerns about getting further care either by phone or during non-business times."

Client Survey Highlights

- Six percent of survey respondents felt that because a language barrier exists they have problems understanding agency staff when they come in for or request services.
- Approximately 33% of participants did not know that translations services, including services for the visually and hearing impaired, are available if they are asked for before the set appointment.
- Of those individuals who completed the Ambulatory/Outpatient Care survey, 41% of patients stated that they felt uncomfortable talking to their provider about personal or intimate issues.
- Twelve percent of patients stated that they never, rarely, or sometimes receive their ADAP HIV medications in a timely manner.
- Of those individuals who completed the Substance Use survey, approximately 27% of clients felt that if they were to relapse back into drugs, their substance use counselor could not help them work on the problems that led to them using drugs again. Of the participants that were interviewed, 26% indicated that if they needed their substance use counselor could not help them to get into a residential drug treatment program.
- Of those individuals who completed the Oral Health survey, 36% of patients stated that they are unaware of how to resolve issues regarding their dental care. Sixteen percent of patients stated that either they were unsure or their provider did not ask them about their teeth and a referral was made to see a dentist.
- Of those individuals who completed the Mental Health survey, approximately 33% of respondents indicated that if further help is needed from their mental health provider they could not be assisted.
- Of those completing the Case Management survey, 9% were not sure or didn't know if they had a case manager. Respondents stated that they meet with or speak with their case manager at least once every 3 months, but approximately 31% indicated that in the last 3 months to a year they have either only met with or spoken to their case manger once or not at all.
- Approximately 19% of clients indicated either that they were unsure or their provider did not ask them whether they needed help to tell their sexual partner about their HIV status and a referral was made if help was needed.

- Of the clients completing the survey, 11% stated that their provider either did not ask or they were not sure if they were asked about how they were eating and a referral was made to a nutritionist if needed.

2009 SCSN Participant Evaluation: Participants were surveyed at the completion of the meeting to determine there level of satisfaction with the process. A Lickert Scale was utilized in the evaluation process to determine responses. On a scale of 1 to 5, 1 = strongly agree and 5 = strongly disagree. A total of 84 participants completed the survey. Overall the meeting was well received by participants. Sixty-one (61) percent of participants strongly agreed that the meeting was beneficial, additionally; thirty five (35) percent agreed the meeting was beneficial. See **Appendix 3 -** for survey results.

SCSN Stakeholder Input Summary Tables
SCSN Meeting - October 1-2, 2008

What's working well	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Coordination of services, including Title II funded services	ADAP access, not the process	Linking newly diagnosed HIV positives to care and services	OB/GYN doing testing on pregnant women.	Ambulatory outpatient providers, medications
	Level of experienced providers	Availability of quality primary care	ADAP process in administration	Peer advocacy program	Mental Health Services
	Access and availability to services in each health district	Availability of education for providers	Social services and case management effectively assessing consumers needs	Primary Care Physicians and services	Case Managers/Social Service Providers, Peer Advocates
	Effective documentation of services	Access to providers/doctors has improved	Food assistance and distribution through community agencies (e.g., Project Open-Hand)	No waiting list for ADAP, shorter waiting time for ADAP	ADAP
	Improved health benefits	Training of staff-TB,STD staff	Grady Infectious Diseases Program	Availability of medication	Specialty care referrals, Oral Health, Vision Care
	Increased coordination of services prior to a prisoners release	Increased HIV testing	Coordination of social services	Case management services	Translation Services
	DHR office providing models of care, standards of care	Quality Management Program	Public and private partnerships	Peer Advocates	Quality Improvement

What's working well	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
		Access to ADAP and the AMDP, availability of new classes of medicine though the ADAP formulary	State provided case management training. Development of case management standards of care	Health clinics-labs, medication, all accessible at one location- "one stop shop"	Good transportation
		Incorporating HIV prevention messages	ADAP pharmacy on site. AMDP project		Patient flow, enhanced confidentiality
		More availability of clinical trials for patients outside of Atlanta	Adolescent clinic		
		Quality if care is good despite limited funding	Collaboration between Metro Atlanta agencies to maximize		
			Coordination between health departments and correctional clinic		
			Peer advocate program		
			Good relationship with HOPWA and homeless authority in Savannah. Long term rental assistance		

What's working well	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
			Rotating staff between clinics		
			Consumer Advisory board		
			Utilization of faith based organizations		
			Creative funding initiatives		
			Collaborative relationship with state		
			Substance abuse-coordination with services early intervention and testing		
			Many service under one agency – allows client education (TB/HIV et.) Part B and C		

Gaps/Unmet Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Some support services including: transportation, in-home services, housing, translation/interpretive services, food, limitations of funding regardless of services, job training and placement, need for staff to be trained in palliative and hospice care, lack of mechanisms to financially support peer services	Oral health care services	Funding and staffing	Case management for the self-managed	Impact on budget cuts- consumers need to know

Gaps/Unmet Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Mental health/substance abuse services including: criteria for providers, screening, developmental testing for children, staff, inpatient care for SA, Community Service Board support services, move to privatization of MH/SA services, continuity of medication care and MD/SA services for individuals released from incarceration, Limited funding, translation services, Limited availability of inpatient and outpatient services	Transportation	Transportation outside Metro Atlanta	Transportation	SSI eligibility should continue with HIV diagnosis not only AIDS diagnosis
	Benefits: emergency Medicaid (30 days), dual eligibility, assistance for copay/deductibles, Indigent care trust funds decreasing, lack of temporary benefits, Medicare Part D gaps in Coverage	Mental health/ substance abuse services	Mental health – decreased funding, lack of providers, lack of expertise and education of current providers	Funds for emergencies (i.e. housing and utilities)	At least one wellness center open on weekends

Gaps/Unmet Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Primary care: Lack of staff, low salaries, training, continuity of funding, access to specialty care for non-HIV conditions including oral health, decrease in availability of experienced providers, more providers not accepting Medicaid, staff turnover, lab funding/coverage, lack of funding for primary care services, coordination of care between services, Lack of Oral Health Providers	ADAP process	Disparity in funding for health services	Coordinated medical services	Less stringent housing criteria
	State issues: Local knowledge of state policies, lack of multi-year funding, community level resources, prevention initiatives, HIV training for all nurses, scope of work for nurse practitioners, collaboration with DFCS and Mental Health, declining public health infrastructure	Retention/tracking of services	Providing services for consumers just above Federal Poverty Level		Need an advocate to explain policies and procedures of disability insurance and other benefits.

Gaps/Unmet Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
		Decreased access to non HIV-primary care and specialist care.	Housing for special populations	Adherence counseling	Substance abuse and mental health Services
		Decreased access to public health services, lack of funding	Mental Health and Substance abuse services	Providers	Housing, Transitional housing and transportation
		Lack of awareness of clinics/resources that exist. Lack of treatment resources for Hep C treatment.	Medicaid providers. Co-pay Assistance	Confidentiality	Vision care
		Lack of services for undocumented patients	Medication other than HIV related medication		Subspecialty services. Subspecialty doctors refusing to see people with HIV
		Medication waste	Housing for special need population: HIV/AIDS, Rural, MH/SA, Felons, Transgender, Affordability, Pregnant women, Family size and age, undocumented residents		Peer Advocates
		Access to education	Transportation		Case management
		Lack of provider education	Satellite Centers		Primary care doctors refusing Medicaid/Medicare clients

Gaps/Unmet Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
			Coordination of Prevention and Primary Care		Staff training and shortages
			Single mothers self care vs. household and children's needs		Facility space
			HIV/AIDS education for family and/or caretakers		Non-HIV related primary care services
			HOPWA		Domestic partner/family mental health services
			Outreach for teens		Peer counselors
			Fear of continuation of funding/legislation		Nutrition/food pantry
			Case management vs. self management in the EMA. How to meet the needs of self managed clients		Youth directed services
			Lack of patient support system		
			HICP requirements		
			Delayed Social Security decisions and long appeal process		
			Legal Services		
			Need for training on how to qualify for patients for "Soar"		

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Limited funding	Limited funding	Limited funding	Seeing a nurse instead of a doctor and shortage of doctors	Transportation – no bus, no taxi in area
	Legislative limitations	Georgia pharmacy laws - medication waste	Non-competitive compensation for staff working with HIV population	Wait times and provider bias	Not knowing where to go, or what resources are available
	Fear of HIV -lack of knowledge	Limited providers for complex patients/situations	Decision makers are not front-line staff who know real issues	Scheduling for children	Inadequate days and hours of clinic operation
	Shortage of providers	Dental health care - limited funding, access, providers and resources	Client responsibility and accountability	Access to dental care	Financial eligibility based on income for SSI and other entitlements
	Lack of control for local implementation	ADAP - limited funding, complex application and lengthy approval process, limited ADAP staff, items get lost	The state does not have a mandate for prevention - the focus is mainly on treatment and care	Lack of insurance/eligibility	No financial access to care – either for private-pay or for insurance (premiums, co-pays, deductibles).
	Working in silos	DHR Bureaucracy	Attempts to standardize certain systems	Predatory services attached to primary care and community based services	Lack of coordination between agencies
	Social norms	Travel restrictions	Substance abuse	Housing requirements to attain medication and services	Lack of funding
	Closing of local public health clinics	Stigma	More rules and paperwork	Eligibility to obtain housing for mothers, drugs users and elders. Nothing for young singles.	Staff shortages

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Difficulties working with Medicaid Care Management Organization	Prescriptive authority for Nurse Practitioners in Public Health	Strenuous HICP requirements		Lack of volunteer help
	Cooperation between departmental agencies	ADAP application still barrier-they get sent back	Lack of legal services		Incompetent care
	Apathy towards HIV	Lack of communication with the ADAP staff	Increased rules, regulations, documentation		Illiteracy
	Competition with other disease	Lack of collaboration and training of clinic staff	Lack of one stop shopping		Slow reimbursement to programs
	Current policies and barriers to address funding shortage	Demand for care exceeding availability of providers	Territorial turf guarding		
			Plan to act but don't actually implement		
			Quality vs. Quantity. We don't learn from other states		
			Change – Out with the old in with the new. Antiquated system		
			DHR-Budget cuts-unfilled positions. DHR reorganization		
			Fear		
			State salaries too low to get the best candidate		

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Reductions in funding	Medicare Part D, Medicaid CMO changes	Medicare Part D, State and Federal efforts on Medicaid reform	Coordinated medical services for parent and children	Eligibility tied to diagnosis but eligibility determination not made in real time, and when it is made, T-cell counts have changed, which changes the diagnosis, which changes the eligibility
	Complicated Medicare and Medicaid reforms – Medicare Part D	Increased infection in young people	Increasingly poor insurance coverage	Education	Not enough money
	Increase in diversity	Women and HIV infection (esp. in rural areas)	Reauthorization of the RW CARE Act	Self Management-case management contact	Public education and awareness for the public to remove stigma
	Pharmacy law	Hepatitis B and C co-infection	Federal funds are shrinking	Legal services	ADAP availability of medication
	Conservatism	Aging of surviving patients		Provider education	Continuation of Ryan White funding
	Increase in survival – elderly, perinatal	Aging of provider population	Increased efforts in prevention with positives	Long term care for long term survivors	Access to Social Security Benefits
	Undiagnosed cases	Provider burnout	Unique needs of long-term survivors and seniors	Education for seniors and there providers	Furloughs at the state
	Increased surveillance	Recruitment of providers	Needs of HIV positive children	HIV peer advocates-more attention on the there valve and role	Hiring freeze/staff shortage
	Coverage for undocumented	Language barriers	Housing for those with felonies	Mental and emotional health	Budget cuts
	Changes in public health guidelines	Changing Georgia demographics	Children born HIV positive are now adults and are having babies	Career skill building for HIV positive people	Travel restrictions

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Resources/training for youth, MSM, and providers	Increase in undocumented HIV-infected persons	Regulation of pharmacy costs, increased cost of medications	Funding	Rise in number of cases
	Cost of insurance	Retention and linkages to care	Addressing the needs of those who are incarcerated		Emerging senior population
	Cost of healthcare	Increase in patients and decrease in funding	Shift in prevention from accountability to service prevention		Medicaid reimbursement reduced
	Increase in teen pregnancy	Prescriptive authority for nurse practitioners	Rising Latino population / addressing needs, cultural barriers, language barriers, testing, prevention, and treatment for undocumented communities		Housing for elder with HIV
	Early testing for HIV	Secondary prevention/STD prevention	Domestic violence/sexual assault are increasing - lack of services, as well as increased confidentiality requirements (silent community)		Nursing home care
	Aging population, lack of geriatric programs	Transition from adolescent/pediatric care to adult care	Delayed response in AIDS/HIV data – affecting funding		Nursing shortage
	Increase in prison population	Not seizing the opportunity to educate young people in school	Continued lack of mental health/substance abuse treatment		Medicaid refusing to pay for Trophile testing

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Increase in drug resistance	Translation services	Public backlash expected because of decreased funding, accountability, testing, long-waits, etc.		Availability of clinical trials
	Human resource shortage	Higher cost of clinical care	People outside Metro Atlanta EMA are not being served		Cancer screening for long term survivors
	Cost demand of natural disasters	Increase in high risk behavior due to crystal meth/substance abuse	Need acceptable ways to recycle meds		Timely economic crisis
	Increase of youth infections	Lack of competent care for pregnant women	Military returning home and testing HIV positive		Failure of prevention messages
	Change in federal direction	Anticipation of more patients because of opt-out HIV testing	Provider and consumer education about emerging treatment and diagnostic tools		Services availability for heterosexuals
	Increase emphasis QA and performance and accountability	Gas crisis-availability and cost	Rising numbers of methamphetamine users and the impact on the HIV population		Abstinence only messages don't work
	Decrease in grant funding	Access to advancing technology	Required testing: All pregnant women in GA – what is the assurance? Sex offenders Implications of forced testing		Increase in Hispanic clients
	Restructuring of public health	Training of providers in academia	Increased focus on identifying positives – need increased resources		Increase in immigrant population

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Lack of providers		Increase methamphetamine		No emergency Medicaid for undocumented immigrant women
	Decrease in indigent care funds to hospitals		Stigma		Increase in undocumented immigrants
	Workforce development and staffing		Services for younger teens		
	Shortage of dental schools, shortage of news dentists		Our economy and increase need		
	Transition from psychosocial case management to medical case management		Senator Kennedy's Health – lack of other leadership		
	Increased clients with decreased or flat funding		AIDS exclusives		
			Undocumented pregnant women		

Development of Strategy Area Action Steps

Utilizing the summary and the met and unmet needs, barriers, and emerging issues identified by the five groups during the morning sessions, meeting participants were divided into five geographic groups (North Georgia, Metro Atlanta Group 1, Metro Atlanta Group 2, Middle Georgia and South Georgia). Each group was assigned barriers and/or issues and was tasked to develop broad action statements and strategies for their assigned barriers and/or issues See table below.

Barrier/Issues	Assigned Groups
Identifying individuals who know their status but are not in care, informing them about available treatment services and bringing them into care. How do we help persons, who know their status and are not in care, access care? How do we help them stay in care and fully participate in their care?	North Georgia, Metro Atlanta Group 1
Coordinate the provision of services programs for HIV prevention, including outreach and early intervention services. How can we better coordinate HIV care and prevention services?	South Georgia
Prevention and treatment of substance abuse. How can we better provide or link to substance abuse prevention services? How do we improve access to substance abuse treatment?	South Georgia
Eliminating disparities in access to core medical services and support services (In terms of sub-populations, hard to reach populations, and those historically underserved) Realizing that not everyone has equal access to services, how do we ensure that everyone has access to care and services?	Metro Atlanta Group 2, and Middle Georgia

Barrier/Issue: Identifying individuals who know their status but are not in care, informing them about available treatment services and bringing them into care.

How do we help HIV+ that know status and not in care, access care?

- Inform clients of available services
- Identify the population and provide education - Education at local venues, hangouts for specific populations
- Education of providers, share flyers
- Outreach and marketing to providers
- Use patient population to educate their peers
- HRSA suggestion – "in-reach" social network of clients who come into clinic, to get out to their peers and their social network

- Educate clients during testing about available services
- Have information available in Spanish in the community and in local venues (gay clubs)
- Place information on website
- Refer to case managers, even if using private provider
- Focus groups, interview clients to determine reasons not accessing
    - Fear of undocumented coming to care – provide information to population, how do we help them become aware? Information into the clinics, via media, churches, community groups, in Spanish
- Peer to peer outreach
- Strengthening the link between testing and care
- Staff training for clinic staff on PCRS instead of waiting on CDS
- Enhance PCRS services – have positives sign a contract
- Utilize unmet need data to help identify sub-populations to target
- Identify geographic locations of new cases

How do we help people who are in care, stay in care and fully participate in care?

- Social worker to contact and follow-up with those who drop out of care
- Communicate with clients, find out what is going on with them
- Assist with ongoing maintenance
- Utilize peers to contact clients and follow-up
- Make them feel welcome, personal touch – a welcoming environment in the clinic
- Have client take ownership in their care by partnering with clinic - Empower clients to have ownership in his/her care
    - Peers
    - Idea to patient that this is our process, what are the other services that can be added, how many other people can we serve
- Clinic orientation –group, then individual, with all staff available
- Assist when issues arise
- Case conferences for patients frequently missing appts., - from anyone in the clinic that identifies need, with staff, peer, family, partners, - express concerns, identify barriers, develop plans
- Help to inform the family that the client needs their support; involve family and loved ones in pt. care
- Help pt. to recognize strengths
- Have patients sign up for drug delivery service
- New pts. must come to main clinic for comprehensive services
- Consider other models of care including MH and SA interventions by HIV providers
- Behavior modification
- Take patients entire scenario into consideration before developing a treatment plan - Readiness for HAART, adherence issues
- Address cultural barriers
- Changing the care paradigm to move to empowerment (from directive)
- Planning with, not planning for
- Cross training of staff

- Pregnant women task force to develop a comprehensive plan to address issues
- How do you balance empowerment and confidentiality? Will bring on greater responsibility, empowering and careful
- Stigma issues – stand alone clinic may help
- Advocate for clients
- Clinic location is important
- Walk-in appointments (Flexibility)
- Help pts. disclose
- Schedule appts. as groups re: geographic area, group transportation

Barrier/Issue: Coordinate the provision of services programs for HIV prevention, including outreach and early intervention services.

How do we coordinate the provision of services programs for HIV prevention, including outreach and early intervention services?

- Ongoing education – may be overlooked because HIV has been out there for so long. May be missing whole population that doesn't know they are at risk.
- Provider education – especially private practice MDs
- Need to continue to do prevention with HIV positive individuals, i.e., expound more on risk level – for example may think it is ok to have sex with another individual who is also positive. Need to make them understand that some sexual practices are still risky behaviors.
- Funding for more than plain condoms. Need more options – teach them what is more fun, accessible, etc. that will practice rest of their lives. Need options to keep themselves safe but still have fun
- Need to use peer advocates more – these are committed individuals who can help provide education, help them understand re-infection, missed appointments, adherence, etc. Important to hear from someone who is been through it too. Need to help consumers understand have more treatment choices. Utilize peer advocates more across spectrum of services.
- Updating what services are available on a more regular basis – for example, dental providers who accept Medicaid. Regular updates on changes in prevention and care providers, services offered.
- Need to educate new staff – particularly about available resources. Make sure are trained properly.
- Statewide initiative and plan to get opt out testing and OraSure in hospitals. Hospitals cite lack of funding and staff to conduct tests.
- Need to circulate dentist and medical students/interns in HIV clinics to get experience. Get more providers trained in process early on – both to get more of them to work in HIV arena and/or understand HIV/AIDS issues but also to help address provider shortages. For example, can inform clinics of local medical training programs and build collaboration. Try to get local care providers linked with schools. For example, PH has program with MCG where medical students work in rural clinics. Could do the same thing with HIV clinics for both medical students and dental students. Try and set up rotations. Need to meet standards required by schools. State will also need to educate

district leaders that it is ok to use medical students, etc. Need to identify and address variety of barriers – way need state plan to roll out such a strategy.

- State did get some funding to do emergency room testing in Augusta and Grady as a pilot and to see what prevalence rate is in people coming through ERs. Need state plan and roll out. Early findings form pilot might help support case for CDC to provide additional funding to expand testing.
- Expanded use of telemedicine – such as Augusta. Waycross is also starting a telemedicine program. Like video conferencing with provider in one site and client in another setting – such as with client in correctional setting. Might be possible to do case management with clients in correctional setting. Are some start up costs in getting the equipment and in getting it to work. Also need to make sure it is introduced correctly to provider. Also needs to be used appropriately with right clients and in right circumstances. Ware County uses for Daisy Clinic and Children Can't Wait Clinic. Connect with MCG. Waycross is now using it for intake housing – initial intake and application to cut down travel for client. Example of better linkage with other programs to improve delivery of services for clients. With limited resources, need to find out about what's available in other programs, including non HIV programs, and build linkages and share resources.
- Link between clinic and HOPWA – HOPWA needs to reinforce that if individual gets HOPWA services as a positive person that they need to stay in care. In some districts, HOPWA will not see client without referral from clinic. Need to make sure are in care and stay in care. Need to educate HOPWA about importance of care – both locally and at state level. Also need uniform policy across state. Need good ongoing communication between HOPWA and HIV providers. Need to improve relationship with DCA – make them understand DCA understand the importance of treatment and care. Individuals in bad need of housing – offers opportunity to get them in care, develop ISP and help them stay in care.

How can we better coordinate HIV care and prevention services?

- Disconnect because prevention does not have local planning in many cases. May be way at local level to come up with structure that includes care and prevention. Need to start this at state level as well. Prevention funds community-based organizations often and at care level, fund districts. Need to figure how to bring these stakeholders together and improve communication, collaboration. Need to increase awareness of various care and prevention providers.
- Also disconnect between social services agencies – hard to know who is serving your clients. For example, could have card that indicates various agencies provide services for the agencies. Has been tried in homeless arena.
- Work with new Oral Health Coalition.
- Implement HIV statewide awareness campaign – needs to be directed at both community and at elected officials. Work at both at community and state level – with multi marketing – custom info to local level. Would be great if a media package/toolkit could be developed that communities could adapt for use at the local level. There are lots of toolkits at national level that could use in developing one for Georgia. Currently, there is no toolkit that covers everything that needs to be covered. Also need state rollout. JAMA article pointed out the need for a call to action. Need key stakeholder engagement. Are

doing it now on prevention. Need both sides. Strategic planning that pulls stakeholders from all directions with state agency facilitating work. Power of collective speaks – at all levels.

- Important to be in the conversation – doesn't mean have to come in through front door. Just want to be "in the house."
- Need to think long term – not clear what will have to RW funding with reauthorization. Important to build collaborations.

Barrier/Issue: Prevention and treatment of substance abuse.

How can we better provide or link to substance abuse prevention services?

- At state level, need to make sure Behavioral Health and PH are on same page, talk, work together, especially given upcoming creation of new Behavioral Health Department. Need better sharing of resources.
- Need total care clinics that address all needs, including SA. Multi services under one roof – like some of efforts to serve homeless.

How do we improve access to substance abuse treatment?

- Need more SA resources. In some rural areas, very limited resources, especially for women. Beds always full in some areas of state. Improved coordination doesn't help if don't have services.
- Need to know what requirements are for each system – such as SAMSHA requirement that pregnant women have priority.
- Advocate for need and educating programs, etc. about need for SA services for people who are HIV infected.
- Look at sharing providers – help pay for part of SA provider if they come to HIV facility
- Need to prove need for these services – assessment needs to include this.
- Increased cross training – assessment tools and training
- Identify SA screening tools – work with Office of Addictive Diseases to identify these tools and learn how to use them – note: need to address issue of when identify those at high need of SA services – who to get them those services
- Look at opportunities to apply for funding with SA providers – e.g., SAMHSA grants

Barrier/Issue: Eliminating disparities in access to core medical services and support services (In terms of sub-populations, hard to reach populations and those historically underserved).

Realizing that not everyone has equal access to services, how do we ensure that everyone has access to care and services?

- Advertising Programs (thru media outlets)
- Target high risk youth and incarcerated populations for testing and referral
- Translation Services
- Linguistic and Cultural Competency
- Indentifying issues thru focus groups and consumer advisory councils
- Identifying subcontractors for primary and sub-specialty care
- Reexamine client service funding based on need/emerging demographic changes.

- HRSA designations should consider changing demographics
- Diversify Funding Sources
- Collaboration with other clinics/community health centers (330 Clinics)
- Disseminating more printed material/advertising service.
- Involve local/private agencies (support/collaboration)
- Education/Acknowledging - HIV/AIDS in community among politicians, private business etc.
- Emphasizing economic savings/feasibility of acknowledging HIV/AIDS with business community
- Redistribution and HIV/AIDS care in urban and rural communities (decentralization of care services) [including satellite clinics]
- Partner with communist base organizations.
- Satellite Clinics
- Combining HIV testing with other infection testing (HIV and TB)
- Raise awareness of HIV thru piggy-backing on other infections awareness (HIV and TB)
- Staggered hours at clinics (nights and weekends)
- Identifying community gate keepers
- Canvassing special populations for best practices for messaging and outreach
- Utilizing social networks
- Using Social Programs/Events to disseminate HIV/AIDS messaging
- Market social event primarily
- Summer Recreation for Teens
- Add HIV messaging to program
- Normalizing HIV/AIDSA testing and care to minimizing stigma
- Flexibility in meeting clients where they are especially among hard to reach/marginalized folks
- Early risk reduction
- Patient involvement in treatment plan
- Environment – rapport with clients from clinic gate keepers
- Readmission of peer counselors
- Incorporating structural level interventions (structural issues that affect society and HIV care [racism, homelessness etc.]
- Faith base/traditional/alternative beliefs being valued in western medication
- Social and medical program integrations in HIV/AIDS care

The five geographic groups developed broad action statements for their assigned barrier/issues. These action statements, along with the Input Summary tables, guided the development of Georgia's Comprehensive HIV Services Plan on page 53. The SCSN will also be used to guide the development of programs to provide services to persons living with HIV/AIDS in Georgia and to encourage effective collaboration and coordination among service providers across funding streams. As a living document, the SCSN will evolve to reflect the changing landscape of HIV in Georgia through subsequent revisions.

Section 3: How Will We Get There? How Does Our System Need to Change to Assure Availability of and Accessibility to Core Services?

The Georgia Comprehensive HIV Services Plan that follows provides the goals, objectives, and strategies that will be used to guide the further development and monitoring of the state's HIV/AIDS health care delivery system. The needs and barriers findings of the updated 2009 SCSN and the HRSA strategy area key action steps developed by SCSN meeting participants have been incorporated into the goals and objectives.

The Division of Public Health's HIV Unit will ensure that all grant-in-aid, contracts and state direct services are compliant with the comprehensive plan goals and objectives.

Georgia's Statewide FY 2009-2012 Comprehensive HIV Services Plan

Goal 1: Improve access to HIV-related core services.

Objectives	Strategies	Time Frame	Accountability	Measure
1.1. Ensure continuity and availability of HIV primary care consistent with Public Health Services guidelines.	1.1.1. Identify and assure points of entry for services exist in each health district.	Years 1-3	Part A Grantee, Part B Grantee Offices	HIV clinics in each health district and EMA.
	1.1.2 Establish system to regularly disseminate current contact information on all identified access points to providers throughout state.	Years 1-3	Part A Grantee, Part B Grantee Offices	HIV clinic and contact information posted on HIV Unit and Ryan White Part A web pages
	1.1.3. Assure transitional discharge planning for incarcerated individuals.	Years 1-3	Part B Grantee Office, Georgia Department of Corrections	The number of post released inmates who seek HIV primary care services
	1.1.4. Establish standardized referral form and documentation requirements throughout the state.	Years 1-2	Georgia Case Management Sub-Committee, Ryan White Case Management Task Force	
1.2. Provide essential comprehensive oral health care.	1.2.1. In collaboration with the State Chief Dentist, establish an oral health workgroup to develop state oral health plan.	Year 1	Part B Grantee Office, HIV Unit Director, State Chief Dentist	Oral Health Workgroup
	1.2.2. Provide continuing education opportunities for oral health providers.	Years 1-3	Southeastern AIDS Training and Education Center (SEATEC)	The number of trainings conducted
	1.2.3. Develop and implement strategies to integrate oral health care education in clinic settings.	Years 1-3	SEATEC, HIV Clinics	

Objectives	Strategies	Time Frame	Accountability	Measure
	1.2.4. Develop relationships with dental schools and oral hygiene programs.	Years 1-3	HIV Clinic Managers	The number of contracts and memorandums of understanding (MOU) established by HIV Clinic Managers
1.3. Improve access to mental health and substance abuse services.	1.3.1. Increases linkages and collaboration at the state and local level with public and private mental health and substance abuse providers.	Years 1-3	Part B Grantee Office, HIV Clinic Managers	The number of established linkages, contracts and MOUs established by HIV Clinic Managers
	1.3.2. Evaluate current availability of mental health and substance abuse services at the local level.	Year 1	Part B Grantee Office	The number of mental health and substance abuse services at the local level.
	1.3.3. Train local clinic staff to screen mental health and substance abuse status on clients.	Years 1-2	SEATEC	The number of trainings conducted
1.4 Ensure access to care for newly identified HIV positives.	1.4.1. Improve linkages between HIV counseling and testing and HIV care.	Year 1	Part B Grantee Office, HIV Prevention Program	
	1.4.2. Coordinate outreach with early intervention services and HIV care.	Years 1-3	Part B Grantee, Part C Grantees	
	1.4.3. Encourage clinic sites to dedicate a specific time/date for new patient evaluations.	Years 1-3	Part B Grantee	The number of clinic sites with a specific time/date for new patient evaluations.
	1.4.4 Utilize trained peer advocates to facilitate new client enrollment in HIV Clinics	Years 1-3	Part B Grantee Office, MAI funded clinics	The number of clients who attended an orientation session by a peer advocate.

Objectives	Strategies	Time Frame	Accountability	Measure
1.5 Ensure HIV clinics provide clients with medical visits two or more times at least three months apart annually.	1.5.1 Monitor clinic utilization data. 1.5.2. Work with providers to develop and implement strategies to ensure clients are accessing care on a regular basis, as defined in PHS.	Years 1-3 Years 1-3	All Ryan White Grantees	The number of clients with medical visits two or more times at least three months apart annually.
1.6 Ensure mechanisms to maximize utilization of Medicaid and Medicare.	1.6.1. Improve the linkages and collaboration between all Parts and Medicaid/Medicare. 1.6.2. Monitor the effects of Medicaid and Medicare policy changes on clients. 1.6.3. Monitor the impact of Medicare Part D and ADAP on clients. 1.6.4. Monitor the effects of reductions in standard Medicare and Medicaid reimbursement rates.	Years 1-3 Years 1-3 Years 1-3 Years 1-3	All Ryan White Grantees HIV Clinics	Percent of HIV-infected consumers utilizing Medicaid/Medicare. Percent of HIV-infected clients utilizing Medicare Part D.
1.7 Identify and address client transportation barriers.	1.7.1. Assess transportation barriers and resources by health districts. 1.7.2. Identify and implement possible solutions to key transportation barriers	Year 1 Years 1-3	Part B Grantee	List transportation resources by health districts.
1.8 Improve efficiency of the Georgia Health Insurance Continuation Program (HICP) and the AIDS Drug Assistance Program (ADAP).	1.8.1 Maintain HICP and ADAP workgroup. 1.8.2. Collaborate with Medical Advisory Committee to ensure newly FDA approved medications are added to the ADAP formulary. 1.8.3. Improve HICP and ADAP application process (e.g., web-based application process).	Years 1-3 Years 1-3 Years 1-2	Part B Grantee	Percent of HIV-infected clients approved or denied for ADAP enrollment within two weeks of the

Objectives	Strategies	Time Frame	Accountability	Measure
				ADAP receiving a complete application.
	1.8.4. Revise and disseminate HICP and ADAP policies and procedures.	Year 1		
	1.8.5. Conduct internal audits of up to five percent of HICP and ADAP new client applications and or recertification forms quarterly	Years 1-3		The percentage of application or recertification forms audited.
	1.8.6 Establish and implement a policy to allow Advance Practice Registered Nurses (APRN) ADAP and HICP signature authority.	Year 1	Part B Grantee	APRN signature authority policy.
	1.8.7 Explore options to assist clients with health insurance co-payments for medications	Year 1	Part B Grantee	

Goal 2: Improve the quality of health care and health outcomes.

Objectives	Strategies	Time Frame	Accountability	Measure
2.1. Ensure Ryan White providers are meeting standards included in the Public Health Services guidelines.	2.1.1. Collaborate with SEATEC to provide education and training as needed to providers.	Years 1-3	Part B Grantee, SEATEC	Number of trainings conducted.
	2.1.2. Monitor HAB performance measures.	Years 1-3	All Ryan White Programs	Performance measures reports.
	2.1.3. Mentor HIV inexperienced providers.	Years 1-3	SEATEC, Part B Grantee	
	2.1.4. Notify providers of revised PHS guidelines.	Years 1-3	Part B Grantee	
2.2. Improve HIV/AIDS case management services throughout Georgia.	2.2.1. Provide case management training.	Year 1	Part B Grantee, SEATEC, Part A Grantee	Number of trainings
	2.2.2. Develop, test, and implement a case management client Acuity Scale.	Years 1-2	Part B Grantee, Case Management Sub Committee	Acuity Scale development.
	2.2.3. Develop and implement Women and Children specific case management standards.	Years 1-3		Women and children case management standards.
	2.2.4 Implement standardized case management intake forms.	Year 1	Part B Grantee	Number of districts utilizing forms.
	2.2.5 Develop standardized referral form.	Years 1-3	Case Management Sub-Committee, Ryan White Case Management Task Force	Standardized referral form
	2.2.6 Monitor HAB case management performance measures	Years 1-3	All Ryan White Programs	Performance measures reports
	2.2.7 Maintain Case Management Sub-Committee.	Years 1-3	Part B Grantee	

Objectives	Strategies	Time Frame	Accountability	Measure
2.3. Implement statewide Ryan White Part B quality management plan.	2.3.1. Provide quality improvement workshops.	Years1-3	Part B Grantee, Part B QM Core Team	Number of trainings conducted.
	2.3.2. Assure quality improvement projects occur at state and local levels.	Years 1-3	Part B Grantee, Part B QM Core Team	QM quarterly reports
	2.3.3. Communicate findings to key stakeholders at least biannually.	Years 1-3	Part B Grantee	Presentations and reports
	2.3.4. Update the QM plan at least annually and the QM work plan at least quarterly.	Years 1-3	Part B Grantee, Part B QM Core Team	QM plan and work plans
	2.3.5. Require that all Ryan White Part B funded-sites revise written QM plans annually, and submit quarterly QM progress reports.	Years 1-3	Part B Grantee	Local QM plans and quarterly reports
	2.3.6 Maintain QM Core Team.	Years 1-3	Part B Grantee	
2.4. Reduce the number of newly diagnosed individuals entering into care with an AIDS diagnosis.	2.4.1. Work with HIV/AIDS Surveillance to establish process to collect and report data.	Year 1	Part B Grantee, HIV/AIDS Surveillance	Percent of individuals who progress to an AIDS diagnosis within 12 months of an HIV diagnosis
	2.4.2. Monitor the percentage of new clients entering into care with an AIDS diagnosis.	Years 1-3	Part B Grantee	
	2.4.3 Work with HIV prevention provider agencies to develop and implement subpopulation strategies to identify HIV positive individuals and get them in care.	Years 1-3	Part B Grantee	
2.5. Enhance efforts to retain clients in care and treatment.	2.5.1. Provide clients with treatment and care adherence education.	Years 1-3	HIV Clinics	The number of clients with medical visits two or more times at least three months apart annually.
	2.5.2. Train and utilize peer advocates to provide outreach, education, advocacy and retention	Years 2-3	MAI Funded Clinics and contract funded trainers.	

Objectives	Strategies	Time Frame	Accountability	Measure
	services. 2.5.3. Identify and implement client self management and adherence approaches (e.g., client/provider contracts)	 Years 2-3		
2.6. Improve recruitment and retention of health care staff.	2.6.1 Mentor HIV inexperienced providers. 2.6.2. Collaborate with SEATEC to provide training and onsite technical assistance. 2.6.3. Collaborate with the Public Health Nursing (PHN) Section to address workforce crisis. . 2.6.5. Reduce the time that staff positions are vacant.	Years 1-3 Years 1-3 Years 1-3 Years 1-3	SEATEC , Part B Grantee Part B Grantee, PHN Section Part B Grantee	The number of trainings conducted Number of days established positions remain unfilled.

Goal 3: Eliminate health disparities and barriers to care.

Objectives	Strategies	Time Frame	Accountability	Measure
3.1. Identify health disparities and barriers to care.	3.1.1. Identify an academic partner to assist with the needs assessment process. 3.1.2. Develop the statewide needs assessment. 3.1.3. Implement the statewide needs assessment 3.1.4. Analyze findings and prepare a written report,	Years 1 Years 1-2 Years 2-3 Years 2-3	Part B Grantee	Statewide Needs Assessment
3.2. Improve cultural competency of service providers and programs.	3.2.1. Coordinate training and education on cultural competence issues (i.e., language, race/ethnicity, literacy, religion, sexual orientation, gender identity, physical challenges). 3.2.2. Improve client involvement in planning and implementation of programs. 3.2.3. Encourage the use of culturally and linguistically materials and resources.	Years 1-3 Years 1-3 Years 1-3	Part B Grantee All Ryan White Programs	Number of participants.
3.3. Increase the number of clients with affordable, stable and safe housing.	3.3.1. Assess clients for housing needs and eligibility for housing resources, (e.g., HOPWA, Section 8, public housing). 3.3.2. Ensure clinic sites, community-based organizations, and other providers have current housing resource information for their area. 3.3.3. Establish linkages at local level between case managers and housing resources.	Years 1-3 Years 1-3 Years 1-3	HIV Clinics Part B Grantee HIV Case Managers	Percentage of clients referred for housing assistance and received.

Objectives	Strategies	Time Frame	Accountability	Measure
	3.3.4. Improve collaboration between Part B Grantee and HOPWA.	Years 1-3	Part B Grantee	
3.4. Improve the utilization of interpretation and translation services for clients.	3.4.1. Encourage Part B providers to budget funds for interpretation services where needed. 3.4.2. Collaborate with DHR Limited English Proficiency and Sensory Impairment program to ensure clients have access to all interpreter services as needed.	Years 1-3 Years 1-3	Part B Grantee Part B Grantee	Percentage of clients receiving interpretation and or translation services.
3.5. Encourage consumers to become active partners in their healthcare and improve the quality of their lives.	3.5.1. Train and utilize peer counselors to provide outreach, education, advocacy and retention services. 3.5.2. Identify and implement consumer self management and adherence approaches (e.g., consumer/provider contracts). 3.5.3. Improve client involvement in planning and implementation of programs.	Years 1-3 Years 1-3 Years 1-3	MAI Funded Clinics and contract funded trainers. HIV Clinic Staff All Ryan White Grantees	Number of peer advocates providing outreach, education, advocacy and retention services. The number of clients involved in the planning and implementation of programs.
3.6. Improve access and utilization of emergency financial assistance to clients.	3.6.1. Encourage Part B providers to budget funds for emergency financial assistance where needed. 3.6.2. Monitor use of Part B funds for emergency financial assistance. 3.6.3. Encourage collaboration with local community based agencies to assist with emergency financial services.	Years 1-3 Years 1-3 Years 1-3	Part B Grantee	Quarterly expenditure reports.

Goal 4: Enhance collaboration and communication with partners statewide.

Objectives	Strategies	Time Frame	Accountability	Measure
4.1. Enhance relationship with state partners to identify common goals and coordinate utilization of resources.	4.1.1. Coordinate statewide HIV/AIDS meetings to share information and best practices and identify collaborative opportunities.	Year 1	Part B Grantee	Number and type of meetings held.
	4.1.2. Work with the Department of Community Health to facilitate data sharing agreement.	Year 1		Data Sharing agreement
	4.1.3. Work collaboratively with the Southeast AIDS Education and Training Center (SEATEC) to improve the quality of provider and program staff education.	Years 1-3		
	4.1.4. Maintain Part B Grantee participation in the Metro-Atlanta EMA Planning Council.	Years 1-3		
4.2. Improve communication, cooperation, and collaboration among HIV providers and key stakeholders.	4.2.1. Facilitate meetings and conference calls/and other communication technologies.	Years 1-3		Number and type of conference call and meetings.
	4.2.2. Develop and sustain state work groups to address system-level issues (e.g. oral health workgroup).	Years 1-3		

Section 4: How Will We Monitor Our Progress: How Will We Evaluate Our Progress in Meeting Our Short- and Long-Term Goals?

Implementation, monitoring, and evaluation: 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. The FY 2009-2012 Comprehensive HIV Services Plan 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 HIV Unit and Part B sub-recipients will generate reports from the CAREWare database to monitor consumer level utilization of core services. By complying with the Client Level Data (CLD) reporting requirement, sub-recipients will more comprehensively enter client level data elements into CAREWare. Performance measures (PM) reports generated in CAREWare will be more accurate and useful for quality improvement activities. CLD reports as well as PM reports will be reviewed by the Part B Program staff and the QM Core Team to identify opportunities for quality improvement.

The Part B Program will utilize CAREWare to report CLD to HRSA. All Part B funded sub-recipients will be required to use CAREWare for data collection. The Part B Program will participate in all HRSA training on client level data to assure understand and compliance with reporting requirements. Upon finalization of the CAREWare centralization, technical assistance will be provided to health districts providing outpatient/ambulatory medical care and medical case management services. The Part B Program will continue to collaborate with other Ryan White Parts to maximize opportunities for training and technical assistance

Part B Consortia and sub-recipients will report on progress toward goals and objectives via quarterly reports**.** Part B sub-recipients are required to fulfill the quality management components of the Part B Program GIA contracts. Deliverables in the FY 2008 GIA included QM Program requirements. These requirements include: Ensure that the medical management of HIV infection is in accordance with the U.S. Department of Health and Human Services (DHHS) HIV-related guidelines; develop and implement a quality management (QM) program that include the following: a written QM plan; a leader and team to oversee the QM program; organizational goals, objectives, and priorities; performance measures and mechanisms to collect data; project-specific continuous quality improvement plan (CQI); and communication of results to all levels of the organization, including consumers when appropriate; participate in the statewide Part B QM Program; and monitor performance measures as determined by the QM Core Team.

The Part B QM Plan includes monitoring clinical outcomes and key performance measures. In 2008, the QM Core Team decided to limit outcome measures to the following: HIV/AIDS mortality rates, progression to AIDS within the first 12 months after diagnosis, and HIV perinatal transmission rates. Members of the Essential Preventive Clinical Services Team, Evaluation and

Reporting Section and the HIV/AIDS Surveillance Unit assist with data collection strategies. Data sources include the following: the Access database for ADAP applications; CAREWare; eHARS; Vital Records; and clinical and case management charts. Data collection will use appropriate sampling methodologies. The Core Team will annually assess the QM Program for effectiveness.

Clinical performance measures will be monitored through the following methods: The QM Program will monitor the approved HAB performance measures in all 16 Part B funded public health districts at least annually. Based on findings of key clinical performance measures, the following are objectives in the FY09 Part B Grant: Increase the percentage of clients with AIDS who are prescribed HAART from 87% to 90%; increase the percentage of HIV-infected clients who have a dental examination at least annually from 20% to 50%; and increase the percentage of HIV-infected female clients $\geq$ 18 years old who have a Pap smear at least annually from 70% to 90%. The Core Team will review the measures and compile reports.

Beginning in October 2007, sub-recipients were required to report quarterly on three performance measures: 1) percent of HIV-infected new clients with an AIDS diagnosis admitted during this reporting period; 2) percent of HIV-infected clients diagnosed with AIDS who were prescribed HAART; and 3) percent of HIV-infected clients on HAART with HIV viral loads $<$ 75 copies/mL. In 2009, these reports will continue as part of the GIA quarterly reports.

Data sources for the clinical performance indictors are CAREWare and client records review. The QM team utilized the Scantron® Class Climate system for data collection during the 2007-08 clinical chart reviews.

ADAP and HICP will be evaluated through the following methods: ADAP will continue to monitor monthly indicators: 1) percentage of Georgia ADAP clients recertified for ADAP eligibility criteria at least annually, and 2) percentage of newly applying ADAP clients approved or denied within two weeks of ADAP receiving a complete application; and percentage of correctly completed new ADAP applications submitted to ADAP. Two new indicators were added in 2008 for HICP: percentage of active HICP clients recertifying before their six month due date to prevent delays in payment of health insurance premiums; and the percentage of correctly completed new HICP applications submitted to HICP. Administrative site visits will be conducted to monitor the validity of local ADAP programs. Data sources for the ADAP/HICP indicators are the customized Access database for ADAP applications, HICP Excel spreadsheets, CAREWare, and case management client records.

Fiscal Accountability will be evaluated through the following methods: The statewide accounting system, People soft, will be used to monitor all expenditures on a monthly basis to ensure accomplishment of program activities. A contract monitoring site visit tool is used to monitor HIV providers at the local level to ensure allowability of cost. The tool enables state staff to review line items expenditures ensuring funds are expended appropriately.

Administrative and Case Management performance measures will be evaluated through the following methods: The HIV Care District Liaisons will continue to assess the programs' compliance with Ryan White guidelines and regulations by closely monitoring programmatic and fiscal requirements of all contracts and GIA awards including quality management requirements. They ensure QM/QI findings/reports are shared at public health districts meetings. The District Liaisons, at least annually, conduct administrative site visits at each sub-recipient. During administrative site visits, District Liaisons assess the following: client's eligibility for Ryan White Part B-funded services and availability of other benefits; the clinic's sliding fee scale policy, grievance policy, client rights and responsibilities; client enrollment in case management (medical and non-medical) and case management notes; clinic confidentiality and security procedures; linkages to external providers; submission of reports; fiscal accountability; and quality management plans. Upon completion of the performance review (administrative site visit), a summary of findings is sent to the HIV Coordinator and District Health Director. If corrective action is recommended by the state office, the district is expected to complete and submit an action plan that identifies key actions and time frames to improve program performance for those areas that require corrective action. Upon receipt of the final administrative report, the service provider has 45 days to submit their corrective action plan to the state office. If corrective action measures are not implemented within the specified timeframe, funding may be restricted.

Case management client file review or performance measures reports in CAREWare will be utilized to monitor case management indicators. The QM Coordinator developed a chart review tool to assess implementation of the newly approved Part B Program CM Standards. The tool includes the following CM performance measures: ISP updated every 6 months, ISP signed and dated by the client and CM, completion of standardized Intake and Income/Expense Spreadsheet, follow-up of primary medical care and treatment adherence at least every 6 months, collaboration and coordination of services, face-to-face contact every 4 months, referrals and follow-up, goals established during assessment/reassessment. The QM Coordinator will make recommendations on methods to improve CM services and documentation based on findings from this chart review process.

Data sources for the administrative and case management indicators include: case management client files, review of district level client satisfaction survey results, sub-recipient quarterly reports, QM plan reviews, and CAREWare.

Appendix 1

Statewide Coordinated Statement of Need Meeting Participants*

Erica Ahmed, Georgia Department of Human Resources, HIV Section
Eileen Albritton, West Central Health District 7
Wendy Armstrong, Emory University, Grady Infectious Disease
Deanna Baker, North Georgia Health District 1-2
Deborah Bauer, Atlanta Family Circle
Jeronia Blue, Grady Health Systems
Sanford Boshart, Clayton County HIV Consortium
Robbie Bowman, South Central Health District 5-1
Jeffrey Brock, Georgia Department of Human Resources, HIV Section
Tary Brown, Rural Health Center
Libby Brown, Georgia Department of Human Resources, HIV Section
Deanna Campbell, Georgia Department of Human Resources, Epi Section
Robin Cavin, Northwest Health District 1-1
Jeffrey Cheek, Fulton County Government, Atlanta EMA Part A
Marie Cherry, Infectious Disease Association
Michael Coker, Georgia Department of Human Resources, HIV Section
Stephon Collins, Georgia Department of Human Resources, HIV Section
Delores Cooper, Coastal Health District 9-1
Chiquita Covington, Georgia Department of Human Resources, HIV Section
Jennifer Creighton, Fulton County Department Health and Wellness
Rebecca Culyba, SEATEC
Mary Daise Basil, Georgia Department of Human Resources, HIV Section
Renata Dennis, SEATEC
Robert Devito, Piedmont Healthcare
Hawaly Dicko, Georgia Department of Human Resources, HIV Section
Dazon Dixon Diallo
Kimberley Dobson, Georgia Department of Human Resources, HIV Section
Marie Dockery, North Georgia Health District 1-2
Rosemary Donnelly, Georgia Department of Human Resources, HIV Section
Laura Donnelly, SEATEC
Aisha Dubose, Open Hand
Tracy Elliott, AID Atlanta, Inc.
Helen Ellis, East Metro Health District 3-4
Johnny Fambro, Central City AIDS Network, Inc.
Jevon Gibson, Georgia Department of Human Resources, Office of Essential Preventive Clinical Services
Lashawne Graham, South Health District 8-1
Anthony Hall, Georgia Department of Human Resources, HIV Section
Veda Harrell, Cobb/Douglas Health District 3-1
Karla Hendriquez, North Health District 1-1

Statewide Coordinated Statement of Need
Meeting Participants

Carolyn Hodges, DeKalb County Ryan White Early Care Clinic
Mikki Hollinger, St. Joseph's Mercy Care Services
Raphael Holloway, Georgia Department of Human Resources, HIV Section
Maryette Horton, Southeast Health District 8-2
Larry Howell, Medical College of Georgia
Kelly Howerton, North Central Health District 5-2
Sarina Jackson, Grady Health Systems, The Family Clinic at Ponce
Jennifer Jeffers, Cobb/Douglas Health District 3-1
Ruth John-Bonnette, Georgia Department of Human Resources, HIV Section
Rollin Johnson, South Health District 8-1
Deontray Jones, AID Atlanta, Inc.
Chondra Kelley, Georgia Department of Human Resources, HIV Section
Jay Kirk, Grady Health Systems, Infectious Disease
Antonio Lawrence, West Central Health District 7
Jennifer Lee, DeKalb County Ryan White Early Care Clinic
Larry Lehman, AID Gwinnett, Inc.
Elizabeth Lense, Georgia Department of Human Resources, Family Health
Sheryl Lewis, Southeast Health District 9-2
Katherine Lovell, Open Hand
David Malebranche, Grady Health Systems, Infectious Disease Program
Twalla Marshall, Georgia Department of Human Resources, HIV Section
Natlyn McGhee, Georgia Department of Human Resources, HIV Section
Elandis Miller, St. Joseph's Mercy Care Services
Jeffrey Moody, Georgia Department of Human Resources, HIV Section
Jacqueline Muther, Grady Health Systems, Infectious Disease Program
Joe Norman, Georgia Department of Human Resources, HIV Section
Michelle Osborne, LaGrange Health District 4
Doris Pearson, East Central Health District 6
Pamela Phillips, Georgia Department of Human Resources, HIV Section
Shayla Pierce, Sister Love, Inc.
Jane Powell, Northeast Health District 10
Kenneth Prince, St. Joseph's Mercy Care Services
Kevin Ramos, Emory University
Chayne Rensi, Georgia Department of Corrections
David Reznik, Grady Health Systems, Infectious Disease Program
Beverly Robertson, North Health District 1-1
Angela Robinson, Clayton County Board of Health, District 3-3
Nicole Roebuck, AID Atlanta, Inc.
Lynne Rollins, Northwest Health District 1-1
Cotina Routh, Georgia Department of Human Resources, HIV Section
Chanel Scott-Dixon, Southwest Health District 8-2
Betty Simmons, Coastal Health District 9-1

Statewide Coordinated Statement of Need
Meeting Participants

Shantisa Spenser, Georgia Department of Human Resources, EPI Section
Tomi Jay Stultz, AID Gwinnett, Inc.
Anitra Sumbry, Emory University
Marie Sutton, Georgia Department of Human Resources, Office of Addictive Disease
Pradnya Tambe, Fulton County Department of Health and Wellness
Jennifer Taussig, Georgia Department of Human Resources, EPI Section
Sandra Vincent, Fulton County Government, Atlanta EMA Part A
Angelle Vuchetich, Grady Health Systems, Infectious Disease Program
John Warchol, AIDS Legal Project
Dale Washington, Northeast Health District 10
Dianne Weyer, SEATEC
Lisa Diane White, Sister Love, Inc
Kathy White, Fulton County Government, Atlanta EMA Part A
Kevin Williams, Grady Health Systems, The Family Clinic at Ponce
Sylvia Williams, East Central Health District 6
Sri Wilmore, SEATEC
Donna Wilson-Fant, AID Atlanta, Inc.
Yvette Wing, SEATEC
Patricia Yancey, North Central Health District 5-2
Harry Young, Georgia Department of Community Health

Appendix 2

Georgia Statewide Coordinated Statement of Need (SCSN) Update Meeting

Wednesday, October 1, 2008
AGENDA

12:00 noon	**Registration**
1:15 p.m.	**Welcome/Purpose** Elizabeth Ford, M.D. Acting Director, Division of Public Health Raphael Holloway HIV Unit Director, DHR Jeff Cheek Director, Metro Atlanta EMA Ryan White Part A Program
1:30 p.m.	**Overview of the Day** John Blevins
1:45 p.m.	**HIV/AIDS Epidemiology Profile** Deanna T. Campbell, MPH Georgia Division of Public Health HIV Surveillance
2:30 p.m.	**Ryan White Grantee Update** Jeff Cheek –Ryan White Part A Jeffrey Brock – Ryan White Part B Marie Dockery –Ryan White Part C Jacque Muther – Ryan White Part D Dianne Weyer – Ryan White Part F
3:00 p.m.	**BREAK (Check In)**
3:30 p.m.	**2006 – 2009 Comprehensive Plan Update** **Goal 1 – Improve Access to HIV Related Core Services** *The State of Oral Health in Georgia – David Reznik, DDS* **Goal 2- Improve the quality of healthcare and health outcomes** *Ryan White Statewide Client Satisfaction Survey – Mac Coker, DHR* *Ryan White Part A Consumer Survey – Rebecca Culyba, SEATEC*

Local Needs Assessment District 5-2 Macon – Derek Stokes

Goal 3 – Eliminate Health Disparities and Barriers
HIV/AIDS in the Correction Setting – Kevin Ramos, Emory University

5:30 p.m. **Wrap Up/Adjourn**

Georgia Statewide Coordinated Statement of Need (SCSN) Update Meeting

Thursday, October 2, 2008

AGENDA

8:00a.m.	**Breakfast/Registration**
9:00 a.m.	**Overview of the Day/Review of Day One** Jim Sacco
9:15 a.m.	**Breakout Session 1 (Main Room / Breakout Rooms)** - Consumer Focus Groups - Healthcare Providers/Administrators/Social Services Providers
12:00 noon	**LUNCH**
1:00 p.m.	**Report Out** Jim Sacco
1:30 p.m.	**Breakout Session 2 (Main Room / Breakout Rooms)** - By Geographical Area
2:45 p.m.	**BREAK**
3:00 p.m.	**Wrap-up/Evaluation**
3:30 p.m.	**Adjourn**

Georgia Statewide Coordinated Statement of Need (SCSN) Meeting 2008
No. of responses = 84

Legend: Strongly Agree = 1
Agree = 2
Neutral = 3
Disagree = 4
Strongly Disagree = 5

General questions about the meeting

Question	Left pole	1	2	3	4	5	Right pole	n	av.	md	dev.
The meeting was beneficial.	Strongly Agree	61%	35%		2%	2%	Strongly Disagree	84	1.51	1	0.83
The meeting started on time.	Strongly Agree	57%	32%	4%	6%	1%	Strongly Disagree	82	1.62	1	0.91
The meeting was facilitated well.	Strongly Agree	76%	20%		1%	2%	Strongly Disagree	84	1.33	1	0.77
The meeting length was appropriate.	Strongly Agree	60%	34%	2%	1%	2%	Strongly Disagree	82	1.52	1	0.82
The meeting room was comfortable.	Strongly Agree	37%	34%	11%	12%	6%	Strongly Disagree	82	2.17	2	1.23
I had opportunities to express my opinions.	Strongly Agree	69%	27%		1%	2%	Strongly Disagree	81	1.41	1	

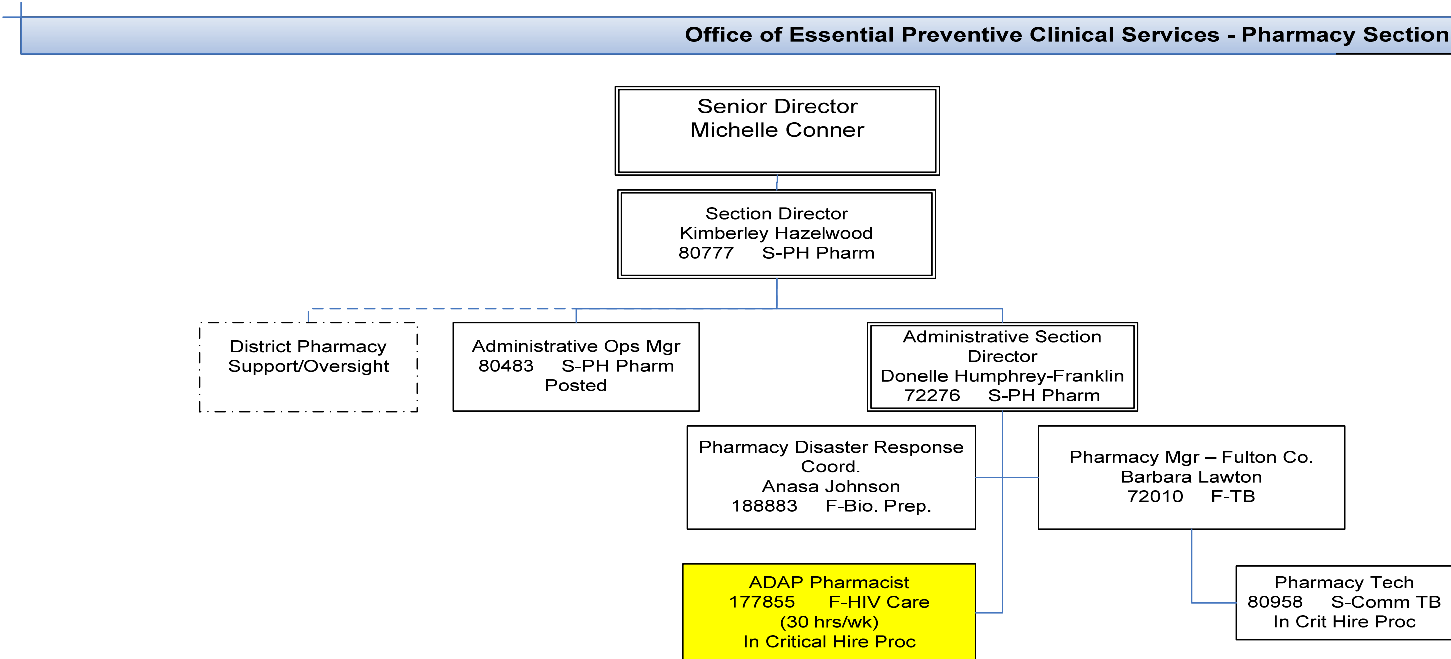
Appendix 4: Profile of Ryan White Part B Funded Providers

Agency	FY2008 Part B Base Award	Part B Funded Services
Northwest Health District (Rome)	$142,960	Primary Care, Mental Health, Medical Nutritional Therapy, Medical Case Management, Substance Abuse, Emergency Financial Assistance, Medical Transportation, Psychosocial Support Services
North Georgia Health District (Dalton)	$142,923	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Mental Health, Medical Nutritional Therapy, Substance Abuse, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Housing Services, Medical Transportation,
North Health District (Gainesville)	$139,943	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Mental Health, Medical Nutritional Therapy, Substance Abuse, Case Management (non-Medical), Emergency Financial Assistance, Food Bank/Home Delivered Meals, Medical Transportation
Cobb/Douglas Health District	$275,889	Primary Care, AIDS Pharmaceutical Assistance, Mental Health
Clayton Health District	$138,602	Primary Care
East Metro Health District (Gwinnett)	$342,189	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Medical Case Management, Case Management (non-Medical)
LaGrange Health District	$294,044	Primary Care, Dental Care/Oral Health, Medical Nutritional Therapy, Case Management (non-Medical), Emergency Financial Assistance, Linguistics Services, Medical Transportation
South Central Health District (Dublin)	$159,942	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Health Insurance Premium & Cost Sharing Assistance, Emergency Financial Assistance, Health Education/Risk Reduction, Housing Services, Medical Transportation, Outreach Services
North Central Health District (Macon)	$616,154.	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Health Insurance Premium & Cost Sharing Assistance, Case Management (non-Medical), Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Housing Services, Medical Transportation, Treatment Adherence Counseling
East Central Health District (Augusta)	$737,877	Primary Care, Case Management (non-Medical), Emergency Financial Assistance, Housing Services

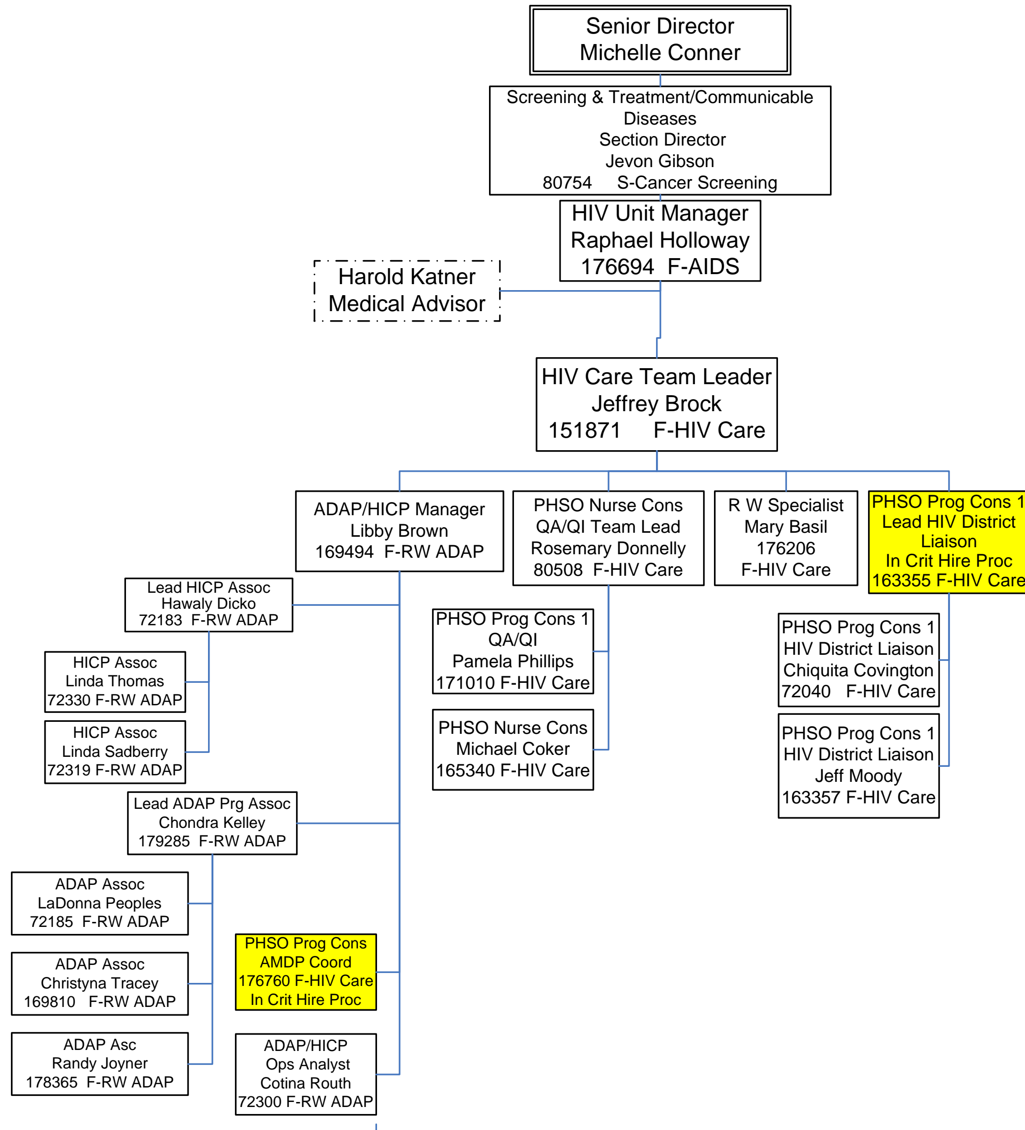
Agency	FY2008 Part B Base Award	Part B Funded Services
West Central Health District (Columbus)	$496,991	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Medical Case Management, Case Management (non-Medical), Emergency Financial Assistance
South Health District (Valdosta)	$179,937	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Health Insurance Premium & Cost Sharing Assistance, Medical Nutritional Therapy, Medical Case Management, Health Education/Risk Reduction, Medical Transportation, Outreach Services
Southwest Health District (Albany)	$653,550.	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Health Insurance Premium & Cost Sharing Assistance, Mental Health, Case Management (non-Medical), Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Housing Services, Medical Transportation
Coastal Health District (Savannah)	$813,081.	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Mental Health, Medical Nutritional Therapy, Medical Case Management, Substance Abuse, Case Management (non-Medical), Medical Transportation
Southeast Health District (Waycross)	$432,472.	Primary Care, Dental Care/Oral Health, AIDS Pharmaceutical Assistance (local), Health Insurance Premium & Cost Sharing Assistance, Emergency Financial Assistance, Health Education/Risk Reduction, Housing Services, Medical Transportation
Northeast Health District (Athens)	$217,764.	Primary Care, AIDS Pharmaceutical Assistance (local), Health Insurance Premium & Cost Sharing Assistance, Medical Case Management, Emergency Financial Assistance, Health Education/Risk Reduction, Food Bank/Home Delivered Meals, Medical Transportation
Department of Corrections	$70,555.	Case Management (non-Medical)
Fulton-DeKalb Hospital Authority	$85,712.	Primary Care

Appendix 5

ORGANIZATIONAL CHART

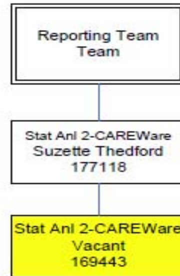


Office of Essential Preventive Clinical Services - HIV Unit



Health Information, Policy, Strategy & Accountability

Office of Epidemiology, Evaluation & Health Information



Appendix 6
RESOURCE INVENTORY

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
A Friend's House	Macon				x															x				
Absolute Wellness	Atlanta EMA										x	x												
Adult Health Promotion Clinic	Tifton				x	x	x		x	x		x									x			
Adult Health Promotion Clinic	Valdosta (testing in 10 co.)				x	x	x		x	x		x									x			
AESM	Atlanta EMA		x	x	x	x	x					x	x					x	x	x	x	x		
AID Atlanta	Atlanta EMA		x			x	x		x	x	x	x							x	x				
AID Gwinnett	Gwinnett		x	x		x				x									x		x			
AIDS Alliance of Northwest Georgia	Northwest Georgia										x										x	x	x	
AIDS Coalition of Northeast Georgia	Northeast Georgia				x	x																		
AIDS Law Project	Middle Georgia																						x	
AIDS Legal Project	Atlanta																						x	

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
AIDS Now Grasps Every Living Soul (ANGELS)	Middle Georgia				x																x			
AIDS Research Consortium of Atlanta (ARCA)	Atlanta					x																		
Alpha and Omega AIDS Foundation	Atlanta										x													
Amethyst Project, Inc.	Statesboro				x							x												
AM Ministries	Rome, Griffin, Carrollton, Dalton, Gainesville, LaGrange																		x	x				
ANIZ, Inc.			x		x						x	x	x											
Atlanta AIDS Interfaith Network	Atlanta				x						x	x												
Atlanta Area Service Group	Metro Atlanta and around Georgia											x												
Atlanta Harm Reduction Center	Atlanta		x										x											
Atlanta Union Mission Men and Women Homeless Shelters	Atlanta																			x				

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Atlanta Urban Ministries	Atlanta																				x			
Beulah Grove Church	Richmond County		x		x	x														x	x			
Bridge, the	North Georgia				x							x	x											
Bulloch Wellness Center	Bulloch, Candler, Evans Co.				x	x	x																	
Care and Counseling Center of Georgia	Atlanta											x												
Center for Black Women's Wellness	Atlanta					x																		
Center for Family Resources	Atlanta (one time rent and utility assistance)																		x	x	x			
Center for Pan-Asian Community Services	Atlanta EMA		x	x						x		x						x						
Central City AIDS Network	Macon																			x				
Chatham County Board of Health	Chatham & Effingham Co.	x	x	x	x	x	x	x	x	x							x				x	x	x	
Childkind, Inc.	Atlanta																							x
City of Refuge	Warner Robins		x		x						x													

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Clarke County Board of Health	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Oconee, Oglethorpe, Watson Co.	x					x			x							x			x	x			
Clayton College and State University Dental Hygiene Department	Clayton (cleaning and x-rays only)							x																
Clayton County Board of Health	Clayton Co.	x			x		x		x	x		x									X			
Clayton Mental Health Substance Abuse Center	Clayton Co.											x	x											
Clifton Sanctuary Ministries Shelter	Atlanta																			x				
Clifton Springs Physical Health Center	Clifton Springs					x																		
Cobb Board of Health	Cobb & Douglas Co. Atlanta EMA (Part A)	x				x	x	x	x	x	x	x												

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Coffee Wellness Center	Douglas				x	x	x																	
Community Outreach Program	Columbus, West Central Georgia				x												x							
Comprehensive AIDS Resource Encounter Inc. (CARE)	Jesup/ Southeast Georgia			x	x						x									x				
CSRA EOA	Richmond County				x					x										x				
CSRA AIDS Resources and Education, Inc. (CARE)	Central Georgia			x							x	x					x							
DeKalb County Addiction Clinic	DeKalb											x	x											
DeKalb Board of Health	DeKalb Atlanta EMA (Part A)					x	x	x	x		x	x	x											
Diversity House Project	Macon																			x				

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Dougherty County Board of Health	Baker, Calhoun, Colquitt, Decatur, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas and Worth Counties	x				x	x	x	x	x							x			x	x	x		
Douglasville Community Health Center	Douglasville					x																		
Edgewood SRO	Atlanta																			x				
Emory Psychological Counseling Center	Atlanta											x												
Extended Sisters	Columbus		x			x																		
Families First	Atlanta											x												
Family MASAI AIDS Project	Atlanta		x																					
Feed the Hungry Foundation	Atlanta																				x			
Feminist Women's Health Center	Atlanta					x																		
First Call for Help	Atlanta											x							x	x	x			

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
First Metropolitan Community Church	Atlanta																				x			
Floyd County Board of Health	Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haralson, Paulding, Polk and Walker counties	x					x	x	x	x							x			x	x	x		
Fulton County Health Dept.	Fulton, Atlanta EMA (Part A)						x	x	x			x												
Gay and Lesbian AA Club	Atlanta												x											
Genesis Shelter for women and newborns	Atlanta																			x				
Georgia Council for the Hearing Impaired	Atlanta, Statewide											x												
Georgia Department of Corrections										x														
Georgia Law Center for the Homeless	Statewide																						x	
Georgia Legal Services - Atlanta	Statewide																						x	

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Georgia Mutual Assistance Association Consortium	Statewide – services for refugees and immigrants		x															x						
Georgia Perimeter College Dental Hygiene Clinic	Atlanta							x																
Georgia Regional Hospital	Atlanta											x												
Georgia State University Psychology Clinic	Atlanta										x	x												
Georgia Therapy Associates, Inc.	North Central Georgia												x											
Gift of Grace Home	Atlanta																			x				
Glynn County Board of Health	Bryan, Camden, Glynn, Liberty, Long, and McIntosh Counties	x					x	x		x											x			
God's House of Human Services, Inc.	Albany				x					x														
Grady IDP	Atlanta EMA				x		x	x	x	x	x	x	x					x	x	x	x	x		x

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Grady Women's Health Services	Fulton and DeKalb Counties/Atlanta EMA				x	x	x	x	x	x	x	x				x		x	x	x	x	x		
Greater Deliverance Ministries, Inc.	Donalsonville			x	x																x		x	
Gwinnett County Board of Health	Gwinnett, Newton, Rockdale counties	x				x	x	x	x	x														
Gwinnett County Mental Health Center	Gwinnett											x												
Hall County Board of Health	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, and White Co.	x					x	x	x	x							x				x			
Haven of Hope	Carroll, Heard, Troup, Meriwether, Pike, Upson, Lamar, Spalding, Butts, Henry, Fayette, Coweta Co.				x		x	x		x											x	x		

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Hemophilia of Georgia	Statewide (for people with bleeding disorders and their partners)					x																		
HIV/AIDS Legal Project	Central and South Georgia																						x	
HIV Outpatient Services	Savannah					x	x	x		x													x	
HIV Outpatient Services	Waycross				x	x	x																	
Home But Not Alone	Atlanta																			x				
Hope Center	Macon, Warner Robins, Fort Valley, Milledgeville, surrounding areas		x			x	x	x		x		x	x									x		
IMANI Project	Atlanta	x			x																			
J&S Consultants	Macon			x	x					x														
Jerusalem House	Atlanta											x								x				
Kirkwood Mental Health Clinic	Atlanta																							
La Gender	Atlanta										x													
Lanier Tech Dental Hygiene Clinic	North Georgia							x																

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Lauren County Board of Health	Bleckley, Dodge, Johnson, Laurens, Montgomery, Pulaski, Telfair, Treutlen, Wheeler, and Wilcox Co.	x				x	x	x		x							x				x			
Legacy House	Atlanta																			x				
Legacy Village	Atlanta																			x				
Liberty Wellness Clinic	Bryan, Camden, Liberty, Long, McIntosh, Glynn Co.				x	x	x																	
Link Counseling Center	Atlanta and Marietta										x	x												
Living Room	Atlanta EMA															x				x				
Lowndes County Board of Health	Ben Hill, Berrien, Brooks, Cook, Echols, Irwin, Lanier, Lowndes, Tift, and Turner Co.	x			x	x	x	x	x								x			x				

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Macon-Bibb Board of Health	Baldwin, Bibb, Crawford, Hancock, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Washington, and Wilkerson Co.	x				x	x		x	x							x				x	x	x	
Marietta Mental Health	Marietta											x												
Matthew's Place	Atlanta																			x				
Medical College of Georgia Adult ID Clinic	Central Georgia/ Richmond County	x			x		x	x	x							x				x	x	x		
Medical College of Georgia Dental Clinic	Central Georgia/ Richmond County							x																
Medical College of Georgia Pediatric ID Clinic	Central Georgia/ Richmond County				x		x		x		x										x	x		
Medical College of Georgia Title III-B	Richmond County	x	x			x																		
Michelle Antionette Jones Crisis Center, Inc.	Atlanta									x		x	x											

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Midtown Assistance Center	Atlanta																		x		x			
Miracles AIDS Network	Atlanta		x		x						x	x	x											
Morehouse School of Medicine, PADP	Atlanta EMA				x		x		x	x									x	x	x	x		
Muscogee County Board of Health	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marian, Muscogee, Quitman, Randolph, Schley, Stewart & Sumter Co.	x				x	x	x	x	x														
My Brothaz Home, Inc.	Savannah		x		x																			
National AIDS Education and Services for Minorities	Atlanta		x		x	x					x	x					x			x	x			
National Black Men's Health Network	Atlanta		x		x																			
New Start	Atlanta												x							x				
New Visions Women's Program	Atlanta												x											

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
North DeKalb Mental Health Center	DeKalb											x												
North Fulton Regional Health Center	North Fulton					x																		
North Georgia AIDS Alliance	North Georgia				x																			
Northside Behavioral Health	Atlanta											x	x											
Northwest Georgia Specialty Care Clinic	Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haralson, Paulding, Polk, Walker Co.						x																	
Our Common Welfare	Atlanta EMA		x		X	x						x	x							x				
Outreach, Inc.	Atlanta		x	x	X	x					x											x		
Planned Parenthood	Central Georgia				x	x																		
Planned Parenthood	Savannah, Southeast Georgia				x	x																		
Planned Parenthood of Georgia	Atlanta				x	x																		
Positive Impact	Atlanta EMA		x	x	x						x	x												

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
PrimeCare of Augusta	Central Georgia				x	x					x			x										
Project DUNBAAR	Atlanta				x																			
Project Open Hand – Atlanta	Atlanta plus limited areas in Cobb, Clayton, Gwinnett Co.																				x			
Rainbow Partners	Waycross				x																			
Raksha, Inc.	Atlanta – assistance for immigrants from India, Pakistan, Bangladesh, Bhutan, Nepal, Sri Lanka			x														x						
Richmond County Board of Health	Burke, Columbia, Emanuel, Glascock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliafero, Warren and Wilkes Co.	x				x	x	x										x		x		x	x	
Rome AIDS Resource Council	Rome		x		x	x				x	x													

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Ropheka Rock of the World, Inc.	Atlanta		x																					
Rural HIV Clinic	Albany						x																	
Salvation Army	Atlanta												x						x	x	x			
Secular Organizations for Sobriety (SOS)	Atlanta												x											
Sharing and Caring, Inc.	Toombs, Jeff Davis, Appling, Tattnall Co.				x						x											x		
Shepherd's Inn	Atlanta												x							x	x			
Shrine of the Immaculate Conception	Atlanta																				x			
SisterLove, Inc.	Atlanta EMA		x	x	x																	X		
Someone Cares, Inc.	Atlanta		x		x	x					x										x			
Southside Medical Care Substance Abuse Center	Atlanta												x											
Springfield Imani Church	Richmond County		x		x												x							
St. Ann's AIDS Ministry	Cobb and North Fulton																				x	X		
St. Joseph's Mercy Care	Atlanta EMA		x		x	x	x				x	x						x						

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
St. Jude's Recovery Center	Atlanta												x											
St. Mark United Methodist Church	Atlanta										x													
St. Stephen's Ministry	Augusta			x	x					x	x						x			x	x	X		
St. Thomas the Apostle	South and West Cobb																				x			
St. Vincent de Paul Society	Atlanta																		x					
Sullivan Center	Clayton, DeKalb, and Fulton Co.																		x					
Task Force for the Homeless	Atlanta																			x				
TEAM Survival Project	Atlanta		x																					
Toombs Wellness Center	Toombs, Jeff Davis, Appling, Tattnall Co.				x	x	x																	
Travelers Aid of Metro Atlanta	Atlanta											x								x		x		

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Troup County Board of Health	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup and Upson Co.	x				x	x	x		x							x					x		
Union Mission Phoenix Project	Savannah				x															x				
Unique Community Women's Club	Soperton				x																			
United Hospice of Macon	Macon														x					x				
University of Georgia Student Health Center	Athens – students only					x						x												
University Hospital Retroviral Disease Outpatient Clinic	Augusta, Central Georgia				x		x		x													x		
Veterans Affairs Medical Center ID Clinic	Statewide – veterans only					x	x				x	x												
Visiting Nurse	Atlanta EMA													x										

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Ware County Board of Health	Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Ware, and Wayne Co.	x				x	x																	
Ware Wellness Center	Ware, Pierce, Charlton, Brantley Co.				x	x	x																	
Wayne Wellness Center	Wayne Co.				x	x	x																	
Welcome House	Atlanta																			x				
Wellness Clinic	Bryan, Camden, Liberty, Long, McIntosh, Glynn Co.				x	x	x	x						x										
Wellness House	Atlanta																			x				
Whitfield County Board of Health	Cherokee, Fannin, Gilmer, Murray, Pickens, and Whitfield Co.	x				x	x	x	x								x				x	x		
Wholistic Stress Control	Atlanta		x		x																			

Provider	Service Area	Early intervention services	Outreach/case finding	Peer education/co.	Health ed/risk reduction	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Winn Way Mental Health Center	DeKalb											x												
Women's Resource Center for Battered Women and Their Children	Atlanta																			x				
World Youth Alliance, Inc.	Atlanta				x																			
Youth Pride	Atlanta		x		x	x																		

* Many providers that offer HIV medical care work with local OB/GYNs to provide care for HIV positive pregnant women.

Additional Resources

HIV/AIDS Information Lines/Services

- Centers for Disease Control and Prevention National STD/AIDS Hotline - statewide
- Feminist Women's Health Center – statewide women's health help line
- Georgia AIDS/STD Information Line – statewide
- Helpline Georgia – statewide
- MIST Line (Medical Information Service via telephone) – for health care providers statewide
- National HIV Telephone Consultation Service – for health care providers statewide
- Public Health Information Line – statewide
- M.O.M.A.S. (Mothers on a Mission Against AIDS) (confidential support and information for families affected by HIV) – Macon
- Project Inform HIV Treatment Hotline – statewide
- Project WISE (Women's Information Service and Exchange) – statewide
- St. Ann's AIDS Ministry Phone Line - Cobb and North Fulton
- Veterans Affairs Medical Center ID Clinic – information services only available to veterans

Advocacy

- AID Gwinnett (client services) – Gwinnett
- AIDS Legal Project – statewide
- AIDS Survival Project – statewide advocacy training through Positive Action Network
- ANIZ, Inc. – Atlanta
- Center for Women Policy Studies – statewide
- Committee of Ten Thousand (grassroots nonprofit advocacy and policy group for people who contract HIV and/or HCV through blood products)
- Georgia AIDS Coalition – statewide
- Mothers' Voices/Atlanta Chapter
- National Association of People with AIDS
- SisterLove, Inc.

Clinical Research

- AIDS Research Consortium of Atlanta (ARCA)
- Grady Health System Infectious Disease Program Emory AIDS Clinical Trials Unit
- Emory Center for AIDS Research (CFAR)
- Hope Clinic of the Vaccine Research Center
- Medical College of Georgia Pediatric Clinic
- SHARE Project
- Veterans Affairs Medical Center ID Clinic (available only to veterans)

Practical Support Services

- My Brothaz Home, Inc. – Savannah
- Sisterhood (services and supports for women) – Macon
- AIDS Now Grasps Every Living Soul (ANGELS) (practical support) – Milledgeville
- Extended Sisters (social support to women of color and male mentoring) – Columbus

- Presbyterian Student Center (social and spiritual support) – Athens
- Survivors Support Group – Albany
- Rainbow Partners – Waycross
- Union Mission Phoenix Project – Savannah
- Amethyst Project – Statesboro
- Atlanta Interfaith AIDS Network
- Pets Are Loving Support (PALS) – Atlanta
- St. Ann’s AIDS Ministry – Cobb, North Fulton
- St. Mark United Methodist Church - Atlanta
- Vocational Rehabilitation Services – statewide
- ANIZ, Inc. (therapeutic support for HIV affected children) - Atlanta

Spiritual Support

- Absolute Wellness Brandon Ross Abernathy Community Center – Atlanta
- Alpha and Omega AIDS Foundation - Atlanta
- Atlanta Interfaith AIDS Network (Common Ground and Faithful Care In-Home Respite) – Atlanta
- Care and Counseling Center of Georgia
- Catholic Archdiocese of Atlanta HIV/AIDS Ministry Office – Atlanta
- Congregation Bet Haverim – Atlanta
- First Metropolitan Community Church – Atlanta
- Hillside Chapel and Truth Center – Life Ministry – Atlanta
- Jewish Family and Career Services – Atlanta
- Lutheran Church of the Redeemer – Atlanta
- Lutheran Services of Georgia
- North Decatur Presbyterian Church AIDS Ministry – Atlanta
- North Georgia United Methodist AIDS Ministry, Inc. - North Georgia
- Oakhurst Baptist Church – Atlanta
- Presbyterian AIDS Network – Atlanta
- St. Phillip Benizi Catholic Church AIDS Ministry – Atlanta
- Salvation Army Red Shield Services – Atlanta
- Shrine of the Immaculate Conception – Atlanta
- St. Ann’s AIDS Ministry – Atlanta
- St. Joseph’s Mercy Care Services - Atlanta
- St. Mark United Methodist Church – Atlanta
- St. Thomas the Apostle – Atlanta
- Alpha and Omega AIDS Foundation – faith-based education for clergy and congregations

Buddy Programs

- AID Atlanta – Atlanta EMA
- AID Gwinnett – Gwinnett
- Atlanta Interfaith AIDS Network – Atlanta
- Someone Cares, Inc. - Atlanta

Furniture/Clothing
- AID Atlanta – Atlanta EMA
- First Call for Help – Atlanta
- Furniture Bank - Atlanta
- Coastal Area Support Team –Hinesville
- Project AZUKA, Inc. – Savannah
- Michelle Antoinette Jones Crisis Center – Atlanta
- Midtown Assistance Center Assistance Line – Atlanta
- Miracles AIDS Network – Atlanta
- Salvation Army Family Emergency Services – Atlanta
- Someone Cares, Inc. of Atlanta

Wellness
- Absolute Wellness – Atlanta
- AID Gwinnett
- AIDS Treatment Initiatives

Other
- Georgia Council for the Hearing Impaired (education, counseling, support and referrals to helping agencies) – statewide
- Georgia Relay (telephone relay system for putting hearing persons and hearing-impaired persons who use TTY telephone machines in contact with one another) - statewide
- Hemophilia of Georgia, Inc. – statewide
- Office of Minority Health – statewide technical assistance program support for minority CBOs
- American Red Cross chapters throughout state (HIV/AIDS training)
- Open Arms Home for Medically Fragile Children (residential direct care for children under the age of four with HIV/AIDS. Operated by Lutheran Services of Georgia) – Savannah
- ChildKind, Inc. (foster care for children affected by HIV) – Atlanta

Appendix 7

Contact Information

Georgia Department of Human Resources
Division of Public Health
Office of Essential Preventive Clinical Services
HIV Unit

2 Peachtree Street, N.W.
12th Floor
Atlanta, GA 30303

Website: http://health.state.ga.us/
Telephone: 404-657-3100
Fax: 404-657-3119