State of Georgia
Comprehensive HIV Services Plan
2006 - 2009

Division of Public Health
Prevention Services Branch
HIV SECTION

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March 13, 2006

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Dear Ms. Jones:

On behalf of the Atlanta Family Circle Ryan White Title IV Project, we are confirming our concurrence with the State of Georgia's 2006-2009 Statewide Comprehensive Plan to the Health Resources and Services Administration (HRSA) for the HIV/AIDS funds under Section 2617 (b)(4) of the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act. We believe that 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 CARE Act funding sources, including Title IV.

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 Title IV Project contributed to the development of the state's 2006-2009 statewide comprehensive plan and reached consensus that the priorities and strategies proposed in the statewide comprehensive plan reflected the priorities expressed by the Atlanta Family Circle Ryan White Title IV Project. During the March 3, 2006 SCSN Planning Meeting, Atlanta Family Circle Ryan White Title IV Project staff, sub receipts and consumers provided the state with substantial feedback on the development of the 2006-2009 statewide comprehensive plan.

Sincerely,

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

March 13, 2006

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In developing the plan, Georgia updated the process for conducting and 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 (CCPG) provided input and feedback towards the development of the state's 2006-2009 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 March 3, 2006 SCSN Planning Meeting.

The HIV Section 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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HIV Prevention Manager

cc: Rosalyn K. Bacon, M.P.H.

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Introduction

Comprehensive HIV services planning is a central focus of the Ryan White CARE Act legislation and an essential component of the Ryan White programs. Comprehensive planning is necessary to achieve the goals of the Ryan White CARE Act: 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 Title II state and local programs, the Metropolitan Atlanta Title I Planning Council, and Ryan White Title III and IV 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 (PLWH) 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 PLWH 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 Section 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 Section program areas include both HIV prevention services and HIV/AIDS care services. The Ryan White Title II CARE Act program consist of several network of providers, which we contract with sixteen (16) county health departments and several community-based organizations to deliver HIV/AIDS services throughout the state. Each funded area is served by a Ryan White Title II 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 Title II funds in their respective districts. The HIV Section collaborates with Titles I, III, IV 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 (PLWH) 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 CARE Act providers, other HIV/AIDS providers, other public agency representatives, and PLWH 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:

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- How Will We Monitor Our Progress: How Will We Evaluate Our Progress In Meeting Our Short-and-Long-term Goals?

Georgia's FY 2006-2009 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 2006 SCSN identified needs and barriers have been incorporated into the goals and objectives. 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 Title II staff will ensure the implementation of the FY 2006-2009 Comprehensive HIV Services Plan in collaboration with

colleagues across other Ryan White Titles. 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 2000 federal census, Georgia ranked 10th among the states in population size, with a total population of 8,186,543. This represented an increase in total population of 26.4% 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 (2000 Census)

Characteristic	Georgia	US
Persons under 5 years old	7.3%	6.8%
Georgia persons under 18 years old	26.5%	25.7%
White persons	65.1%	75.1%
Black persons	28.7%	12.3%
Asian	2.1%	3.6%
Other race	4.2%	8.9%
Hispanic/Latino origin	5.3%	12.5%
Foreign born persons	7.1%	11.1%
Language other than English	9.9%	17.9%
High school graduation	78.6%	80.4%
Bachelor's degree or higher	24.3%	24.4%

Source: U.S. 2000 Census Bureau

Data from the 2000 Census, the latest available data, highlights the exceptional growth and increasing diversity of Georgia. With a population growth double the national average (13.2%), lagging only behind California, Texas, and Florida in terms of population increase, Georgia is the fastest growing state east of the Rockies. 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 5th in the percentage of African Americans in the overall population of the state, behind the District of Columbia, Mississippi, Louisiana and South Carolina.

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. Latinos, primarily Mexicans, are the most rapidly growing minority group and now reside throughout Georgia. In 2000, this group represented 45% of all foreign-born Georgia residents. Since the 2000 Census, this growth has been even more dramatic. Georgia's Hispanic population grew faster than any other state between 2000 and 2002 with a growth of 17%, bringing the total number of Hispanics to 516,500. About 6% of all Georgians and 7.5% of those in the metro Atlanta area are Hispanic. Metro Atlanta, during this same time period, experienced the most rapid growth rate among the nation's 20 most populous metro areas. While the population in the region increased overall by 9%, the increase in the Hispanic population was 30% compared to an 11% in the African American population and 7% in the White population.

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 25% of foreign-born Georgians in 2000. Indians now constitute the largest Asian population group in the state with a 271% increase during the 1990s, ranking 7th in numeric growth of the population and 4th in terms of percent increase. 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, Eritea, 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.

The number of undocumented immigrants in Georgia is estimated by the Immigration and Naturalization Service to have increased six-fold since 1996, with an estimated 228,000 undocumented immigrants in 2000. Georgia and nine other states together contain an estimated 78% of the undocumented residents in the U.S. Their arrival, mostly Mexican nationals, has been driven by job opportunities in major industries around the state such as the textile and poultry

plants in north Georgia, service industries in Metro Atlanta, and agricultural operations in South Georgia.

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 4th nationally in the percent of its population who are of working age.

Poverty: A total of 1,125,000 individuals in Georgia had incomes below the poverty level in 2003 ($18,400 for a family of four). There were 183,400 households with children under the age of 18 living in poverty; of which 39,000 households were those with children under the age of five only. Of the state's poor households, 158,700 were female headed households with children under the age of 18, and 26,600 of them were children under five years only.

Health Delivery System Environment: Georgia's health delivery system consists of four interconnected components: private providers, hospitals, community health clinics, and the state's public health system which has two separate elements, the Medicaid/PeachCare payment system and the county public health services.

Providers: The 2004 Health Resources and Services Administration (HRSA) report, "State Health Workforce Profiles," shows Georgia's workforce status across a large range of professions.

Georgia Health Professional Summary, 2000		
Profession	**Number Employed**	**State Rank (of 50)**
Physicians	13,700	39
Psychiatrists	749	25
Physician Assistants	1,232	24
Registered Nurses	68,000	42
Nurse Practitioners	2,260	33
Licensed Practical Nurses	20,000	10
Dentists	5,018	23
Dental Hygienists	4,760	23
Dental Assistants	5,160	47
Pharmacists	6,020	29
Psychologists	1,110	48
Social Workers	7,360	47
Physical Therapists	2,660	43
Occupational Therapists	1,790	35
Dieticians and Nutritionists	940	47
Home Health Aides	6420	48
Optometrists	820	12
Opticians	1910	22

*Reported number of dentists varies, based on reporting source.

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 dropped from 1,669 in FY 2004 to 1,578.5 in FY 2005. This represents a 5.4% reduction in the nursing workforce. The overall turnover rate for nurses increased from 17.7% in FY 2004 to 19.4% in FY 2005. Ten of the state's 18 public health districts reported an increase in turnover during FY 2005. The overall vacancy rate for public health nurses increased from 16.2% in FY 2004 to 18.0% in FY 2005. Eleven public health districts reported a vacancy rate increase.

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. Forty-two whole Georgia counties and seven partial county service areas are currently designated by the federal government as primary care HPSAs as are 84 population groups. These population groups include those below 200% of the federal poverty level, Medicaid eligible individuals, and migrant farm workers within specific geographic areas. In addition, 117 whole counties and 48 partial counties are designated as medically underserved areas. Areas with dental HPSA designation include 27 whole counties, six partial counties, and 59 population groups. Mental

health HPSA designation has been received by 44 entire counties as well as 43 service catchment areas.

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. Among persons served at the state's 38 CHCs, approximately 41% are uninsured and 34% are Medicaid recipients. Almost two-thirds are members of a minority group: 35% are Hispanic, 25% Black, and 4% 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, 24th among all states. Georgia Division of Medical Assistance data indicates that 65% of the state's Medicaid recipients in FY 2004 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 AIDS/HIV prevalence, yet account for only 35% of Medicine recipients.

Over the past two years, the state government in Georgia has reduced Medicaid benefits annually (e.g., over $100 million last year), which has not only had a direct negative impact on Ryan White clients on Medicaid but also a loss in funding of federal matching funds. To further contain costs, DCH is instituting managed care for Medicaid/PeachCare enrollees. Beginning in June 2006, the state will move 1 million people covered by Georgia's Medicaid insurance program for the poor and disabled into three commercial managed care organizations (CMOs). Specifically excluded from coverage by CMOs are elderly and disabled individuals, medically fragile children, and foster children. For excluded Medicaid recipients who are non-institutionalized elderly and disabled individuals, DCH is instituting a Disease Management (DM) program that will provide disease management services for a range of conditions, including but not limited to: asthma, diabetes, coronary artery disease, congestive heart failure, hemophilia, chronic obstructive pulmonary disease, psychiatric disorders, other co-morbid conditions, and risk factors related to chronic illness. The institution of these two approaches, CMOs and the DM program will have profound but yet unknown impacts on the current health provider, hospital, and public health and mental health service delivery systems.

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.

Epidemiological Data

Background: Since the earliest days of the HIV/AIDS epidemic, Georgia has had a substantial number of reported cases of AIDS. In 1999, the state had the eighth highest rate of AIDS among all states and the seventh highest number of persons living with AIDS. The HIV/AIDS epidemic continues to grow in Georgia. The total number of cumulative AIDS cases reported by the end of 2005 was 29,716. Mortality rates have dropped 80% in the past decade. As of December 31, 2005, the state had 14,641 people living with AIDS. The state's AIDS rate of 19 persons per 100,000 is seventh highest in the United States**.** Of reported AIDS cases in Georgia, 69% are within the Atlanta EMA, primarily Fulton and DeKalb Counties. The Atlanta EMA ranks 9th in the country among the 51 Title I EMAs.

Among individuals with newly diagnosed HIV infection, 32% were found to have AIDS. Of those individuals newly reported with "HIV infection, not AIDS," 15% progressed to AIDS diagnosis with 12 months.

The characteristics of the AIDS epidemic in Georgia have gradually shifted since the 1980s from an epidemic mostly represented by whites, men who have sex with men (MSM) and persons residing in metropolitan Atlanta to an epidemic in which African Americans are now the predominant race/ethnicity affected. There are also increasing proportions of women, persons infected through heterosexual context, and persons residing in rural areas. Georgia ranks 13th among all states in the rate of AIDS cases among African Americans, and the rate among Hispanics is similarly high given the lower census rate in Georgia.

Data limitations: The AIDS, HIV and STD surveillance databases are based on case reports that are submitted by clinics, hospitals, and other providers. Although these surveillance systems are standardized, the AIDS, HIV, and STD surveillance databases, as with most surveillance databases, do not represent 100% complete reporting. Moreover, reporting from the public sector tends to be better than from the private sector. This is particularly true for the HIV reporting system which was not implemented until December 2003 and has limited data to date. Therefore, the numbers presented in this document reflect an underestimate of the true number of cases in the state, and it cannot be said that these databases represent all persons in Georgia with a particular infection. Also, data is presented by date of diagnosis. Nevertheless, reporting is considered good overall and very useful for a variety of public health purposes.

Who has HIV/AIDS in Georgia? 2004 AIDS incidence, AIDS prevalence, and HIV (not AIDS) prevalence estimates in Georgia by selected characteristics are presented in the table below.

Georgia 2004						
Characteristic	AIDS incidence		AIDS prevalence		HIV (not AIDS) prevalence estimates	
	No.	%	No.	%	No.	%
Race/ethnicity						
White, not Hispanic	326	19	3,656	26	5,369	26
Black, not Hispanics	1,285	76	9,993	70	14,672	70
Hispanic	73	4	519	4	761	4
Asian/Pacific Islander	5	<1	51	<1	75	<1
American Indian/Alaska Native	<5	<1	13	<1	19	<1
Multi-race	<5	<1	9	<1	13	<1
Unknown	0	0	<5	<1	6	<1
Sex						
Male	1,242	73	10,936	77	16,105	77
Female	449	27	3,310	23	4,810	23
Age group (yrs)						
<13	<5	<1	56	<1	82	<1
13-19	16	1	76	<1	111	<1
20-44	1,165	69	7,905	55	11,606	55
>= 45	507	30	6,210	43	9,116	43
Exposure category						
Male-to-male sex	737	44	6,686	47	9,830	47
Injection drug use	274	16	2,500	18	3,765	18
Male-to-male sex and injection drug use	66	4	781	5	1,046	5
Heterosexual contact	576	34	3,879	27	5,647	27
Other	38	2	399	3	627	3
Total	1,691	100	14,245	100	20,915	100

Percent of change of new AIDS cases, people living with AIDS and the estimated number of people living with HIV (not AIDS) in Georgia for the past two years, 2003-2004

Indicator	2003	2004	Percent change	Trend
New AIDS cases	1,648	1,690	3%	Increased
PLWA	14,023	14,245	2%	Increased
Estimated PLWH (non- AIDS)	18,800	20,915	11%	Increased

The new AIDS cases diagnosed in 2004 increased by 3% compared to the previous year, and this change also constituted the most significant trend change in terms of the indicators analyzed. In addition, people living with AIDS and the estimated number of people living with HIV (not AIDS) increased by 2% and 11% respectively in the last two years.

Trends: Men who have sex with men (MSM) still represent the largest number of people living with AIDS in Georgia. They account for 45% (41% MSM and 4% MSM and inject drugs) of the Georgia cases known living with AIDS as of December 31, 2005.

Recent trends 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. Although African Americans make up only 30% of Georgia's population, 76% of the new cases of AIDS in 2004 among African-Americans.

The HIV/AIDS epidemic in Georgia now affects many women. From 1984 to 2004, the cumulative proportion of AIDS cases among women increased from 4% to 24%. African-American women are disproportionately affected. Heterosexual sex is the primary mode of transmission. Many women are sex partners of men who have used drugs or men who have sex with men. Twenty-three percent (3,356) of the individuals living with AIDS in Georgia at the end of 2005 were female.

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 reduces the transmission rate to 2 to 5%. Mothers with/at risk for HIV infection accounted for the 95% of the pediatric transmission mode for the 224 cumulative pediatric AIDS cases in Georgia as of December 31, 2005. Ninety-seven percent (105) of the pediatric cases known living with AIDS at the end of 2005 were perinatally infected.

Although teens are not likely to perceive themselves at risk for HIV infection, many of the 19% (5,538) of Georgians with AIDS who were diagnosed in their 20s were probably infected as an adolescent. Youth ages 13-19 account for 224 of the 29,716 cumulative cases.

The epidemic is shifting to Georgia's rural areas and small cities and towns. As of December 31, 2004, about 29% of men who have been diagnosed with AIDS, 43% of the women, and 47% of the children with AIDS were living outside the 20-county metropolitan Atlanta area at the time of AIDS diagnosis. In rural areas of the state, resources may be scarce. People are more dispersed and therefore harder to reach with treatment and prevention efforts.

HIV is a sexually transmitted disease (STD) and documenting the presence of other STDs and Hepatitis B and C also captures the potential impact on HIV/AIDS. Georgia consistently ranks among the top five states for STDs, and residents of the Atlanta EMA account for over half of all the state's cases. Chlamydia and gonorrhea are underreported generally, and over represented among women and African Americans. Among Georgia's 159 counties, 45 (28%) had primary and secondary syphilis rates above 3.0:100,000 in 2003; almost half of these 45 counties had rates over 4.0:100,000 and in the past decade over 500,000 citizens have been diagnosed with at least one STD. One in every four women aged 15 to 44 who had lifetime multiple sex partners reported an STD, with a 7% chlamydia positive testing rate, 80% of whom are asymptomatic. Georgia ranks 5th highest in chlamydia and gonorrhea rates and 2nd in the nation for syphilis cases. Half of Georgia's counties with the highest syphilis rates lie in the EMA.

Drug use is also a major factor. People who inject drugs often contract the virus when they share needles with an infected person. People who may not be using drugs themselves may also become infected through sexual activity with infected partners who have used injectable drugs. Alcohol and other drug use may increase high-risk behavior because they reduce inhibitions and

interfere with decision-making. The transmission mode for 21% (16% injecting drug use and 5% MSM and injecting drugs) of Georgia's 289,716 cumulative AIDS cases at the end of December 2005 was injecting drug use.

Georgia ranked ninth in the nation in TB case rates (6.1 per 100,000 persons) in 2003, and continued to have higher case rates than the national average (5.1/100,000). In 2003, 531 tuberculosis (TB) cases were reported statewide, representing a 42% decrease since 1991 – the peak of the TB resurgence in Georgia when 909 cases were reported. TB case numbers have decreased by an average of 4% annually since then, with sporadic year-to-year increases. The less than 1% decrease in case numbers in 2003 from the year before (533 cases) is the lowest percentage decrease reported since 1991. Metropolitan Atlanta accounted for 54% of all 2003 TB cases reported in Georgia. 2003 TB cases in Georgia were predominantly male (60%), non-Hispanic black (59%) and U.S. born (71%). The largest proportion of cases among age groups (38%) occurred in the 25-44 years old age group. The proportion of TB cases that are foreign-born, which had been steadily increasing over the past decade, decreased from 32% (172 cases) in 2002 to 29% (156 cases) in 2003. U.S.-born non-Hispanic blacks together with foreign-born cases constituted 80% of all TB cases in Georgia in 2003.

TB cases co-infected with HIV decreased from 81 (19%) cases in 2002 to 74 (17%) in 2003. This represents a substantial decline from 1993 when 42% of TB cases with known HIV status were positive for HIV. HIV testing among TB cases has improved considerably over the past five years. Reporting of HIV status increased from 68% in 1999 to 84% in 2003. Among TB cases in adults aged 25-44 years old, 92% had HIV test results reported. In TB cases with information on HIV status, HIV co-infection was predominantly present among non-Hispanic blacks (84%), males (64%), and in adults aged 25-44 (65%).

Georgia residents living with AIDS have tremendous obstacles to overcome. Eighty-nine percent of them are living below poverty level and 48% are without health insurance. Only 12% of all Georgia residents are on Medicaid (24th among all States) and according to the Georgia Division of Medical Assistance, 65% of the State's Medicaid recipients in FY 2004 were female. In 2001, Georgia ranked 44th out of 50 States and the District of Columbia in annual spending per Medicaid enrollee ($2,815/year v $3,762 nationally). Due to strict eligibility guidelines, males with HIV must become considerably ill, and be disabled before being eligible for coverage that would afford access to necessary care. Seventy-three percent of the adults and adolescents living with AIDS in Georgia are male.

In 2004, the percentage of non-elderly Georgians without insurance increased to 19%. Georgia ranks 50th in per capita expenditures ($7/person) for <u>public</u> health, or 0.8% of the state health budget allocated to public health. Georgia spends 15% of its state budget on health care expenditures. Georgia Medicaid serves approximately 1,500,000 people with a 50% enrollment growth rate between FY 2000 and FY 2005. This is 100,000 new Medicaid enrollees per year. Medicaid expenses increased 39% between FY 2002 – FY 2005, with acuity levels of illness cited as a primary reason for increased utilization costs. Even with this increase, Georgia has below average Medicaid spending per enrollee. Medicaid expenditures for FY05 totaled $6.6 billion: $2.6 billion in state funds and $4 billion in federal funds. In FY07, there are plans for $41,191,481 reduction in state funds for Medicaid. The federal budget resolution for FY04 cuts

$481,000,000 in federal funds for Georgia over the next ten years: $82,000,000 in healthcare and $76,000,000 for basic supports for low income families. While the uninsured numbers continue to rise, and although the demand for public-funded services increases, the federal and state budgets for meeting medical and basic needs are decreasing. This places greater and greater pressure and expectation on efficient and effective planning for the use of RWCA funds.

Data Sources:

Centers for Disease Control and Prevention HIV/AIDS Surveillance Report, 1999; 11 (No. 2).

Epidemiologic Profile – HIV/AIDS Prevention and Care Planning, Georgia, 2003

State of Georgia Acquired Immunodeficiency Syndrome (AIDS) Georgia Cases Living with AIDS – 4th quarter 2005 Surveillance Report, January 6, 2006.

State of Georgia Acquired Immunodeficiency Syndrome (AIDS) Georgia Surveillance Report for end of 4th quarter 2005 Surveillance Report, January 3, 2006.

State of Georgia Department of Human Resources web-based OASIS data system.

Assessment of Need, Unmet Needs and Barriers to Care

Background: Georgia employs several different mechanisms to determine service needs 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 Southeast AIDS Education and Training Center (SEATEC), district-level Title II CARE Consortia, and other CARE Act Title programs, such as the Atlanta EMA Title I Program. The process of updating the Statewide Coordinated Statement of Need (SCSN) also provides critical information regarding client needs.

SEATEC Needs Assessment Activities: SEATEC has undertaken several research projects for the Georgia Department of Human Resources, HIV Section and the Fulton County Government (Title I) and Metropolitan Atlanta HIV Health Services Planning Council. In 2002-2003, the Center for Applied Research and Evaluation Studies at the Southeast AIDS Training and Education Center (SEATEC), Department of Family and Preventive Medicine in the Emory University School of Medicine conducted an HIV Consumer Survey for the Georgia Department of Human Resources, Fulton County Government, and the Metro Atlanta HIV Health Services Planning Council. The anonymous survey collected information about the HIV care needs of people living with HIV and AIDS in Georgia, who are eligible for Ryan White services. The results of the survey have been used for HIV/AIDS care services planning, delivery, and evaluation.

Ryan White Title II Care Consortia: Georgia's Ryan White Title II Care Consortia provide additional information regarding client needs through local and regional needs assessments. Title II Consortia furnish district-specific client needs information to the state HIV Section through the annual application process for Ryan White Title II funding. In the Title II 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 Section 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 Title 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, Case Management, Oral Health, and Psychological services including Substance Abuse. 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, emergency assistance, 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 CARE Act Titles: The state also gathers additional information regarding client needs through its collaborations with other titles of the Ryan White CARE Act. Title II's work with Title III programs is facilitated by the fact that 14 of the state's public health districts are either Title III Early Intervention Services (EIS) grantees or are affiliated with an agency that is. Title II Consortia frequently utilize the comprehensive needs assessment completed as a component of the Title III EIS application process for their own planning activities and for development of their annual Title II consortium application.

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

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

Other Needs Information: Additional needs information regarding persons with HIV/AIDS is made available to the state through other research projects and service programs funded by the Centers for Disease Control and Prevention. Georgia HIV prevention programs, including HIV Counseling and Testing, gather data regarding newly diagnosed persons. The state also receives data from the CDC funded Perinatal HIV Transmission Initiative, which targets five metro Atlanta counties.

SCSN: The SCSN has guided all Ryan White CARE Act programs in Georgia in planning services to address the needs of PLWH. The March 2006 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 Title II Program and other Ryan White CARE Act programs in the state.

HIV Treatment and Prevention Needs Assessments

Statewide HIV/AIDS Community Services Assessment (CSA): In January 2004, the Georgia Department of Human Resources, Division of Public Health, HIV Section contracted with the Kennesaw AIDS Research and Evaluation Network team at Kennesaw State University and the WellStar College of Health and Human Services 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 priorization 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.

Forty-four key informant interviews have been conducted with HIV community service providers. Sixty-seven individuals participated in the key informant interviews. The public health agency HIV program in each health district and selected community-based organizations (CBOs) were contacted for interviews. Key informant recommended changes in services by geography are summarized below.

Non-EMA	EMA
Duplicated responses	**Duplicated responses**
Increased funding to hire and train staff	Volume of consumers is high – difficult to do interventions
Increase people's comfort level re: testing	Need constant dialogue about HIV
Work more with teenage girls	Training related to linkages and referrals
Expand formulary	Better communication
Rural outreach for testing with OraQuick	Money for research
Mobile van for more outreach and testing	Change public health laws to impact repeated offenders who are spreading infection
More funding for education and prevention	More training on public health laws
HIV testing at Albany State	More help with reports and data management
More testing at primary health care settings	Incentives – paying people to get tested
Programs to get sick people well and back to work (instead of on disability)_	Array of medical services
Increase prevention interventions for HIV positives	More culturally appropriate services
Nutrition services	Access to policymakers to expand teen services – more anonymous testing without parental involvement
Improve literacy rate	Transportation services
Decreased complexity of grant process	Free HIV testing
All communities need HIV prevention messages	Mobile unit for HIV and STD testing
Creative use of federal and state money	

Non-EMA	EMA
Bring informal information to area (especially faith-based)	
More specialized medical care	
More resources for services	
Title III grant	
Need more inpatient beds for substance abuse treatment	
Public official advocate for HIV testing and services to decrease stigma and denial	
Need for consumes to share information about sexual partners to get them in for testing	
Ability to access people who need testing	
More staff in satellite clinics	
More staff	
Money to pay community health department for more testing	
Designated person working each county specifically on HIV	
Increased funding for programs on improving self-image and self-esteem among people living with HIV	
Funding to develop programs to teach PLWH a skill that produces a product could be sold for income (e.g., sheltered workshop)	
Increased staff pay to keep competent qualified staff	
Need a less disjointed case management program	
Transportation services	
Dental services	
Mental health and substance abuse services	
Need media campaign	
Outreach opportunities	
Consequences for risky behaviors for HIV positive individuals	
Improve (staff not caring) mental health and substance abuse services	
HIV education in schools	
Stability of staff at state level	
Change in funding so that it is based on number of consumers served.	
HIV educational programs	
Increased lead time on grant submissions	
Standard reporting time frames for state and federal monies	
Housing/HOPWA	
Need persons dedicated to case management	
Increased funding for identifying and treating other STDs	

Non-EMA	EMA
Increased awareness – people need to open their eyes – think it will not happen to them	
Bilingual staff	
Non-duplicated responses	**Non-duplicated responses**
Seamless system – prevention to care	Peer education programs
Increased need of adherence programs	Stability at state level
Need DOT program	More space to hire another NP
Better communication between CBOs and health department	National direction to focus on problem of HIV in our communities
Social services	Need more direction from DHR
Increased financial resources and volunteers	End confusion at the local level
	Literature specific to transgender
	Access to hormone therapy (transgender)
	Listen to people
	Ryan White should not have annual renewals (3-4 years)
	Capacity building assistance
	Need more training in agency development, fiscal and general management, and leadership skills for small CBOs
	Money for public awareness
	Increased opportunities for non-traditional testing
	Better information systems
	Housing/HOPWA
	Greater access to food pantries
	Organized prevention efforts (e.g., require new STD patient to see prevention worker prior to receiving antibiotics prescription)
	More community support, prevention, primary care
	Better communication between teens and parents

A comparison of EMA and non-EMA provider and consumer areas, based on the 2004 CSA provider and consumer surveys, is provided on the following page. The provider survey was completed by 505 respondents (25% response rate); the consumer survey by 605 respondents (38% response rate).

Comparison between EMA and NEMA Provider and Consumer Areas

(Based on 2004 Provider and Consumer Surveys for the Georgia Statewide HIV/AIDS Community Services Assessment)

	Providers (N=126)		**Consumer** (N=232)					
HIV/AIDS Services in Georgia	**EMA** (45.8%)	**NEMA** (54.2%)	**EMA** (30.6%)			**NEMA** (69.4%)		
			Available	**Used**	**Needed**	**Available**	**Used**	**Needed**
Alternative Therapies	83.3***	16.7***	50***	59.3**	39.4^	50***	40.7**	60.6^
Clinical Research Trials	100***	--	46***	47.2^	34.7^	54***	52.8^	65.3^
Counseling/Peer Services	45.5*	54.5*	36.2**	41.1^	37.1^	63.8**	58.9^	62.9^
Dental Services	50^	50^	33.1^	41.2^	37.2^	66.9^	58.8^	62.8^
HIV Care	61.9***	38.1***	32.9^	35^	37.5*	67.1^	65^	62.5*
Home-Based Services	60*	40*	32.5^	24.2^	39.3^	67.5^	75.8^	60.7^
Housing	68.4***	31.6***	33.3^	34.7^	34^	66.7^	65.3^	66^
Insurance Assistance	61.5**	38.5**	31.2^	25.6^	35.1^	68.8^	74.4^	64.9^
Legal Issues Assistance	66.7**	33.3**	32.8^	33.3^	37.5^	67.2^	66.7^	62.5^
Medical Services & Physical Exams	44.1^	55.9^	33.3^	33.3^	38.9^	66.7^	66.7^	61.1^
Mental Health	73.1***	26.9***	33.8^	33.8^	40.2^	66.2^	66.3^	59.8^
Substance Abuse Services	62.9***	37.1***	34.1^	28.6^	39.6^	65.9^	71.4^	60.4^
Telephone Hotline	90.9***	9.1***	41***	32.4^	37.6^	59***	67.6^	62.4^
Transportation Services	42.9^	57.1^	30.6^	32.8^	35.9^	69.4^	67.2^	64.1^

Chi Square Statistical Significance: ***<.01, **<.05, *<.10, ^ not statistically significant.

Unmet Need Estimate

Georgia chose to use a linked database approach through a collaborative cross titles initiative between the Ryan White Title I and Title II grantees. In addition, the project was extended to address other issues not included in the original UCSF unmet need framework. Specifically, local level providers thought it would be beneficial to quantify the number of individuals receiving less than optimal levels of care (referred to as intermittent care), as distinguished from optimal care (referred to as regular care). The HRSA definition of "in care" is at least one CD4 or viral load or ARV in a 12 month period; therefore, our intermittent care plus regular care equals HRSA's "in care". Therefore, our estimate encompasses three levels of HIV primary medical care utilization:

- Unmet need is defined as no CD4 and no viral load and no ARV in 12 month period
- Intermittent care is defined as only 1 CD4 or 1 viral load or ARV therapy in 12 month period
- Regular care is defined as > 1 CD4 or > 1 viral load in 12 month period

The estimate consists of the number of individuals residing in Georgia who were HIV positive, aware of their status and had an unmet need for HIV primary medical care in calendar year 2003. The estimate was completed in August 2005. The linked database approach was the same method used by the Atlanta EMA in constructing the previous estimate based on calendar year 2001 data. The template Georgia used in estimating unmet need is provided in Appendix 3.

Population estimates – As of December 31, 2003 18,649 people were estimated to be living with HIV/non-AIDS who knew their status; an additional 16,099 people were reported to be living with AIDS in Georgia.

Estimates of people in care – For the period of January 1 – December 31, 2003, 1,642 (9%) PLWH/non-AIDS/aware were receiving intermittent care and 7,341 (39%) were receiving regular care, resulting in a total of 8,983 (48%) receiving any HIV primary care. For this same period, 432 (3%) PLWA were receiving intermittent care and 8,759 (54%) were receiving regular care, resulting in 9,191 (57%) receiving any HIV primary care.

Estimates of unmet need – For the period of January 1 –December 31, 2003, 9,666 (52%) PLWH/non-AIDS aware did not receive HIV primary medical care. During the same period, 6,908 (43%) PLWA did not receive any primary medical care.

Data sources – For population inputs, the estimates of PLWH non-AIDS were provided by the HIV/STD Epidemiology Section of the Georgia Division of Public Health based on earlier estimates constructed by the Centers for Disease Control and Prevention (CDC). Estimates were used because Georgia did not start reporting HIV until December 31, 2003. AIDS case numbers were drawn from HARS data provided by the Division of Public Health. HARS is a computer-based system that uses uniform surveillance case definition and case report forms developed by the CDC to track diagnosed and reported AIDS cases. CAREWare and HARS data were matched in an effort to identify possible underreporting and thereby needed adjustment for the population inputs. Based on this activity and conversations with the Division of Public Health,

reporting was estimated to be 85% complete. Therefore, the HARS data for AIDS were adjusted upward to address underreporting from providers.

For care inputs, three data sources were used; CAREWare, Medicaid and Veteran's Administration. CAREWare data includes data on Ryan White Title I and Title II funded services utilized by PLWH. Source files from all Title I and Title II service providers for 2003 were obtained and unduplicated by CARES. The Medicaid database is a medical claims dataset that tracks services provided to unique recipients through the federal Medicaid program administered through states. Unduplicated records were provided by the Georgia Department of Community Health, Division of Medical Assistance, DSS Analyst and Support Unit. The Veteran's Administration (VA) data contains information on services provided to HIV positive veterans throughout Georgia. The Atlanta data was provided by the VA Medical Center in Atlanta, while information for VA facilities outside of Atlanta was provided through runs done by the VA's Public Health Strategic Health Care Group. The VA dataset does not provide the intermittent versus regular HIV primary care breakdown or include information on antiretroviral (ARV) use for care provided at the VA Medical Center in Atlanta. Although the lack of ARV information may impact the HIV primary care estimates, a previous examination of the data found that most people on ARVs were also receiving labs. Given the relatively small client population of the VA, along with their high level of HIV primary care, the lack of ARV information in this dataset should have an insignificant effect on the final estimates. In order to address the privately insured population, The Healthcare Cost and Utilization Project's National Inpatient Sample (HCUP NIS) was used to adjust the care estimates for those HIV positive individuals who were receiving care in the private system. The HCUP NIS is a database that tracks hospital inpatient stays. It contains information on diagnoses, procedures, patient demographics and expected payment source. Information on disease stage is not collected; therefore the estimates refer to both HIV non-AIDS and AIDS diagnosed individuals. Data were also collected in aggregate form from one large private insurer in order to account for individuals receiving HIV medical care through private providers.

Estimation methods – As previously noted, the grantee used a linked database method in calculating the unmet need estimate. This was felt to be the most accurate and comprehensive method available as, at the time this estimate was construction, there was no one dataset believed to be comprehensive enough to provide the needed estimate, and additional data collection (chart review) was not perceived to be an optimal approach given existing resources. As the UCSF framework outlined, appropriate population estimates were identified and any needed adjustments made as discussed in the previous section. For care inputs, the methods used were intended to encompass all possible components of care - public, private and VA. Medicaid, CAREWare and VA data were all obtained for the public care system. In order to account for individuals in the private care system, a two-step adjustment was completed. First, an estimate of the number of people living with HIV disease covered by private insurance was calculated, based on the percentage of people estimated to be covered by private insurance. Second, this number was further adjusted downward based on the care patterns seen in a sample from a large private insurance source. This process resulted in the calculation of the estimates previously noted inclusive of intermittent and regular care. This approach to calculating the estimate relies heavily on data completeness and quality. Therefore, limitations inherent to these databases may impact the results. For population inputs, HARS data, the source of AIDS estimates, are based

on county of residence at the time of diagnosis, so they do not account for migration not captured by surveillance activities. Georgia contains some of the fastest growing counties in the nation, so care estimates may contain individuals diagnosed outside of the state. In addition, underreporting issues have been noted by the Georgia Division of Public Health. Attempts were made to address these biases by adjusting the AIDS numbers for 85% completeness. This was done with the approval of the Georgia Division of Public Health. In addition, the estimates for HIV non-AIDS are only accurate to the extent that the HIV estimates generated by the CDC mirror the actual prevalence in the population. The care estimates may be impacted by data collection and quality problems. They may overestimate the numbers of individuals in care to the extent that they contain duplicates across data sources. Due to confidentiality restrictions and the lack of comparable elements from which a names-based unique ID could be constructed, CAREWare and Medicaid data were unduplicated using a demographic ID, consisting of date of birth, gender, race and zip code. This ID is a conservative means of unduplicating records, as those changing zip code over the course of the year would be counted as two different individuals. Using this ID without zip code was observed to over-unduplicate records. Given these options, the more cautious approach was chosen. While the VA data were not matched to either of the other public care databases, the Atlanta VA Medical Center estimated that fewer than 5% of their clients received care outside of the VA system. Given the small numbers of HIV positive VA clients, the impact of potential duplication is believed to be minimal. In addition, some variables were not available across all data sources, which may impact HIV primary care estimates. Although these issues only minimally impact the overall estimates, it is important to be aware of the biases potentially affecting the estimates. Some CAREWare sites do not collect information on CD4 or viral load testing. CAREWare data may also underestimate use of ARVs where the use of such drugs is only recorded in the AIDS Drug Assistance Program database. Exposure category was only collected in CAREWare; therefore constructing subpopulation estimates necessitated extrapolating these data to other datasets. The exposure category subpopulation analysis is therefore only as accurate as the CAREWare data in terms of representing exposure categories. Missing race data in Medicaid may upwardly bias estimates of unmet need by race. For the private insurance adjustment, lack of participation among private care sources led to an innovative means of estimating the percent of the HIV positive population receiving HIV primary care through private care sources. Although attempts were made to increase the accuracy and rigor of the estimates as much as possible, the method used is still an indirect means of addressing this aspect of care. The estimates are only accurate to the extent that those covered by our private insurance source is representative of the actual population of PLWH in the private care system.

Assessment of unmet need: Demographics and location of persons who know their HIV Status and are not in care – Table A (below) reflects the results of our preliminary analysis related to demographics of subpopulations with an unmet need for HIV primary care. While location has not yet reviewed, the grantee plans to use location to focus Outreach activities to bring people in to care. As can be seen in the table, males have a higher unmet need for HIV primary care than females for both PLWA and PLWH non-AIDS. In addition, females of childbearing age have a higher unmet need than the general female population. Hispanics and Blacks living with AIDS have higher unmet need than Whites, while again this trend is reversed for HIV non-AIDS. By exposure category, individuals who reported a risk of heterosexual contact had the lowest unmet need regardless of AIDS or HIV non-AIDS; however, given that

these data are based on one dataset which anecdotally is believed to overreport heterosexual contact as a request, these data should be interpreted cautiously. MSM/IDU risk reported has 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 20-29 and 30-36 age groups have the highest level of unmet need for PLWA. However, given that these are smaller populations in the analysis, they are more sensitive to data quality issues and therefore should again be interpreted cautiously.

TABLE A: UNMET NEED BY SUBPOPULATION: PRELIMINARY RESULTS

CATEGORY	AIDS	HIV non-AIDS	HIV+/aware
Total			
Georgia unmet need	43%	52%	48%
Gender			
Females	39%	34%	37%
Females of childbearing age 13-44	49%	41%	45%
Males	65%	50%	63%
Race			
White	35%	59%	48%
Black	47%	51%	49%
Hispanic	54%	56%	55%
Exposure Category			
MSM	47%	65%	57%
Non White MSM	53%	65%	60%
White MSM	38%	68%	54%
IDU	56%	77%	67%
MSM/IDU	61%	78%	70%
Heterosexual contact (-4 w/unmet need)	0%	19%	10%
Age			
13-19	45%	10%	26%
20-29	68%	71%	70%
30-36	55%	68%	62%
37-44	37%	42%	39%
45+	12%	19%	16%

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.

Plans to find people not in care and get them into primary care - This data is being used initially in two ways. First, the data has been shared with the 16 Ryan White consortia 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 section will continue to work with the consortia 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 Section is using this data for planning and program evaluation at the state level by incorporating into the oversight and program monitoring process the need for outreach and retention of these HIV positive consumers not in care.

How the results of the Unmet Need Framework were used in planning and decision making - The 16 consortia will use these results in their local Needs Assessments and will develop priorities for resource allocations to address the needs of those not in care. The HIV Section is using the data in conjunction with other data acquired for the Ryan White Title II Collaborative Demonstration Project: *Improving Care for People Living with HIV Disease.* This project, described in Section 4 of this document, will help the HIV Section in developing its statewide Quality Management Plan and in addressing the issues of clients who are not receiving care. It will also be used to set statewide priorities, resource allocations and systems of care.

Statewide Coordinated Statement of Need

Introduction: 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 CARE Act Titles. Georgia developed its SCSN in 1998. In 2001, the SCSN was updated to reflect changes in the arena of HIV care for the state.

2006 Update of Georgia's SCSN: As the Ryan White Title II grantee for the state, the Georgia Department of Human Resources, Division of Public Health, STD/HIV Program convened a meeting of 151 statewide Ryan White providers, other HIV service providers, public agency representatives, and persons living with HIV/AIDS on March 3, 2006 in College Park, Georgia to update the state's SCSN. (See Appendix 1 for participant list.)

REPRESENTATIVES PARTICIPATING IN SCSN UPDATE MEETING
Title I Grantee, Planning Council representatives
Title I Funded Agencies
Title II Grantee, District Representatives, and Subcontractors
Title III EIS Grantees
Title IV Grantee, Title IV Director and Project Coordinator, Subcontractors
Part F –Dental Providers
Persons Living with HIV/AIDS
Community Based Organizations
HIV Prevention Community Planning Co-Chair
AIDS Surveillance
Housing, HOPWA Grantee
Georgia Department of Community Health
Georgia Department of Corrections
Georgia Department of Education
Georgia Department of Human Resources, Family Health Branch
Georgia Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases
Georgia Department of Medical Assistance

Individuals who could not attend the meeting were given the opportunity to provide input by completing a written "provider" survey on met needs, unmet needs, barriers, and emerging issues. Invited agencies were asked to assist with recruiting persons living with HIV/AIDS for the meeting. Each Title II agency was asked to administer consumer surveys to obtain additional consumer input into the 2006 SCSN.

Meeting participants received a meeting agenda, a copy of the state's 2001 SCSN; the HRSA HIV AIDS Bureau CARE Act Title II Manual chapter on the SCSN; a copy of *Epidemiologic Profile – HIV/AIDS Prevention and Care Planning, Georgia, 2003*, AIDS in Georgia fact sheets, and breakout group assignments. (See Appendix 2 for meeting agenda.) Stuart Brown, MD,

Director of the Division of Public Health and Jeff, Cheek, Director of the Metro Atlanta EMA Ryan White Title I Program, provided an overview of the SCSN process. Luke Shouse, MD, Director of the HIV/STD Epidemiology Section, Epidemiology Branch of the Division of Public Health presented an epidemiologic profile of HIV/AIDS in Georgia. (See page 10 for Georgia's HIV/AIDS epidemiologic profile.) Following the presentations, meeting participants were divided into six groups: administrators, healthcare providers, support services providers, a woman's consumer group, and two male consumer groups.

The administrators, healthcare providers, and support services providers groups were asked to brainstorm responses to four questions and then to rank up to their top five priorities:

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?

The three consumer groups participated in structured focus groups addressing four focus areas:

1) Service availability, utilization, access
2) Satisfaction with services/quality of services
3) Barriers
4) Unmet need

The consumer focus groups were asked to select the five most important priorities in each focus area.

See the following tables for a compilation of the comments that resulted from the provider groups and the consumer focus groups discussions. Emerging issues responses were not ranked. Some responses were grouped with others to build a more concise description of consumer needs, while other issues were condensed to facilitate a broad overview that encompassed many similar needs. 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 CARE Act programs.

SCSN Stakeholder Input Summary Tables
SCSN Meeting - March 3, 2006

What's working well	Administrators	Healthcare Providers	Support Service Providers
	Coordination of services, including Title II funded services	ADAP access, not the process	Linking newly diagnosed HIV positives to care and services
	Level of experienced providers	Availability of quality primary care	ADAP process in administration
	Access and availability to services in each health district	Availability of education for providers	Social services and case management effectively assessing consumers needs
	Effective documentation of services		Food assistance and distribution through community agencies (e.g., Project Open-Hand)
	Improved health benefits		Grady Infectious Diseases Program

Gaps/Unmet Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group #1	Men's Consumer Group #2
	Some support services including: transportation, in-home services, housing, translation/interpretive services	Oral health care services	Funding and staffing	Case management for the self-managed	Impact on budget cuts-consumers need to know	Less stringent housing eligibility criteria
	Mental health/substance abuse services including: criteria for providers, screening, developmental testing for children, staff, inpatient care for SA, Community Service Board support services	Transportation	Transportation outside Metro Atlanta	Transportation	SSI eligibility should continue with HIV diagnosis not only AIDS diagnosis	Peer counseling and consumer advocacy
	Benefits: emergency Medicaid (30 days), dual eligibility, assistance for copay/deductibles	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	Assistance with non-HIV related care
	Primary care: Lack of staff, low salaries, training, continuity of funding, access to specialty care for non-HIV conditions including oral health	ADAP process	Disparity in funding for health services	Coordinated medical services	Less stringent housing criteria	Job training-life skills

Gaps/Unmet Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group #1	Men's Consumer Group #2
	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	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.	Dental
			Housing for special populations			

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group #1	Men's Consumer Group #2
	Limited funding	Limited funding	Limited funding	Seeing a nurse instead of a doctor and shortage of doctors	Transportation – no bus, no taxi in area	Provider shortages
	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	Stigma – confidentiality – use non-identifying literature
	Fear of HIV -lack of knowledge	Limited providers for complex patients/situations	Decision makers are not front-line staff who know real issues	Hours of service	Inadequate days and hours of clinic operation	Services not available for working people
	Shortage of providers	Dental health care - limited funding, access, providers and resources	Client responsibility and accountability	Scheduling for children	Financial eligibility based on income for SSI and other entitlements	Getting medications – prescriptions or non prescriptions
	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	Transportation	No financial access to care – either for private-pay or for insurance (premiums, co-pays, deductibles).	Emergency services
	Working in silos					Medicare Part D
	Social norms					

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group #1	Men's Consumer Group #2
	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	Not enough money
	Complicated Medicare and Medicaid reforms – Medicare Part D	Reduction in services	Increasingly poor insurance coverage			Public education and awareness for the public to remove stigma
	Increase in diversity	Increased infection in young people	Reauthorization of the RW CARE Act			ADAP availability of meds
	Pharmacy law	Women and HIV infection (esp. in rural areas)	Federal funds are shrinking			Continuation of funding for Ryan White
	Conservatism	Decentralization of ADAP pharmacy services	Change in dispensing ADAP medications			Access to Social Security Benefits
	Increase in survival – elderly, perinatal	Hepatitis B and C co-infection	Increased efforts in prevention with positives			

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group #1	Men's Consumer Group #2
	Undiagnosed cases	Aging of surviving patients	Unique needs of long-term survivors and seniors			
	Increased surveillance	Aging of provider population	Needs of HIV positive children			
	Coverage for undocumented	Provider burnout	Housing for those with felonies			
	Changes in public health guidelines	Recruitment of providers	Children born HIV positive are now adults and are having babies			
	Resources/training for youth, MSM, and providers	Language barriers	Regulation of pharmacy costs, increased cost of medications			
	Cost of insurance	Changing Georgia demographics	Addressing the needs of those who are incarcerated			
	Cost of healthcare	Increase in undocumented HIV-infected persons	Shift in prevention from accountability to service prevention			
	Increase in teen pregnancy	Retention and linkages to care	The effects of faith-based initiations for prevention and care and their levels of accountability			

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group #1	Men's Consumer Group #2
	Early testing for HIV	Increase in patients and decrease in funding	Disparity in applications for funding and accountability between faith-based versus community based organizations			
	Aging population, lack of geriatric programs	Keeping emergency meds while waiting approval for ADAP	Rising Latino population / addressing needs, cultural barriers, language barriers, testing, prevention, and treatment for undocumented communities			
	Increase in prison population	Prescriptive authority for nurse practitioners	Domestic violence/sexual assault are increasing - lack of services, as well as increased confidentiality requirements (silent community)			
	Increase in drug resistance		Delayed response in AIDS/HIV data – affecting funding			
	Human resource shortage		HIV home testing			
	Cost demand of natural disasters		Impact of anonymous testing going away – anonymous versus confidential testing			
	Increase of youth infections		Continued lack of mental health/substance abuse treatment			

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group #1	Men's Consumer Group #2
	Change in federal direction		Public backlash expected because of decreased funding, accountability, testing, long-waits, etc.			
	Increase emphasis QA and performance and accountability		People outside Metro Atlanta EMA are not being served			
			Need acceptable ways to recycle meds			
			Military returning home and testing HIV positive			
			Provider and consumer education about emerging treatment and diagnostic tools			
			Rising numbers of methamphetamine users and the impact on the HIV population			
			Required testing: All pregnant women in GA – what is the assurance? Sex offenders Implications of forced testing			
			Increased focus on identifying positives – need increased resources			

<u>Input from Individuals Unable to Attend the SCSN Meeting:</u> Eleven completed "provider" surveys, answering the four questions asked of the administrator, healthcare provider, and support services providers groups at the SCSN meeting, were received from invited individuals who were unable to attend the March 3, 2006 meeting. Many of their responses, summarized below, echo those of SCSN focus group participants.

What is working well?

- Ryan White
- Public health system
- Primary medical care: exams, pap smears, immunizations and labs (one respondent noted that it does not treat overall client needs)
- Access to primary care through Title III EIS where available
- Referrals to other specialties
- Case management services
- Access to medications/medication assistance if patients medically and financially qualify. Access to ADAP.
- Mental health and substance abuse assessment and referral
- Access/referral to support services
- Offering late night/evening clinic services for those who work
- Coordination of services, outside referrals
- Collaborating with CBOs – partnerships, such as AIDS Athens and the University of Georgia
- Housing assistance, although may be eliminated
- Empowerment of patients to help plan their care
- Education
- Medicaid health care and Medicaid medical transport
- Local Ryan White medical provider
- HOPWA housing services and low-income housing
- Patient assistance programs

Gaps/needs

- Transportation
- Patients not keeping appointments or dropping out of care
- Language/translation assistance
- Affordable housing. College towns have higher rental costs, waiting lists for housing programs. "Affordable" housing is not usually "decent" and cannot pass HUD housing standards.
- Non-compliance issues
- Isolation from family or friends for support
- Losing or no financial assistance – no insurance, Medicaid or Medicare
- Need expanded access to pharmaceuticals
- HIV/STD transmission prevention
- Dual diagnosis substance abuse/mental health services
- Appointment adherence and appointment reminder systems
- Spiritual support or family support

- Funding for dental care. Many patients need expensive dental care, such as dentures
- Routine eye care
- Medication copays, especially for people working who have insurance copays with higher percentage (30, 40, 50%) for medication copays
- Lack of substance abuse and mental health treatment. Also some individuals who need these services do volunteer to access treatment.
- People not getting into care early in the disease. Get a lot of patients after they have been HIV positive for many years, but do not seek care until end up in hospital
- Limited resources for working people or those who have private insurance. Patients who are employed and have insurance policies that are 70/30, 60/40, 80/20 with deductible – since HIV meds are so expensive they can't afford their monthly costs of $500-1000 and do not qualify for ADAP meds
- More specialty clinics so transportation would not be a problem. Programs are limited in gas vouchers.
- Food programs
- Help with learning basic life skills like budgeting. Many people do not know how to get/find assistance from phone companies or have old bills.
- No incentives for MD visit and no incentives for taking meds
- Lack of education in schools concerning high-risk drug use
- Social supports

Why gaps are occurring

- Lack of dental care in more rural areas where only Title II funding is available for care
- Dentists not wanting to accept Medicaid and/or HIV patients
- ADAP not having a program to help with patients who have insurance through employer but policy covers little. Employers going with cheaper insurance plans for the employer with employees having to pay more of the costs
- ADAP pays premiums but patients still have exorbitant medical expenses monthly
- Many patients live in homeless shelters or do not have phones. Keeping up with appointments is the last thing on their minds.
- Living outside the area or county where clinics are located. People are without transportation but do not want to disclose to family or friends why need a ride to clinic. Lack of transportation in rural areas. Patients may have to walk a long distance to ride the bus.
- A lot of patients have a mistrust of the medical community and will not take their meds. Others suffer from depression or continue to use drugs and forget to take their HIV medications.
- The stigma surrounding HIV/AIDS forces many to be silent and live with the disease alone. Fear of rejection is the greatest hindrance to receiving care. Many will not tell their families or friends that they are HIV positive.
- Flat funding – monies need to be spent for regular HIV health monitoring, labs, immunizations, etc.
- Funding cuts – particularly concerning ADAP. Also many patients lose their insurance but do not qualify for Medicaid.
- Medicare Part D

- Cultural barriers, particularly communication. Cultural competence of clinic staff. Also need for translators. More Hispanics and other populations that do not speak English are moving into areas that need services.
- Organizational barriers – lack of interpreters or long appointment wait times. Long wait times at county clinics reinforce a negative self-efficacy of person living with HIV/AIDS
- Health system not working properly
- Lack of far sight in public schools in teaching children at young age
- Long term early intervention education
- Financial burden of maintenance-based care, i.e., copays, deductibles
- Socioeconomic – poor education, disparities due to being poor
- People who "fall through the cracks" for programmatic support
- Geographic – rural areas without clinics
- Many times when people first go to their doctor, clinic or community center and are treated poorly (in the eyes of the patient), then they will choose not to return
- Lack of knowledge about the disease process and need for early intervention (care)
- High risk individuals who do not receive HIV testing
- Too strict Medicaid qualification guidelines
- Disclosure issues with bisexual men (down low)
- Need to expand rapid HIV testing in ERs, community health clinics, STD clinics with timely referrals for care
- Patients lose their insurance, Medicare, or Medicaid
- Substance abuse/Meth epidemic/ other substance abuse and mental health issues. Many still using drugs with multiple sex partners.
- Antiquated medical records systems, database issues, transient patient population
- Patients get incarcerated, move, or just decide they do not want to take their HIV meds or drop out of care
- Poor coping skills. Life style that is not organized. Not enough social services to help teach basic life skills.
- Religious beliefs – if they pray, the disease will go away
- Denial and/or fear
- Lack of resources
- Criminal and credit issues keep people from utilities and apartments
- Limitations to existing programs – for example HOPWA does not reimburse late fees for utilities. CBO must rely on line of credit for all of the reimbursable grants. Shelter care program documentation local authorities do not want to acknowledge homeless issue.
- Long appeal process for Social Security
- Food Stamps low for single people needing food to take HIV meds and their stamps decrease with our assistance
- When help people too much they can take it for granted. Important to empower them to manage their own needs.

Future issues and emergent needs

- Continuing rise in the number of HIV infected individuals needing care and flat funding with Title II monies.

- Inability to retain trained staff who are state of Georgia employees and Georgia's inability to compete with private sector pay, especially for nurses
- Cuts in federal funding, i.e., cuts to the 2007 federal budget for the U.S. Department of Health and Human Resources Services Administration. Will impact access to medical care. As demand grows, services will be limited due to decreased funding.
- Cuts to Medicaid program may place many families in need to do without. However, the Ryan White AIDS program should still receive funds
- Increasing costs of medications and other health care costs
- Medicaid Part D plan – issues with medication copays
- Patients who fall into large deductibles and copays with Medicare Part D plans because they work and their income puts them into a gap in the plan
- Costs of insurance premiums and copays so high that patients decide not to take their medications
- Dwindling federal support for Ryan White clinics
- The continued use of "OraQuick" HIV tests and community outreach programs will enable people to be diagnosed sooner and hopefully start care sooner. Rapid testing will increase the number of people who counseled and tested and get into care if positive
- Need to eliminate health disparities for all racial groups, particularly with regard to language barriers.
- Need to make HIV testing an "opt out" choice for all patients seen in STD, women's health, and adult clinics. Hopefully this would increase HIV testing rates.
- Access to pharmaceuticals for long-term maintenance
- Prevention for Positives message – is it "stemming the tide" of the epidemic in the South?
- Promise of vaccines
- Teaching basic life skills
- Sexual promiscuity on the rise

SCSN Consumer Focus Groups and Survey Results

Consumer Focus Groups

Twenty-six consumers participated in the three focus groups during the SCSN Meeting on March 3, 2006. Each consumer completed a SCSN consumer demographic profile and informed consent form prior to participating in a focus group. While the number of respondents was not large, the focus groups did provide insights about individuals receiving care as well as needs and barriers.

Demographic profile data

- Eighteen (69.2%) of the respondents were male and eight (31.8%) were female.
- Three (11.5%) of the respondents were 25-34 years of age, eight (30.8%) 35-44 years old, 13 (50%) 45-54 years old, and 2 (7.7%) were 55 or older.
- Eleven (42.3%) were Black or African American, 10 (38.5%) White, and one (3.8%) multi-race. Race was unknown for 4 (15.4%) of the survey respondents.
- Sixteen (61.5%) were not Hispanic/Latino, three (11.5%) were Hispanic/Latino, and the ethnicity of seven (27%) respondents was known. Ninety-two (24) percent speak English and eight percent (2) Spanish.

- The majority (20 or 76.9%) of the consumers rent or own their home, three (11.6%) live with family, two stay with friends, and one lives in a shelter.
- Seventeen (65.4%) of respondents are gay/lesbian, eight (30.7%) are heterosexual, and one (3.9%) is questioning.
- Twenty-five of the respondents had completed at least an 8th grade education, with five (19.2%) reporting some high school, seven (27%) are high school graduates/GED, one (3.8%) has vocational certification, one (3.8%) has an associates degree, and six (23%) have graduated from college. Information was missing for one respondent.
- Three (11.6%) are employed full time, four (15.4%) are employed part time, 11 (42.3%) are unemployed, one volunteers (3.8%), six (23.1%) checked "other", and data was missing for one consumer.
- Three (11.6%) consumers are Medicaid recipients, seven are Medicare (27%) recipients, seven have Medicaid and Medicare (27%), six (23%) have no health insurance coverage, one (3.8%) has private insurance, one (3.8%) has HMO coverage, and one (32.8%) has Medicare and private insurance.
- All of the respondents had had their HIV diagnosis at least 12 months. Six (23%) were diagnosed between one and four years ago, 11 (42.3%) between five and nine years, and nine (34.7%) were diagnosed ten years ago or more.
- Six (23%) reported very good health, 13 (50%) good health, five (19.3) fair, and 2 (7.7%) poor.
- All but one (3.8%) consumer is on a combination or ARV drugs. Two (7.7%) pay for medications through private insurance, eight (30.8%) have Medicaid, 11 (42.3%) receive ADAP assistance, one (3.8%) has Medicare Part D, and four (15.4%) use "other" means.
- With regard to last CD4 count, four (15.4%) have a count of less than 200, nine (34.6) have counts of 200-350, 11 (42.3%) have counts over 350 and two (7.7%) did not know their count. The majority of respondents (20 or 76.9%) had their last CD4 count within the last three months.
- One hundred percent of respondents had had a viral load test; 19 (73.1%) of the 26 had their last test within the last three months and two (7.7%) had the test in the last three to six months. The information was missing for five respondents.
- Eighteen (69.2%) received services funded by Ryan White, one (3.8%) did not, and seven (27%) were not sure or did not respond to the question.
- None of the female respondents were currently pregnant. Twelve (46.2%) have children. Of these, two (7.7%) have children who are HIV positive.

<u>**Consumer Focus Group Summary Responses**</u>

1. Service Availability, Utilization, Access

Q1.1 What are the most important HIV-related services you have used in the last year? Medical care, transportation, case management, laboratory, obtaining meds, dental, mental health, peer counseling, vision care, ADAP, housing, substance abuse counseling and treatment, nutrition/food banks, translation services, financial assistance

2. Satisfaction with Services/ Quality of Services

Q2.1 Are you satisfied with the particular services you have used?

Not satisfied with medical care because days and hours of clinic operations are inadequate – closed some days of the week. There is inadequate staffing with medical personnel at clinics. The rural areas need a voucher system for transportation. Not satisfied with case management - they need better resources for individuals who are self managed. Not satisfied with dental services because have to travel too far in the rural areas for dental care. Program needs to be developed to supplement the co-pay for private insurance. Dissatisfied with Food Bank because the food items have expired shelf life dates. Dissatisfied with emergency assistance. When trying to access emergency assistance services, the funds are not available. Dissatisfied with Mental Health services. Satisfied with medical care because agency pays for transportation to see doctor.

Satisfied with transportation in the metro areas, but they need to develop reimbursement for gas. The most important service is peer counseling - we need more of it.

Q2.2 Are there instances when you have felt particularly welcomed or uncomfortable? Yes, I have felt welcomed with nursing care. Nurses are well-trained and do their job well. Yes, peer counseling helps newly diagnosed persons work through issues and begin accessing services. I felt unwelcome by some medical personnel. They had a negative attitude - lack of compassion and lack of professionalism.

Q2.3 If there was one thing you could change about services for people living with HIV, or one recommendation you could make to providers or those serving women and children – what would it be? Need more paid, peer counseling positions and have them filled by consumers. Person on staff to sit with patient to fill out all forms from all programs and services, so patients don't have to run all over the place to find forms from DFACS, from SS, from everywhere—i.e. need a one-stop shop for all paperwork. Otherwise, it's overwhelming and patients give up. Meanwhile, there are services available to them but they will never get them. Need more clinics in the rural areas. Train a peer counselor, staff, or community advisory board member to explain benefits and fill out paper work. Dissatisfied with staffing, need additional staff. Should have mental health a part of treatment - it is very necessary. ADAP has unreasonable requirements.

3. Barriers

Q3.1 If you were having a problem getting a service what was keeping you from that service? Transportation – no bus, no taxi in area. Not knowing – where to go, or what resources are available, hours and days of clinic operation, financial eligibility based on income for SSI and other entitlements. No financial access to care – either for private-pay or for insurance (premiums, co-pays, deductibles). Provider shortages. Stigma. Confidentiality – use non-identifying literature. Services not available for working people. Getting medications – prescriptions or non prescription.

Q3.2 While seeking services, have you experienced any problems in trying to get services for you or your children? Women not getting services at the same place as their children.

4. Unmet Need

Q4.1 What services or care do you and/or your children need, but are unable to get? Impact of budget cuts on wellness centers – patients need to know, SSI eligibility should continue with HIV diagnosis and not only AIDS diagnosis, They should put in place less stringent housing eligibility criteria's.

Q4.2 What concerns do you have about getting services or care for you or your children in the future? ADAP availability of Meds, continuation of funding for Ryan White, access to social security benefits, not enough money, public education and awareness for the public to remove stigma.

Consumer Surveys

Each Title II agency was asked to administer consumer surveys to obtain additional consumer input into the 2006 SCSN (See Appendix 5 for a copy of the survey tool). Each agency was instructed to complete a minimum of 10 surveys; and to randomly choose consumers (i.e., the first 10 consumers who come in for services regardless of what they are being seen for). A total of 157 surveys were received from 16 public health districts. Highlights from an analysis of the survey data by the HIV Epidemiology Section are provided below. It should be noted that while the data collected provide valuable insight into the needs and priorities of PLWH currently accessing care at Ryan White Title II funded agencies, survey findings are not representative of all PLWHs in Georgia. Limitations of the survey include: it only included people in care; the sample was not randomized, it was a convenience sample; not all sites participated; and we did not control by confounding variables like gender, race, and age group.

Consumer Survey Highlights

- The majority of the participants were male, in the age group of 36-45, black non-Hispanics, have a low educational level (high school or lower), and either rent or own a house or apartment.
- Forty percent do not have health insurance; 23% have either Medicaid or Medicare.
- Thirty-eight percent and 54% of the participants indicated not knowing their CD4 count and viral load, respectively.
- Most of the participants were aware of their HIV infection for more than 5 years (59%), compared to only 10% who found out they were HIV positive in the last 12 months.
- Of the clients interviewed, 25% were diagnosed with AIDS at their initial HIV diagnosis.
- Fifty-three percent received HIV-related medical care immediately after being diagnosed with the infection.
- Thirty of 157 indicated having an HIV positive household member.
- The majority of the participants are using primary medical care, receiving antiretroviral medication, dental care, support services and counseling, case management, do not use mental health counseling or therapy, and do not use drug or alcohol counseling or treatment.
- Most of the clients think the quality of care they are receiving is affected by their income and HIV status.

- Eighty-nine percent have received information about HIV/AIDS support services and counseling.
- In response a question about what providers should do to serve consumers better, the top three responses were: 1) more experienced and knowledgeable providers, 2) know what HIV services are available, and 3) provide more convenient services.
- The majority of respondents had been given information about HIV/AIDS support services and counseling (89.2%), how to protect others from HIV (92.9%), and how to protect yourself from STDs (93.6%). Forty-five percent had received information on how not to pass HIV baby when pregnant.
- Approximately 83% currently use primary medical care, 79.6% use antiretroviral medications, 63% use other medications, 54.7% dental care, and 55.4% support services/counseling.
- The top four responses with regard to what is working best about HIV/AIDS services were: 1) medical services, 2) accessibility/convenience (e.g., location, appointment times, language), 3) emotional/logistical support (e.g., housing, support groups), and 4) staff responses (e.g. friendly staff, caring and compassionate staff).
- The top three problems with care were: 1) transportation (e.g., long distance), 2) financial issues (e.g., copay, paying bills), and 3) medical services (e.g., medication, appointments).
- Respondents indicated that quality of care was affected by income, HIV status, race/ethnicity, and where live.
- The top three important changes respondents suggested to improve services were: 1) increase information/educational efforts, 2) accessibility/convenience, and 3) increase in financial support.

Development of Strategy Area Action Steps

Prior to the development of strategy area action steps, Melanie Sovine, PhD, meeting facilitator, provided a summary of the priorities identified during the morning session to the SCSN meeting participant. Identified issues were organized into the four broad categories listed below.

1) **Services missing or underdeveloped**
   - Oral health
   - Transportation
   - Mental health/Substance abuse
   - Emergency services
   - Housing
   - Interpreting Services
   - Prevention
   - Non-HIV care
   - Notions of wellness

2) **Patient care issues**
   - Retention
   - Tracking in system of care in reference to health outcomes
   - Distribution of medications
   - Services system that is adjusted for self-managed clients
   - Sense of community or interrelatedness for HIV positive persons
   - Peer counseling/consumer advocacy
   - Job training, life training

3) **Provider issues**
   - Lack of numbers of providers
   - Qualifications, education and training
   - Need to increase interpersonal skills and cultural

4) **Why the issues/gaps are occurring?**
   - Funding
   - Complex medical and social needs (providers not prepared to address full complexity)
   - Compensation and benefits for providers
   - Legislations, laws, and polices (don't understand state polices)
   - Payer systems for clients – not coming together neatly
   - Fear, stigma, discrimination

Utilizing Dr. Sovine's summary and the met and unmet needs, barriers, and emerging issues identified by the six 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 two HRSA strategy areas.

HRSA Strategy Area	Assigned Groups
Strategy I: Improve Access to Health Care	North Georgia, Metro Atlanta Group 1, and Middle Georgia
Strategy II: Improve Health Outcomes	North Georgia and Metro Atlanta Group 1
Strategy III: Improve the Quality of Health Care	Metro Atlanta Group 2 and South Georgia
Strategy IV: Eliminate Health Disparities	Metro Atlanta Group 2, Middle Georgia, and South Georgia

The five geographic groups developed broad action statements for their assigned HRSA strategy areas. These action statements, listed below, guided the development of Georgia's Comprehensive HIV Services Plan on page 67. 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.

Strategy I: Improve Access to Health Care Action Steps

A. Oral Health
- Offer/provide continue education to oral healthcare providers
- Develop relationships with dental schools, oral hygiene programs with education and incentives
- Initiate task force at state level to develop strategies to address HIV and oral healthcare needs (i.e., Dr. Reznik and Medical College of Georgia)
- Develop strategies to integrate oral healthcare education in clinic settings

B. Transportation
- Ryan White clinic establish satellite clinics for patients in need of transportation
- Establish buddy system for traveling to appointments
- Better coordination with local systems of transportation
- Negotiate an alliance between Department of Community Health and Ryan White program on state level
- Boost funding and Medicaid services

C. Substance Abuse/Mental Health
- Coordination of care among different agencies/colleges
- Investigate renewing relationship between Public Health and Mental Health/Substance Abuse (i.e. relationship of Family Planning
- Request for Grady and Department provide training for Ryan White Staff for completing Mental Health/Substance Abuse screening (CM and Nurses)
- Local support of services (consult)
- Research SAMSA Grants (Public Health taking the lead)
- More training for staff re: active substance abuse and HAART

D. Access to care—Communication
- 800-toll free service
- Public relations
- Responsiveness of providers social and clinical
- Public health linkages with other service providers
- Cultural competence

E. Medications
- Co-pay
- Medicare Part D
- Mail order pharmacy
- Legal and legislative issues
- Redistribution/recycle

F. Convenience for consumers:
- Extra hours
- After hours
- Walk-in
- Urgent care
- Child care
- Waiting time Title IV
- Volunteers (students, peers) to promote positive image
- Stable housing
  - Affordability
  - Lack of
  - Legal issues in regards to public housing
- Statewide blog or Internet access for providers and consumers
- Statewide collaboration cross titles

G. Other
- Utilize peer counselors to help patients gain access to care (fill out forms: SA/FS/MOA)
- Offer and provide training for peer counselors
- Develop a patient orientation class (must be documented if they can not attend)
- Have peer counselors work with Ryan White Case Managers (CM)
- Establish state level Consumer Advisory Board that provides training and assistance to peer counselors
- Obtain input from HIV clinical staff and programs in a non-monetary reward
- Provide awareness to Ryan White programs re: incentives for medical providers who serve medically underserved areas
- Streamline the hiring process within DHR
- Collaborate with nursing schools to provide nursing student rotations in HIV clinics (A+ District level)
  - Develop education program for consumers that provide information on how to maximize income for healthcare and how to work and still protect safety net
- Create geographically dispersed services-suburbs
  - Satellite centers
  - Partner with other "non-HIV" providers, e.g., other clinics and faith-based providers
  - Tele-medicine
- Support patient navigator-targeted case management

- Allow local ADAP distribution
- Strengthen relationships among providers
    - Shared funding
    - Shared overhead
- MOAs reduce HIPPA

Strategy II: Improve Health Outcomes Action Steps

A. Retaining Patients in Care
- Contract with patients (i.e. ground rules and written notification) - ground rules and guidelines of expectation of patients and the staff

B. Oral Health
- Meet need for state leadership. Look beyond children and prevention - need adult services in public health
- Recruit providers
- Develop continuing education credits for training
- Coordinate with Medical College of Georgia for part F funding -- Establish clinical rotation
- Increase in money
- Utilize other funding sources, e.g. SPMS
- Partnership for transportation funders should require "after hours" and weekends (late services for those who work during day)
- Buy in to reporting date ➔ increase funding
- Use MMP data as basis for development of statewide resource inventory -- Web accessibility
- Availability of rapid testing and increase counseling and testing

C. Improve Health Outcomes
- Patient tracking and follow up
    - Reengage in care
    - Reeducate clients
- Collect data and demonstrate empirically how services (including support services) improve health status
- Common understanding of level of care partnership between consumers and medical providers group
- Annual meetings to share best practices, providers, and consumers
- Standardized expectations for care
    - Standard indicators
- Greater public awareness of programs - ensure marketing with non HIV partners to get folks in care earlier as a way to improve health
- Standards for all services
    - Performance measures-coordinate statewide quality access to quality services throughout the state
- Improve cultural competence of providers (as well as on going training in current topics, issues, and practices)
    - Web-based training as well
- Ensure care provider understand the full needs of consumers-beyond medical issues

Strategy III: Improve the Quality of Health Care Action Steps

- Facilitate training for staff – funding and creative training (media/Internet)
- Data collection tools and methodologies for measuring indicators
- Collaborate and use standardized indicators for care (health) education, service delivery standards for providers
- Cross training across specialties
- Realistic implementation plan
- Funding for monitoring/evaluation
- Computerized consumer base
- Strategies for retention of self managed consumers
- Cultural diversity training to address internalized stigma and adapt to respect cultural issues
- Increase peer outreach and support services for retention in care
- Ongoing consumer input

Strategy IV: Eliminating Health Disparities Action Steps

- Target identified special populations (i.e. hearing impaired and trans gendered and immigrants)
- Engage consumers on personal level as part of service delivery model
- Educate clients on how your system works
- Innovative ways to deliver care in community setting
- Visiting service providers
- Customer driven care(accurate information verbal and written)
- Interpretation services money for medical, inter. Skill building, ethical considerations
- Flexible health care delivery system hours
- Employee pool-voluntary
- Consumer input-on going
- Advocacy
- Special needs
- System encourages and enables resources to get resources and health
- Money for supportive services
- Prevention/Education Outreach to public
- SAIMH
- Bilingual staff
- Cultural competence
- Dispelling stigma, myths
- Lack of resources in rural areas
- Shelters
- Benefits and compensation for providers
- Lack of funding
- Teen outreach
- Statewide collaboration across titles and services
- Undocumented residents
- Sharing of best practices between health districts

- Petition DOT for funding ($$)
- Medicaid transport for HIV consumers
- Provide gas vouchers
- Resource inventory (jobs, training, and education)
- Life skills/budgeting peer counselors/support groups
- Medical Access
    - Web-based ADAP application
    - Assist with co-pays and deductibles
    - Medicare D assistance
    - Availability of meds at wellness centers
    - Patient assistance programs
- Address poverty/crime
- Substance abuse treatment
- Empower consumers to become active partners in their healthcare

Gaps in Care

Georgia's HIV/AIDS needs assessment and planning efforts, including the findings of the March 2006 SCSN (see page 26), have identified a number of common barriers to care themes. Ryan White CARE Act Programs, by definition, serve clients with low socioeconomic status. Georgia continues to provide services to PLWH whose annual income is below 300% of the Federal Poverty Level. Annual Administrative Report (AAR) and Comprehensive AIDS Data Report (CADR) 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 PLWH's 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 PLWH who need mental health and/or substance abuse treatment.

PLWH 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 PLWH 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. PLWHs may also need 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 PLWH 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.

Description of the Current Continuum of Care

What Georgia is doing to stop the spread of HIV?

The Georgia Division of Public Health (DPH) coordinates a wide range of HIV/AIDS prevention programs that educate people about the consequences of high-risk behavior and teach them how to protect themselves. The HIV Surveillance staff in DPH's Epidemiology Branch monitors trends in reported AIDS cases in Georgia to help guide prevention and care efforts to reflect the trends in Georgia. In December 2003, the state began identifying HIV reporting by name.

Key DPH prevention activities include:

- Providing HIV antibody tests at over 400 sites, including all of Georgia's 159 county health departments. These sites offer HIV counseling and testing, both names reporting and anonymously (no identification is collected).
- Conducting the community planning process to guide its HIV prevention funding and activities. The Statewide HIV Community Planning Group identifies unmet needs, sets priorities and facilitates collaborations between public health programs and citizens.
- Administering grants from the Centers for Disease Control (CDC) and giving technical assistance to community-based organizations (CBOs) and county health departments, which conduct education and prevention programs in communities throughout the state.
- Providing HIV/AIDS prevention education in several different languages, including English and Spanish, to communities, CBOs, and educators throughout the state.
- Providing HIV prevention messages and abstinence education to teens in schools, youth presentations at work sites, and conferences throughout Georgia.
- Funding AID Atlanta, a CBO, to operate the Georgia AIDS and STD Information Line (1-800-551-2728) seven days a week to answer questions about prevention and treatment of AIDS.

HIV Early Intervention Services (EIS), an Office of Addictive Diseases program of the Department of Human Resources' Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD), provides early intervention services for HIV on-site at publicly funded substance abuse treatment centers throughout the state. HIV EIS counselors offer HIV pre-test counseling including risk assessment, free HIV testing, and HIV post-test counseling, during which consumers learn the results of their test. Those who test positive for HIV – whether newly or previously diagnosed – are referred for medical and social services. Consumers are linked to Ryan White clinics, local public health facilities, and community based organizations. Consumers who test positive for other sexually transmitted diseases (STDs) are referred to the local health department for treatment.

In addition to providing counseling and testing, HIV EIS staff lead educational groups for consumers, conduct training for staff, and provide outreach to their communities. Counselors work with students, detainees, inmates, migrant workers, and sex workers. They participate in health fairs, serve on local committees and coalitions, and make presentations at schools, churches, and a variety of community meetings.

What is being done to treat Georgians with HIV – available services, service areas, and providers

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 PLWH. As resources vary in different regions of the state, so do the scope of 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.

Ryan White Title II: The State of Georgia through the Department of Human Resources, Division of Public Health, Prevention Services Branch, HIV Section provides oversight and management of the Ryan White Title II grant. The HIV Section includes HIV Prevention Services funded through the Centers for Disease Control and Prevention (CDC) and the HIV Care Services funded through Ryan White Title II. The organizational structure of the HIV Section allows HIV Care and HIV Prevention to provide a comprehensive approach to all aspects of HIV/AIDS prevention and care in Georgia. This structure has not changed from the previous years.

The HIV Section has incorporated the six (6) Health Resources and Services Administration (HRSA) essential core services: 1) Primary Medical Care consistent with Public Health Service (PHS) Treatment Guidelines; 2) HIV Related Medications; 3) Mental Health Treatment; 4) Substance Abuse Treatment; 5) Oral Health; and 6) Case Management into all Ryan White Title II funded activities. To provide these essential core services the HIV Section uses the allowed Ryan White Title II program components and continues to oversee and monitor all areas. The eligibility criteria for clients to receive Ryan White Title II services is income below 300% of FPL, Georgia resident, HIV positive or affected, and no other payor source.

Georgia's HIV Care Consortia: Two of Georgia's boards of health, Chatham and Glynn, combined in July 2005 to form one single board of health. During FY 2005, the two Ryan White Consortia in this area combined into one Consortium. The HIV Section currently has 16 Consortia within Georgia funded by the HIV Section. The Consortia are responsible for developing, enhancing and strengthening a comprehensive plan to address the continuum of high quality, community-based care needs of low-income people living with HIV within their geographic area. The Consortia are the primary means the HIV Section has to provide services to HIV-positive Georgians and Consortia provide either directly or through referral all six (6) essential core services to HIV consumers. In addition, Consortia provide a number of allowable services per Ryan White Title II guidance outside of the essential core services. These supportive services are directly linked with getting consumers into care and keeping them in care.

Consortia submit yearly applications, based closely on the HRSA Title II guidance, to the HIV Section demonstrating continued ability to provide high quality services. This allows the HIV

Section to closely monitor the Consortia and provide assistance, guidance, and to develop comprehensive standards statewide.

Home and Community-Based Care: The HIV Section 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 RN 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.

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 Title I, II, and IV programs.

Health Insurance Program: The HIV Section 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 Title II funds to pay premiums and deductibles for eligible consumers to offset the cost to other Ryan White programs and services.

State Direct Services (State Pharmacy HIV Viral Load Testing): The HIV Section and the Georgia Public Health Laboratory collaborate to offer all Title II 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 Section provides direct oversight through fiscal monitoring, monthly Quality Management reports and testing updates submitted from the lab.

ADAP: The HIV Section manages the AIDS Drug Assistance Program (ADAP) to ensure low income HIV-positive Georgians have access to ADAP services. There are 23 ADAP enrollment sites, located in all 18 Public Health Districts as well as other key sites. Currently, Georgia ADAP includes 57 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.

Although the State of Georgia did not begin HIV reporting until December 2003, there is sufficient data to report HIV trends during 2005 as well as AIDS demographic trends in the state. ADAP data reveals a current ADAP enrollment of 6150 clients inclusive of 76.33% males, compared to 81% of cumulative AIDS cases; Women represent 23.50% of the current ADAP clients, compared to 19% of cumulative AIDS cases. With regards to race/ethnicity categories, African/Blacks represent 63.38% of current enrolled clients compared to 66% of cumulative AIDS cases; Whites represent 28.52% of ADAP enrollment compared to 31% of cumulative

AIDS cases; Hispanic clients represent 4.23% of ADAP enrollment compared to 3% of cumulative AIDS cases. Currently, the state of Georgia does not have a waiting list for ADAP enrollment; however, there is a capped enrollment of 45 clients for Fuzeon usage due to limited funding from the State. Program enrollment for 2005 demonstrated a 5% increase over 2004. Projections for 2006 indicate a 5% increase in ADAP enrollment for services to 6600 clients. Current utilization increased to 66% in 2005 compared to 64% utilization in 2004.

The Georgia ADAP is available to all eligible Ryan White Title I, II, III and IV clients. Eligible clients may enroll through district health clinics and approved agencies throughout the state. The Title II grantee currently receives funding from Title I and the state to provide medications for ADAP enrollees.

During the ADAP enrollment process, case managers assess applicant's eligibility through an intense screening method. The ADAP application is a structured document which captures all pertinent information needed to review all resources available to prospective clients and assess eligibility based on program criteria. The Georgia ADAP continues to monitor Medicaid eligibility by checking the Medicaid database for each new applicant prior to approval for enrollment into the program. If the Medicaid database provides information that the applicant is receiving Medicaid benefits, the individual is declared ineligible for the 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 last resort.

The HIV program is still determining the impact of the Medicare Part D program on ADAP. The HIV program is attempting to link with Medicare to determine the number of clients enrolled in ADAP who would be eligible for Medicare Part D. At this time, Georgia's ADAP does not have a mechanism in place at the state office to assess numbers of clients affected. Initial feedback from ADAP enrollment sites show that 10-20% of ADAP clients are eligible for Medicare Part D.

Minority AIDS Initiative: Georgia receives Ryan White Title II 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), HIV/AIDS primary care, and/or HIV-related support services. Georgia uses MAI funds to increase minority participation in the AIDS Drug Assistance Program (ADAP) and supportive services by providing outreach and education through our contracts with Grady Hospital Infectious Disease Program (IDP) and the Department of Corrections (DOC) pre-release program.

Ryan White Title I: There is one Title I 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 Title II funding, but Fulton and DeKalb Counties, where the largest percentage of PLWH 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.

Title I funding helps support the EMA's coordinated continuum of care available to PLWH through a comprehensive range of core services that are often on-site at primary care facilities: 1) outpatient primary care (including assessments, diagnostic testing, treatment and medications); 2) clients have access to FDA-approved medications through ADAP the local drug reimbursement program; 3) extensive preventative and restorative oral health services; 4) case management services to help clients become self sufficient; 5) individual and group mental health services and medications; and, 6) substance abuse treatment and counseling. Other essential support services which facilitate access and retention in treatment include: peer counseling, client tracking to locate those lost to care, food, transportation, home health, hospice care, and health education/risk reduction.

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. The EMA strives for cultural competency in the provision of all services.

Ryan White Title III: There are 17 Ryan White Title III EIS grantees operating in Georgia, providing services such as testing, counseling, partner notification and treatment. Twelve of the 17 Title III grantees are public health districts. Fourteen grantees work collaboratively with local Title II programs.

Ryan White Title IV: Georgia has two Title IV 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 Title IV Project. The Title IV 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 Title IV services are low-income minorities. Georgia's other Title IV program is located in Waycross and serves a rural area of the state.

Special Projects of National Significance (SPNS): The Ryan White Title I Early Care Clinic at the DeKalb County Board of Health formed the Prevention with Positives Collaborative (PWPC); a collaboration with the AIDS Research Consortium of Atlanta, to address the complexities of providing prevention messages in the clinical setting to HIV positive individuals. Based on the collective strengths of the partners, the PWPC believes that it can provide a unique

model for prevention strategies in the clinical setting. The Title I Early Care Clinic is the site of the PWPC's demonstration project. With the clinic's patient population of 917 (74% African-American) the target for the interventions will be the urban African American population.

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.

Dental Reimbursement Programs: Emory University's Dental School receives funding under the Dental Reimbursement Program. The Title I Planning Council representative for this category is also Director for Oral Health Services for SEATEC, and Director of Oral Health Services for Grady Health System. Services are coordinated and clients are referred to Emory University Oral Health Clinic at Grady Memorial Hospital for oral health surgery that cannot be provided in the EMA's oral health programs. The Medical College of Georgia's Dental Program in Augusta also participates in the Dental Reimbursement Program.

Other State and Federal Resources

Medicaid: The Department of Community Health, Division of Medical Assistance, which administers Medicaid, is the largest payer for the majority of services for the care of HIV disease, particularly for inpatient care. FY05 expenditures of $48,744,262 are 11% less than the FY04 expenditures of $54,898,596.

State Children's Health Insurance Program: Enrollment in PeachCare (Georgia's SCHIP) is available by referral or on-site at primary care sites throughout the state. The majority of infants, children and youth (l8 and under) in the Atlanta EMA receive services at the Grady Pediatric IDP. Families are assigned a social worker who assists with the enrollment process.

Veterans Affairs (VA): Clients eligible for VA services typically receive primary care in the VA clinic, but may, instead choose to access Ryan White funded services. Title I funds on-site case management services for HIV patients at the VA.

HOPWA: The Housing Opportunities for Persons with AIDS (HOPWA) program is the federally funded HUD program that primarily provides housing assistance (emergency, shelter, transitional and/or permanent) for lower-income persons with HIV/AIDS. In Georgia, HUD provides formula funds to three government entities: the Atlanta HOPWA Program, Augusta-Richmond County Program, and the Balance of the State HOPWA Program. The largest recipient in Georgia is the City of Atlanta. Atlanta receives a formula share for the Atlanta "Metropolitan Statistical Area" (MSA) and makes numerous sub-grants within twenty-eight (28) counties for housing and related services. In the Atlanta MSA, Living Room performs intake and assessment, and assists people living with HIV/AIDS and their families or partners to access housing and service programs. Augusta-Richmond County receives a formula share for four Augusta MSA counties. The State of Georgia, through the Department of Community Affairs

(DCA), received $1.5 million in 2005 to provide HOPWA funding for the balance of the state (127 counties). DCA currently funds nine (9) regional programs located in Atlanta (covers North Georgia), Athens, Statesboro, Macon, Brunswick, Jesup, Columbus, Valdosta, and Savannah.

CDC Prevention: In Georgia, the Department of Human Resources is the recipient of the majority of funding through the CDC Prevention Program. A representative for the program participates in the Title I, II, and IV planning meetings. Four Title I funded agencies receive a total of $411,182 in Prevention with Positives funding. Activities include: linkage to care, evidence based intervention in clinical and group settings, and case finding. These activities facilitate coordination and promote access to primary care.

Services for Women and Children: To facilitate access to other programs, eligible women may enroll in the WIC Program at their primary care site.

Other State and Local Social Service Programs: Georgia Division of Family and Children Services (DFCS) programs, including foster care, may be accessed on-site at four of the Title I primary care sites for enrollment in general assistance and food stamp programs. DFCS programs throughout Georgia are often co-located with public health clinics.

Substance Abuse and Mental Health Treatment Services: The core of substance abuse and mental health treatment services in Georgia are funded through the Georgia Division of Mental Health, Developmental Disabilities and Addictive Disease (MHDDAD). Georgia has a set-aside for services to PLWH in substance abuse treatment funding from the Substance Abuse Mental Health Services Administration (SAMHSA) for HIV/AIDS services through MHDDAD. The required 5% set-aside for HIV for FY 2006 is $2,542,879. The State is divided into five Regional Boards and 27 Community Service Boards (CSBs). MHDDAD allocates set-aside funding to provide HIV counseling, testing and HE/RR programs in substance abuse treatment centers. Persons who test positive for HIV are referred for care and treatment to public and private primary care providers within the continuum of care. Substance abuse treatment services funded by SAMHSA block grant funds are prioritized by the various community service boards and availability of services may differ among counties. Ryan White funded outpatient and residential substance abuse treatment programs expand the capacity to address the increasing demand and facilitate access to care and treatment for the dually diagnosed.

Resource Inventory

A resource inventory describing HIV/AIDS care resources and services in Georgia is provided in Appendix 4. 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, 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,* Title I, II, III, and IV 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 2004 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.

There are limitations associated with the resource inventory information. For example, some of the returned surveys were not fully completed. Variations also occurred in how providers defined "number of people served."

Ryan White CARE Act Funded Provider Profile by Service Category

The Georgia Department of Human Resources' IV Section allocates funds to the six core services; Primary Medical Care, HIV Related Medications, Mental Health, Substance Abuse Treatment, Oral Health and Case Management, through the HIV Consortia, Home and Community-Based Care, State Direct Services, and ADAP. The yearly guidance to the consortia includes language from HRSA concerning how funds locally should be allocated to the six core service areas. Yearly budgets from the consortia are submitted and approved by the HIV section to ensure funds are being allocated in these areas. The HIV Section allocates funds to the six core service areas in all state direct services and contracts with Title II funds and state match funds. The funding levels for the coming fiscal year will tentatively be at the following levels:

Primary Care	$4,525,239
HIV Medications	$41,137,719
Oral Health	$106,683
Case Management	$1,245,121
Mental Heath	$0
Substance Abuse	$0

The HIV Section does not at this time have funds allocated to substance abuse treatment due to consortia currently not requesting assistance with this service. While substance abuse is a need identified by consortia there are local resources through Georgia's Division of Mental Health, Developmental Disabilities and Addictive Diseases. The HIV Section will allocate funds in the coming fiscal year if consortia request funding for this core service.

The HIV Section ensures that resource allocations for services to women, infants, children, and youth (WICY) are in proportion across the state by including this requirement in all contracts and grant-in-aid for services. Consortia are required to report how they allocate funds for these populations and the HIV section reviews these allocations to ensure compliance. Contracts and other state office services have this requirement included and are monitored by the HIV section.

The Minority AIDS Initiative (MAI) goal is to provide education and outreach in order to increase minority participation in the AIDS Drug Assistance Program (ADAP), HIV/AIDS primary care, and/or HIV-related support services. Georgia will use MAI funds to increase minority participation in the AIDS Drug Assistance Program (ADAP) and HIV/ AIDS Primary Care statewide by investing these funds in ADAP to directly purchase HIV treatment medications. Currently Georgia's ADAP has 6,150 patients enrolled in the program and 67.6% of patients are considered a minority population.

Georgia allocates funds and provides services that support the overall goals and objectives of the Healthy People 2010 initiative by improving the health status of Georgian who are HIV positive. The HIV Section supports the 17 goals outlined in chapter 13 (HIV) of the Healthy People 2010 initiative through the allowable components of the Ryan White Title II program. Through these components the HIV Section addresses directly or through partnerships all the goals and objectives outlined for HIV in Healthy People 2010.

Areas of Concern/Challenges

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 core and support services that will improve the overall health of HIV positive individuals. In addition to the unmet needs and barriers for PLWH, described on page 50, challenges include the following:

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. The traditional role of Public Health in providing Medicaid reimbursable services and outreach is shifting with the state's move to a Medicaid managed care model. Beginning in June 2006, the state will move 1 million people covered by Georgia's Medicaid insurance program for the poor and disabled into three commercial managed care organizations. This shift is requiring a re-examination of Public Health's role and structure in the new health care environment.

Georgia's Medicaid managed care reform and new cost sharing proposals may affect Medicaid recipients living with HIV/AIDS. These proposals include reducing coverage of medically necessary health care services, higher levels of cost sharing for HIV/AIDS medications and inpatient care, new and possibly expensive proof of citizenship for native-born Americans, and denial of care for inability to pay cost sharing.

The full impact of Medicare's new prescription drug benefit (Part D) on Medicare and Medicaid/Medicare recipients, including PLWH, is unknown. Some individuals have experienced problems in enrolling in a Medicare drug plan and/or obtaining coverage for needed medications. It is important that PLWH 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. Many clients may experience a significant increase in out of pocket costs after enrollment. Changes in and difficulty understanding formularies are also of concern.

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. An inadequate supply of safe, affordable and adequate housing for low-income individuals is also an issue throughout Georgia, and in particular in rural regions. A decrease in HUD funding is impacting housing availability as is Section 8 increased federal and local restrictions on eligibility. HOPWA covers approximately 67,000 individuals, down from 78,464 in 2003. In addition, recent changes in Atlanta Housing Authority (AHA) regulations prohibit anyone with a felony conviction in the last 20 years from living in their facilities. Also, a number of AHA housing facilities for the

elderly and disabled are now being restricted to the elderly only. Continuing HUD funding cuts have also caused housing AHA to increase rents or percentages to be paid by occupants.

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, leaving large portions of the state without access to this care. Forty-two whole Georgia counties, and seven partial county service areas are currently designated by the federal government as primary care Health Professional Shortage areas (HPSAs) as are 84 population groups. In addition, 117 whole counties and 48 partial counties are designated as medically underserved areas. Areas with dental HPSA designation include 27 whole counties, six partial counties, and 59 population groups. Mental health HPSA designation has been received by 44 entire counties as well as 43 service catchment areas.

Public health nursing shortages are becoming critical. Lack of nursing staff have resulted in some county health department clinics having to reduce the number of clinics, number of hours, and individuals served. In October 2005, district public health nursing and clinical directors and county nurse managers who represent urban and rural areas of the state documented the continuing difficulties encountered in recruiting and retaining a quality public health nursing workforce in Georgia and the impact on the delivery of services. Findings suggest that low salaries have impeded nurses from applying for jobs in public health. Districts are not able to compete with the salary paid by hospitals, home health agencies, and hospice agencies. Those districts that are able to fill nursing vacancies have found, in many cases, that after completing 9-12 months of on-the-job training in public health, the nurses leave for higher salaried positions in the private sector.

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, collaboration between Ryan White Title Programs and other HIV resources, and evaluation become increasingly important.

Additional ongoing and emerging issues, identified by the March 2006 SCSN meeting participants, can be found in the tables beginning on page 28.

Section 2: Where do we need to go: What system of care do we want?

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 there are now 14,641 people living with 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 CARE Act programs and titles, and allocating and utilizing resources to address identified needs, especially those of traditionally underserved populations and subpopulations.

In developing a 2006-2009 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 2006-2009 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.
11. Prevention, education, and early intervention.

Section 3: How will we get there?

Introduction

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 2006 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 section 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 2006-2009 Comprehensive HIV Services Plan

Goal 1: Improve access to HIV-related core services.			
Objectives	**Strategies**	**Time Frame**	**Measure**
1.1. Ensure continuity and availability of primary care consistent with Public Health Services guidelines.	1.1.1. Identify and assure points of entry for services exist in each county. 1.1.2 Establish system to regularly disseminate current contact information on all identified access points to providers throughout state. 1.1.3. Assure transitional discharge planning for incarcerated individuals. 1.1.4. Establish standardized referral form and documentation requirements throughout the state and across Titles.	Year 1 Year 1 Years 1-2 Years 1-3	Georgia will provide primary medical care through coordinated funding sources. Proportion of HIV-infected people accessing HIV primary care.
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. 1.2.2. Identify and access alternative funding mechanisms. 1.2.3. Provide continuing education opportunities for oral health providers. 1.2.4. Develop and implement strategies to integrate oral health care education in clinic settings. 1.2.5. Develop relationships with dental schools and oral hygiene programs.	Years 1-3 Years 1-3 Years 1-3 Years 1-3 Years 1-3	Georgia will provide oral health care through coordinated funding sources. Proportion of HIV-infected consumers accessing HIV oral health.

1.3. Improve access to specialty care.	1.3.1. Establish referral relationships and service provision at the local level for sub-specialty services, e.g., gastroenterology, dermatology, neurology, etc.	Years 1-3	Percent of HIV-infected consumers referred for specialty services. Percent of HIV-infected consumers accessing specialty services.
1.4. Increases linkages and collaboration at the state and local level between the Division of Mental Health/Developmental Disabilities/Addictive Diseases (MHDDAD), the Division of Public Health, and other community providers.	1.4.1. Strengthen collaboration between Public Health and MHDDAD within the Department of Human Resources to delineate and address barriers to mental health and substance abuse services. 1.4.2. Identify and assure points of entry for mental health and substance abuse services exist in each county. 1.4.3 Establish system to regularly disseminate current contact and eligibility information on all available mental health and substance abuse access points to providers throughout state.	Years 1-3 Years 1-3 Years 1-2	Proportion of CARE Act providers and agencies that have linkages with local mental health/substance abuse providers. Proportion of HIV-infected consumers accessing mental health/substance abuse services.
1.5. Address consumer identified access/convenience issues.	1.5.1. Require clinic sites to establish written after hours/urgent care policies and share policies with consumers. 1.5.2 Develop and implement one-time consumer access/convenience survey that collects information on wait times, extended hours, childcare, after hours, etc. 1.5.3. Encourage clinic sites to provide non-traditional hours of operation and/or establish satellite	Year 1 Year 1 Years 2 -3	Proportion of clinics with after hours/urgent care policies. Proportion of HIV-infected consumers accessing after hours and satellite clinics. Proportion of HIV-infected consumer satisfied with clinic operations.

	clinic sites.		
1.6 Ensure access to care for newly identified HIV positives.	1.6.1. Improve linkages between counseling and testing and care and treatment. 1.6.2. Coordinate outreach with early intervention services and care and treatment. 1.6.3. Monitor cohort of new clients over time. 1.6.4. Encourage clinic sites to dedicate a specific time/date for new patient evaluations.	Years 1 – 2 Years 1-3 Years 1-3 Years 1-3	Percent of newly diagnosed HIV-infected consumers who are accessing care.
1.7 Require that consumers are seen by a primary care provider (physician and/or mid-level provider) every six months.	1.7.1 Monitor clinic utilization data. 1.7.2. Work with providers to develop and implement strategies to ensure consumers are accessing care on a regular basis, as defined in PHS.	Years 1-3 Years 1-3	Percentage of HIV-infected consumers seen by primary care providers every 6 months.
1.8 Ensure mechanisms to maximize utilization of Medicaid and Medicare.	1.8.1. Improve the linkages and collaboration between all Titles and Medicaid/Medicare. 1.8.2. Monitor the effects of Medicaid and Medicare reform on consumers. 1.8.3. Determine the impact of Medicare Part D and ADAP on consumers. 1.8.4. Educate consumers and providers on Medicare Part D including relationship to ADAP. 1.8.5. Determine the effects of reductions in standard Medicare and Medicaid reimbursement rates.	Years 1-3 Years 1-3 Year 1 Years 1-3 Years 1-3	Percent of HIV-infected consumers utilizing Medicaid/Medicare. Percent of HIV-infected consumers utilizing Medicare Part D.

1.9 Identify and address consumer transportation barriers.	1.9.1. Assess transportation barriers and resources by geographic areas. 1.9.2. Improve utilization of Medicaid Transportation. 1.9.3. Identify and implement possible solutions to key transportation barriers	Years 1-3 Years 1-3 Years 1-3	List transportation resources by geographical area.
1.10 Maintain consumer access to HIV-related medications (ADAP).	1.10.1 Establish work group to identify and address gaps and establish cost containment strategies. 1.10.2. Collaborate with Medical Advisory Committee to ensure newly FDA approved medications are added to the ADAP formulary. 1.10.3. Improve ADAP application process (e.g., web-based application process). 1.10.4. Develop and disseminate ADAP policies and procedures. 1.10.5. Develop online case management training to assist with accurate completion of ADAP applications.	Years 1-3 Years 1-2 Year 1-2 Year 2 Year 1 Years 2-3	Percent of HIV-infected consumers approved or denied for ADAP enrollment within two weeks of the ADAP receiving a complete application. Percent of ADAP enrollees recertified for ADAP eligibility criteria at least annually.

Goal 2: Improve the quality of health care and health outcomes.			
Objectives	**Strategies**	**Time Frame**	**Measure**
2.1. Ensure CARE Act 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. 2.1.2. Develop and monitor key performance indicators. 2.1.3. Mentor HIV inexperienced providers. 2.1.4. Notify providers of revised PHS guidelines.	Years 1-3 Years 1-3 Years 1-3 Years 1-3	Percent of providers using the core performance measures.
2.2. Establish and implement statewide case management standards.	2.2.1. Establish work group that includes representative from other Titles. 2.2.2. Develop standardized intake assessment form. 2.2.3. Develop statewide case management standards, adapted from Title I standards.	Year 1 Years 1-2 Years 1-3	Percent of Title II Case mangers using a standardized intake assessment form.
2.3. Establish and implement statewide quality management plan.	2.3.1. Establish quality management core team. 2.3.2. Finalize written statewide quality management plan and update annually. 2.3.3. Require Title II providers to write and implement local quality management plans. 2.3.4. Provide quality improvement/management training at the state and local level. 2.3.5. Assure quality improvement projects happen at the state and local	Year 1 Years 1-3 Year 2 Years 1-3 Years 1-3	Statewide QM plan will be developed and implemented. Number of trainings conducted.

	level. 2.3.6. Monitor local quality management plans and provide technical assistance as needed.	Years 2-3	
2.4. Reduce the number of newly diagnosed individuals entering into care with an AIDS diagnosis.	2.4.1. Work with HIV Epidemiology Section to establish process to collect and report data. 2.4.2. Work with HIV prevention provider agencies to develop and implement subpopulation strategies to identify HIV positive individuals and get them in care.	Year 1 Years 2-3	Percent of individuals newly reported with HIV infection that also have AIDS diagnosis.
2.5. Enhance efforts to retain consumers in care and treatment.	2.5.1. Provide consumers with treatment and care adherence education. 2.5.2. Train and utilize peer counselors to provide outreach, education, advocacy and retention services. 2.5.3. Identify and implement consumer self management and adherence approaches (e.g., consumer/provider contracts)	Years 1-3 Years 2-3 Years 2-3	Percent of individuals with either a CD4 or viral load in the last 6 months.
2.6. Improve cultural competency of service providers and programs.	2.6.1. Provide ongoing training and education on cultural competence issues (i.e., language, race/ethnicity, literacy, religion, sexual orientation, gender identity, physical challenges). 2.6.2. Involve consumer in planning and implementation of programs. 2.6.3. Provide linguistically and grade appropriate consumers materials, resources, and tools.	Years 1-3 Years 1-3 Years 1-3	Number of trainings conducted.

2.7. Improve recruitment and retention of health care providers.	2.7.1 Establish a statewide HIV specialty mentoring program. 2.7.2. Collaborate with SEATEC to provide training and onsite technical assistance. 2.7.3. Work with the statewide DHR Nursing Workforce Crisis Workgroup. 2.7.4. Explore salary disparities among job titles within the public health system and encourage movement to mid-point salary. 2.7.5. Reduce the time that staff positions are vacant.	Years 2-3 Years 1-3 Year 1 Year 1 Years 1-2	Mentoring program established. Number of days established positions remain unfilled.

Goal 3: Eliminate health disparities and barriers to care.			
Objectives	**Strategies**	**Time Frame**	**Measure**
3.1. Improve activities to eliminate disparities in underserved populations.	3.1.1. Identify PLWH subpopulations that are not in care. 3.1.2. Identify primary care needs, barriers, and gaps. 3.1.3. Assure policies and procedures are in place to assist consumers in use of services.	Years 1-3 Years 1-3 Years 1-3	Proportion of consumers in care with alignment of demographics
3.2. Reduce the number of consumers who lack stable, affordable, and safe housing.	3.2.1. Assess consumers for housing needs and eligibility for housing resources, (e.g., HOPWA, Section 8, public housing). 3.2.2. Ensure clinic sites, community-based organizations, and other providers have current housing resource information for their area. 3.2.3. Establish linkages at local level between case managers and public housing authorities.	Year 3 Year 3 Year 3	Percentage of consumers referred for housing assistance and received.
3.3. Provide interpretation and translation services for non-English speaking clients.	3.3.1. Instruct Title II providers to budget funds for interpretation services where needed. 3.3.2. Encourage bilingual staff	Year 1 Years 1-3	Percentage of consumers receiving interpretation and or translation services.

	to take medical language courses or if English is a second language to attend interpreter training.		
	3.3.3. Collaborate with DHR Limited English Proficiency and Sensory Impairment program to ensure clients have access to all interpreter services as needed.	Years 1-3	
3.4. Empower consumers to become active partners in their healthcare and improve the quality of their lives.	3.4.1. Collaborate with local agencies to provide life skills training. 3.4.2. Develop and implement a state level consumer advisory board. 3.4.3. Train and utilize peer counselors to provide outreach, education, advocacy and retention services. 3.4.4. Identify and implement consumer self management and adherence approaches (e.g., consumer/provider contracts). 3.4.5. Collaborate with Georgia Department of Labor to provide and identify vocational rehabilitation services (e.g. job training).	Year 3 Year 3 Years 2-3 Year 3 Year 3	Number and type of trainings conducted. Number of peer counselors providing outreach, education, advocacy and retention services.

3.5. Improve and enhance access to emergency financial assistance to consumers.	3.5.1. Utilize CARE Act funding to provide emergency financial assistance where applicable and feasible. 3.5.2. Collaborate with local community based agencies to assist with emergency financial services.	Years 1-3 Years 1-3	Percent of CARE Act funds allocated for assistance.

Goal 4: Enhance collaboration and communication with partners statewide.			
Objectives	**Strategies**	**Time Frame**	**Measure**
4.1. Enhance relationship with state partners to identify common goals and coordinate utilization of resources.	4.1.1. Hold statewide HIV/AIDS meeting to share information and best practices and identify collaborative opportunities. 4.1.2. Work with the Department of Community Health to facilitate data sharing. 4.1.3. Work collaboratively with the Southeast AIDS Education and Training Center (SEATEC) to improve the quality of provider and program staff education. 4.1.4. Encourage the Title II and State Prevention Representatives to actively participate in the Metro-Atlanta Title I EMA Planning Council.	Year 1 Year 1 Years 1-3 Years 1-3	Number and type of meetings held.
4.2. Improve communication, communication, cooperation, and collaboration among HIV providers and key stakeholders.	4.2.1. Facilitate meetings and conference calls/and other communication technologies. 4.2.2. Develop and sustain state work groups to address system-level issues (e.g. oral health workgroup).	Years 1-3 Years 1-3	Number and type of conference call and meetings.

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:

The HIV Section and Title II sub recipients will generate reports from the CAREWare database to monitor of consumer level utilization of core services

Title II Consortia and sub recipients will report on progress toward goals and objectives via quarterly reports.

ADAP enrollment will be evaluated through the following methods:

- ADAP applications will be monitored through the access database for accuracy and completion.
- Through CAREWare, we will be able to monitor client's progression for ADAP services.
- Administrative site visits will be conducted to monitor the validity of local ADAP programs.

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 Site Visits will be evaluated through the following methods:

- State office staff conducts administrative site visits to each HIV provider at the local level at least twice a year during the grant period. During the initial site visit, the following is monitored; Clients eligibility fro Ryan White title II, funded services and availability of other benefits; The clinics sliding fee scale policy, grievance policy, and clients' rights and responsibility; client enrollment in case management and case management notes; clinic confidentiality/security procedure, linkages to external providers; submission of reports; and fiscal accountability. If deficiencies are noted in any of the areas monitored, the HIV providers must submit corrective action plans within sixty (60) days and the liaisons makes follow-up visits to reevaluate the progress toward corrections.

Quality Management

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 FY2006-2009 Comprehensive HIV Services Plan Goals and Objectives will be monitored by the Ryan White Title II staff, in collaboration with Prevention staff and colleagues across other Ryan White Titles. 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.

Georgia is one of eight states/jurisdictions participating in the Ryan White Title II Collaborative Demonstration Project: *Improving Care for People Living with HIV Disease*. As a component of the Collaborative, the HIV Section developed and is implementing a FY 2005-2006 Quality Management (QM) Plan. Georgia's QM plan will incorporate monitoring and evaluation of the state's 2006-2009 Comprehensive HIV Services Plan's goals, objectives, and strategies as much as possible.

The QM plan will include determination of quality improvement projects and will use continuous quality improvement methodology to guide these projects. All project findings will be reviewed by the QM Core Team; and summary reports will be prepared and shared with Title II sub-recipients, HIV Section, and within the DPH. Title II sub recipients will monitor selected performance measures and report those measures to the HIV Section. The Core Team will review the measures and compile reports. The Core Team will annually assess the QM Program for effectiveness.

The HIV Section Data Team and the HIV/AIDS Surveillance Unit will assist with data collection strategies. Data sources include the following: new Access database for ADAP applications; CAREWare; HIV/AIDS Reporting System (HARS); and Vital Records. The HIV/AIDS Surveillance Unit will attempt to obtain access to Medicaid data. The CAREWare database will be utilized whenever possible to collect data for statewide performance measures.

Title II Consortia are required to fulfill the quality management components of the Title II Grant-in-Aid contracts. The FY 2006 Grant-in-Aid deliverables include the following QM language: "develop and implement a QM plan (i.e., a local QM plan); participate in Title II QM pilot (i.e., the Collaborative); and provide information related to the local QM program as requested by the HIV Section." Similar language will be in the FY 2007 contract.

Appendix 1

Statewide Coordinated Statement of Need Meeting Participants*

Francilla Allen, AID Atlanta, Inc.
Susan Alt, Coastal Health District 9-1
Rosalyn Bacon, Georgia Department of Human Resources, Prevention Branch
Forest Bankston, Georgia State University
Deborah Bauer, Atlanta Family Circle Ryan White Title IV Program
Valencia Beckley, Georgia Department of Human Resources, STD Section
Harriett Bennett, Southeast Health District
Edith Biggers, MD, Fulton County Department of Health and Wellness
Carolyn Bolton, Grady Infectious Disease Program
Sandy Boshart, Clayton County Health Department/AID Atlanta
Kandace Boyd, Fulton County Ryan White Title I Program
Stacy Bolling, NAESM, Inc.
Jeffery Brock, Georgia Department of Human Resources, HIV Section
Libby Brown, Georgia Department of Human Resources, HIV Section
Stuart Brown, MD, Georgia Department of Human Resources, Division of Public Health
Consuelo Campbell, Georgia Department of Human Resources, Family Health Branch
Deanna Campbell, Georgia Department of Human Resources, Epidemiology Branch
Rudolph Carn, NAESM, Inc.
Frank Caughman, DMD, MED Medical College of Georgia, School of Dentistry
Jeff Cheek, Fulton County Ryan White Title I Program
Mary Cowans, Grady Pediatric Infectious Disease Program
Carol Crawford, CSC Enterprise
Janie Dalton, Health District 2 (Gainesville)
Joan Davis, Georgia Department of Human Resources, HIV Section
Tiffanie Davis, Private Practice
Hawaly Dicko, Georgia Department of Human Resources, HIV Section
Robert Divito, Metro Atlanta HIV Health Services Planning Council
Kim Dobson, Georgia Department of Human Resources, HIV Section
Marie Dockery, North Georgia Health District
Rosemary Donnelly, Georgia Department of Human Resources, HIV Section
Mark Douglas, My Brothaz Home, Inc.
Melanie Durley, Georgia Department of Human Resources, HIV Section
Monique Eadon, Georgia Department of Human Resources, HIV Section
Helen Ellis, East Metro Health District
Cara Emery, AIDS Survival Project
Tori Endres, Health District 7 Clinical Services
Johnny Fambro, Central City AIDS Network, Inc.
Zoe Fludd, Georgia Department of Human Resources, HIV Section
Jeff Graham, AIDS Survival Project

Felicia Guest, SEATEC
Anthony Hall, Georgia Department of Human Resources, HIV Section
Theresa Headen, Clayton County Health Department
Karla Hendriquez, Hall County Health Department
Kimya Hodari, Grady Infectious Disease Program
Dia Hodnett, SisterLove, Inc.
Jaime Holbert, Georgia Department of Education
Amy Holcombe, North Georgia Health District 1-2
Bruce Hoopes, Georgia Department of Human Resources, Division of Mental Health, Developmental Disabilities, Addictive Diseases
Natasha Howard, Health District 4 Health Services
Eric Hudgins, The Living Bridge Center Consumer Advisory Council
Hermeyone Hunter, Morehouse Medical Associates/AID Atlanta
Deborah Ivins, Medical College of Georgia
Jeanelle Jenkins, Grady Pediatric Infectious Disease Program
Ruth John-Bonnette, Georgia Department of Human Resources, HIV Section
Anasa Johnson, Georgia Department of Human Resources, Division of Public Health, Office of Pharmacy
Rollin Johnson, South Health District 8-1
Shean Johnson, Georgia Department of Human Resources, HIV Section
Harold Katner, MD, The Hope Center
Prem Khanna, DeKalb Board of Health
Latasha King, Georgia Department of Human Resources, HIV Section
Kathleen Kinsella, Georgia Department of Human Resources, Family Health Branch
Rachel Krause, Georgia Department of Human Resources, Family Health Branch
Larry Lehman, AID Gwinnett
Jeffrey Lenox, MD, Grady Infectious Disease Program
Mary Leslie, City of Atlanta Grants Management
Pam Leslie, Hope Center
Xiomara Llaverias, Saint Joseph's Mercy Care Services
Twalla Marshall, Georgia Department of Human Resources, HIV Section
Meshell McCloud, Georgia Department of Human Resources, HIV Section
Sanda McFadden, Health District 4 Health Services
Vonda Kay McFadden, CAST
Natalyn McGhee, Georgia Department of Human Resources, HIV Section
Rick Mendiola, Georgia Department of Human Resources, HIV Section, Community Planning State Co-Chair
Nell Moton-Kapple, Georgia Department of Community Health
Arene Mutcher, CARE
Jacqueline Muther, Grady Infectious Disease Program
Autumn Neighbors, Northwest Georgia Specialty Care
Joe Norman, Georgia Department of Human Resources, HIV Section
Sheri Oliver, Georgia Department of Human Resources, HIV Section
Evelyn Ortiz, South Health District 8-1
Rhonda Page, Georgia Department of Human Resources, Family Health Branch
Bettye Patterson, Haven of Hope

Doris Pearson, Ryan White Projects
Coti Perez-Espinoza, Georgia Department of Human Resources, HIV Section
Larry Polen, Central City AIDS Network, Inc.
Ann Poole, Georgia Department of Human Resources, TB Program
Kenneth Prince, DeKalb County Board of Health
Joann Pullins, South Central Health District
Chayne Rensi, Georgia Department of Corrections
David Reznik, DDS, Grady Health Systems Infectious Disease Program
Beverly Robertson, Hall County Health Department
Angela Robinson, Clayton County Health Department
Teresa Robinson, AIDS Resource Council
Nicole Roebuck, AID Atlanta, Inc.
Lynne Rollins, Northwest Georgia Specialty Clinic
Jeffery Roman, TAKE Project
Jay Saville, Rural Health Clinic
Chanel Scott-Dixon, Health District 8-2
Jesse Sephens, Past President of CCC
Sanjay Sharma, Grady Infectious Disease Program
Luke Shouse, MD, Georgia Department of Human Resources, Epidemiology Branch
Grace Simon, Central City AIDS Network, Inc.
Ben Sloat, Georgia Department of Human Resources, Immunization Program
Jeffery Smith, Health District 4 Health Services
Melanie Sovine, PhD, Meeting facilitator
Angela Stephens, Fulton County Ryan White Clinic
Derek Stokes, Health District 5-2 Ryan White II Consortium Chair
Tomi Stultz, AID Gwinnett
Pradya Tambe, MD, Fulton County Department of Health and Wellness
Jennifer Taussig, Georgia Department of Human Resources, Epidemiology Branch
Aubrey Taylor, South Health District
Suzette Thedford, Georgia Department of Human Resources, HIV Section
Lola Thomas, AIDS Alliance of Northwest Georgia
Melanie Thompson, MD, AIDS Research Consortium of Atlanta
Katie Tilley, North Georgia Health District 1-2
Henrie Treadwell, Community Voices
Carol Vasbinder, Focus group recorder
Kathy Whyte, Fulton County Ryan White Title I Program
Sheryl Wilkerson, Southeast Health District
Harriet Williams, Grady Health System, Women's Health
Noah Williams, RHEMA Connections, District 6
Sean Williams, Grady Infectious Disease Program
Sylvia Williams, East Central Health District 6
Kizzy Wilson, Grady Pediatric Infectious Disease
Donna Wilson-Fant, AID Atlanta, Inc.
Linda Womack, Morehouse School of Medicine
Cynthia Wynn, Georgia Department of Human Resources, Section
Patricia Yancey, The Hope Center

*Consumer participants' names removed, unless representing a specific agency

Consumer, Southwest Health District
Consumer, North Georgia Health District
Consumer, North Georgia Health District
Consumer, Morehouse School of Medicine
Consumer, South Health District
Consumer, Coastal Health District
Consumer, West Central Health District
Consumer, West Central Health District
Consumer, North Health District
Consumer, North Health District
Consumer, North Health District
Consumer, Northwest Health District
Consumer, Northwest Health District
Consumer, Southeast Health District
Consumer, Health District 4 Health Services
Consumer, Southeast Health District
Consumer, Southwest Health District
Consumer, Northwest Health District
Consumer (area of state unknown)
Consumer (area of state unknown)
Consumer (area of state unknown)

Appendix 2

Georgia Statewide Coordinated Statement of Need (SCSN) Update Meeting

Friday, March 3, 2006

AGENDA

8:00 a.m.	**Breakfast/Registration**
8:45 a.m.	**Welcome/Purpose** Stuart T. Brown, M.D. Director, Division of Public Health Jeff Cheek Director, Metro Atlanta EMA Ryan White Title I Program
9:00 a.m.	**Overview of the Day** Melanie L. Sovine, Ph.D.
9:15 a.m.	**HIV/AIDS Epidemiology Profile** Luke Shouse, M.D., M.P.H. Section Chief, STD/HIV Epidemiology Section
9:30 a.m.	**BREAK**
9:45 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** Melanie L. Sovine, Ph.D.
1:20 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**

Appendix 3 – Georgia's Unmet Need Framework Table Template

Column 1	Column 2	Column 3	Column 4	Column 5
	Population Sizes	**Value**		**Data Source(s)**
Row A.	Number of persons living with AIDS (PLWA) and aware as of 12/31/03	16,099		HARS with 85% adjustment to address reporting issues
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware as of 12/31/03	18,649		Midpoint of CDC estimate
	Care Patterns	**Value**		**Data Source(s)**
Row C.	Number of PLWA who received HIV primary medical care in the previous 12 months	9,191		Medicaid, RW and VA data inclusive of adjustment for private insurance based on HCUP NIS database and private insurer data
Row D.	Number of PLWH/non-AIDS/aware who received who received HIV primary medical care in the previous 12 months	8,983		Medicaid, RW and VA data inclusive of adjustment for private insurance based on HCUP NIS database and private insurer data
	Calculated Results	**Value**	**Percent**	**Calculation**
Row E.	Number of PLWA who did not receive primary medical services	6,908	43%	Value: Value A - Value C. Percent: Value E/Value A.
Row F.	Number of PLWH/non-AIDS/aware who did not receive primary medical services	9,666	52%	Value: Value B - Value D. Percent: Value F/Value B.
Row G.	Total HIV+/aware not receiving specified primary medical care services (quantified estimate of unmet need)	16,574	48%	Value: Value E + Value F. Percent: Value G/(Value A+Value B)

NOTE: The data in "Percent" cells of Column 4 Rows E, F, and G is calculated with a formula. Once grantee fills "Value" data in Column 3 Rows A, B, C, and D, the "error" will correct itself.

Appendix 4
RESOURCE INVENTORY

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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	
AIDS Now Grasps Every Living Soul (ANGELS)	Middle Georgia				x																x			

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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 Research Consortium of Atlanta (ARCA)	Atlanta					x																		
AIDS Survival Project	Statewide			x	x	x					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				
Atlanta Urban Ministries	Atlanta																				x			

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
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												
Caring Corner	Carroll, Heard, Troup, Meriwether, Pike, Upson, Lamar, Spalding, Butts, Henry, Fayette, Coweta Co.				x		x	x		x											x	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				

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
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													
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 xrays 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																		

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
Coastal Area Support Team	Brunswick				x					x											X			
Coastal Area Support Team	Hinesville				x					x										x	X			
Cobb Board of Health	Cobb & Douglas Co. Atlanta EMA (Title I)	x				x	x	x	x	x	x	x												
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 (Title I)					x	x	x	x		x	x	x											
Diversity House Project	Macon																			x				

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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 svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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 (Title I)						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	

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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 Legal Services - Atlanta	Statewide																						x	
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 svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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 svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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 svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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				
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	

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
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											
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		

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
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											
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											

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
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												
Positive Response	Carroll, Heard, Troup, Meriwether, Pike, Upson, Lamar, Spalding, Butts, Henry, Fayette, Coweta Co.				x		x			x	x										x	x		
PrimeCare of Augusta	Central Georgia				x	x					x			x										
Project AZUKA	Savannah		x			x															x			
Project DUNBAAR	Atlanta				x																			

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
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													
Ropheka Rock of the World, Inc.	Atlanta		x																					
Rural HIV Clinic	Albany						x																	

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
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						
St. Jude's Recovery Center	Atlanta												x											
St. Mark United Methodist Church	Atlanta										x													

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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. 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		
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																			

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
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										
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																	

Provider	Service Area	Early intervention svcs.	Outreach/case finding	Peer education/co.	Health ed/risk reduc.	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
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																			
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 5

Consumer Survey 2006

Introduction

Welcome and thank you for talking with me today. My name is _________ and I would like to speak to you about improving services for people living with HIV/AIDS and their families in Georgia. This will only take a few minutes. All information we collect here today is confidential. We will not identify any of the participants. Confidential means we will not use your name, address, or any other identifying information in reports or other materials related to this study, and your responses will be used only in combination with those other respondents. Completion of this survey is voluntary. If you choose not to participate at any time, that will be okay.

Do you have any questions so far?

Okay, let's begin.

Consumer Survey 2006

Q1 What is your gender? a. Female b. Male c. Transgender	***Q2 How old are you?***[3] a. Under 13 years b. 13-24 years c. 25-35 years d. 36-45 e. 46-55 f. Over 55 years
Q3 What is your racial/ethnic background?[4] Answer origin **AND** race sections: **Origin:** a. Hispanic or Latino b. Not Hispanic or Latino **Race:** (More than one category may be chosen.) a. American Indian or Alaska Native b. Asian c. Black or African American d. Native Hawaiian or other Pacific Islander e. White	***Q4 What languages do you speak?*** a. English b. Spanish c. Vietnamese d. Other (specify)_______________ If the subject identifies multiple languages, or non-English as the single language spoken: How comfortable are you receiving services in English? a. Very comfortable b. Somewhat comfortable c. Not comfortable
Q5 What is the highest education level you have completed? a. 8th grade or less b. Some high school, but did not graduate c. High school or GED d. Vocational certification e. Some college f. Completed college g. Post-graduate education	***Q6 Where are you living now?*** a. Rent or own house or apartment b. Halfway house or drug treatment program c. Housing for persons living with HIV d. Shelter (*e.g.*, homeless, abused spouse) e. Living with family d. Staying with friends e. Other (specify)_______________
Q7 What county do you live in? ___________________________	***Q8 What health insurance do you have (select all that apply)?*** a. Medicaid

Consumer Survey 2006

	b. Medicare c. Private Insurance d. Other (specify)_______________ e. None
Q9 What is your CD4 count?[5,6] a. Less than 200 b. 200-350 c. Over 350 d. Don't know **When was your CD4 count last tested?** **_____ months ago**	***Q10 What is your viral load?*** a. _________ b. Don't know **When was your viral load last tested?** **_____ months ago**
Q11 How long ago did you learn you were HIV-positive? a. Less than 12 months b. 1-4 years c. 5-9 years d. 10 years or more e. Don't remember	***Q12 Were you diagnosed with HIV and AIDS at the same time?*** a. No b. Yes c. Don't remember
Q13 How soon after being diagnosed with HIV or AIDS did you receive HIV-related medical care? a. Not in medical care b. Immediately after being diagnosed c. Within 6 months of being diagnosed d. Within a year of being diagnosed e. When I got sick f. Other (specify)________________________________	***Q14 Do you have a regular place you go for HIV health care?*** a. No b. Yes If yes, do you have a regular doctor or nurse who takes care of your HIV health care needs? a. No b. Yes
Q15 Do you have any children of your own or are you caring for children? a. No (If no, please skip to Q17)[7] b. Yes	**For mothers:** **(If you are a caregiver but not the mother, answer the question as it applies to the mother.)** ***Q16 Were you on AZT, Combivir, or another antiretroviral***

	regimen that contains AZT during pregnancy? a. No b. Yes
For all women: ***Q17 Are you pregnant now?*** a. No b. Yes If yes, are you on AZT, Combivir, or another antiretroviral regimen that contains AZT? a. No b. Yes c. Don't know	***Q18 Is there anyone else in your household (family members, partners/spouses, close friends living with you) who is also HIV positive?*** a. No b. Yes If yes, how many others? _____ c. Don't know

Consumer Survey 2006

This next section of questions deals with services you may have needed or wanted this past year. Please tell me which of these services you needed, whether you tried to obtain them, and whether you had any problems getting services***.***

	Did you need it?			
Do you currently use …	Yes (end)	N0	Tried to get Service?	Can you think of reasons why you may not have gotten this service?
Primary Medical Care				
Antiretroviral medications, including protease inhibitors				
Medications other than antiretroviral				
Dental Care				
HIV/AIDS support services and counseling				
Case Management				
Professional Mental Health counseling/therapy				
Drug or alcohol counseling				
Drug or alcohol treatment				
Drug or alcohol day program				
Translator/Interpreter Services				

Q20 What is working the best with your HIV/AIDS services?[10]

____
____
____

Q21 Do you think the quality of care you received is affected by: (Circle all that apply)

a. Your income?
b. Your HIV status?
c. Your race/ethnicity?
d. Your gender?
e. Where you live?
f. Other reason? (Specify)____

Q22 List the three biggest problems that you have faced when trying to get HIV-related services.

a. ____

b. ____

c. ____

Q23 What is the most important change you would suggest to improve services for individuals or families living with HIV?

____
____
____

Consumer Survey 2006

Q24 Which of the following should providers do to serve you better? (Circle all that apply)[11]
a. Be experienced/knowledgeable about providing HIV care, such as antiretroviral treatments, dealing with opportunistic infections such as PCP, and monitoring and explaining my health status
b. Know what HIV-related services are available in the Georgia and provide referrals to them
c. Provide services in a more convenient manner (such as better office hours, quicker appointments, less waiting, in a location that is easier to get to)
d. Advocate for my needs within the service system
e. Know how to work with people from other cultures
f. Know a language other than English
g. Other (specify)____

Consumer Survey 2006

This next set of questions deals with information about your harm and risk reduction needs.

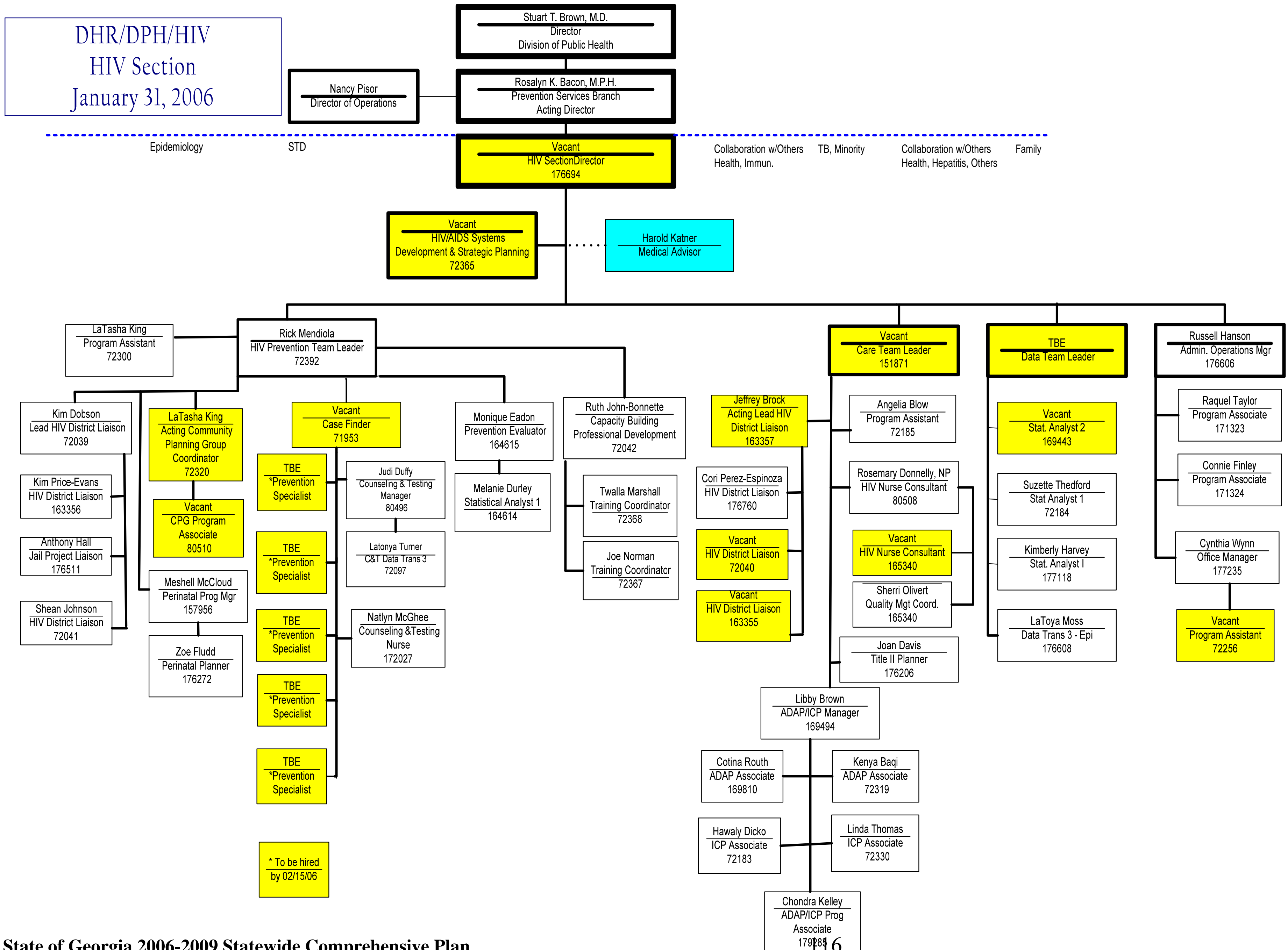
Have you been given information about …	Yes	No	Have you tried to get info?	Can you think of reasons why you may not have gotten this service?
HIV/AIDS support services and counseling				
How to protect other people from getting HIV from you				
How to protect yourself from getting sexually transmitted diseases from other people				
How not to pass HIV to your baby if you are pregnant				

Q25 Is there anything else you'd like to add?

____

____

____



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Rosalyn K. Bacon, M.P.H. Prevention Services Branch Acting Director
Epidemiology
STD
Vacant HIV SectionDirector 176694
Collaboration w/Others Health, Immun.
TB, Minority
Collaboration w/Others Health, Hepatitis, Others
Family
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LaTasha King Program Assistant 72300
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Vacant Care Team Leader 151871
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TBE *Prevention Specialist
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* To be hired by 02/15/06
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Appendix 7

Contact Information

Georgia Department of Human Resources
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