

**STATE OF
NORTH CAROLINA
2012
HIV Care and Prevention
STATEWIDE COORDINATED
STATEMENT OF NEED (SCSN)/
NEEDS ASSESSMENT
and
COMPREHENSIVE PLAN**

**2014 Update
September, 2014**

Table of Contents

Introduction	3
HIV/AIDS Epidemiological Analysis	6
Unmet Need	8
Early Identification of Individuals with HIV/AIDS (EIIHA)	11
Statewide Coordinated Statement of Need (SCSN)	23
HIV Prevention Needs Assessment	42
Care and Prevention Needs	53
HIV Care Comprehensive Plan	54
HIV Comprehensive Prevention Plan	74
HIV Care and Prevention Comprehensive Planning	83
List of Participants	85
2014 SCSN/NA/CP Update Questionnaire	88
Attachments	89

2014 Update

North Carolina has made significant progress in moving its HIV/AIDS Care and Prevention program forward since the development of the original 2012 assessment and plan. Along with our partners in care and prevention, we have also identified some gaps in our original analysis, and have been inundated with a number of significant changes to the health care environment in which we operate.

This update is meant to apprise the State's prevention and care programs, our community partners and the federal agencies that help to support our efforts about some of these things.

The process for this update was simple. We sent out a questionnaire (See Attachment 12) to all of those who had participated in the previous process, plus those who had become newly involved with our programs. A total of 15 responses were returned, but those responses were very instructive. Just over half indicated that they felt the original document was comprehensive and needed no change. The remaining seven responses ranged from suggestions of wording to inclusion of some new needs and priorities to one response suggesting a significant number of changes which needed to be made. All of these suggestions were carefully reviewed, and a number of them were incorporated in this document.

It should be noted that the Care material was reviewed by HRSA and accepted in its entirety. CDC also carefully reviewed the Prevention material, and made suggestions for changes (primarily in the way material was presented, not in the content); those changes are also incorporated in this document.

An omnibus meeting to discuss these changes was held with a broad cross-section of the care and prevention communities on May 16, 2014. The discussions from that meeting have been incorporated into this document.

Introduction

Needs assessment and planning is a cornerstone of any well-managed program effort. Identification of needs is the key to defining the series of action steps which comprise a comprehensive plan, and which lead to a well-conceived program to allocate scarce resources. Congress and HRSA have consistently recognized this for the Ryan White program by requiring the submission of a Statewide Coordinated Statement of Need (SCSN) and Comprehensive Plan (CP) to cover all Ryan White activities within a state or territory. Similarly, the Centers for Disease Control (CDC) requires a comparable set of activities and compilation of a document for all State HIV/STD prevention programs. Thus, although the requirements are not identical, the State of North Carolina has elected to develop a combined Care and Prevention Needs Assessment and Comprehensive Plan.

Nationally, there is an increasing focus on the importance of viewing HIV care and prevention in a joint context. Care for HIV-positive individuals is an extremely complex and expensive proposition, and anything which can be done to prevent new infections means greater availability of resources for those who are already ill. And morally, we should be focusing on preventing the spread of infection to those who are not infected.

Both HRSA and CDC have placed increasing emphasis on better coordination and programming between the two activities. Thus, HRSA stresses that prevention be an active partner in developing and maintaining effective care practices, and CDC similarly emphasizes the need to ensure that prevention activities have a strong focus on identifying positive individuals and getting them into care so as to minimize future infections. Although legislative and historical mandates still require program differentiation, there has been considerable movement toward a common perspective.

Thus, in North Carolina, we have chosen this time of needs assessment and planning to foster the closer integration of these two perspectives. While we continue to recognize the need to address the differences which still exist, we also recognize the reality that care and prevention are in fact "two sides of the same coin," and that the time to start putting this realization into practice is now.

The other reality which must be a recognized component of these activities is that change is a constant part of what we do. In a sense, simply by conducting these activities and describing them, we have initiated a series of changes which, to some extent, make what is recorded here outdated. Thus, this document should be considered as a living organism which will grow and change as need and circumstance dictates.

The process of assessing HIV/AIDS Care needs in the State of North Carolina has been a continuous, on-going effort. The original 2012 document was the first to be a Prevention and Care needs assessment/comprehensive plan, and this is the second update of that document.

The HIV/STD Needs Assessment process under CDC focuses primarily on the capacity of the State and local prevention activities to perform the roles identified as necessary for the development of a prevention comprehensive plan. HRSA's focus on Needs Assessment is more heavily dependent on a broader perspective of what system and service needs are, although the capabilities of the system to develop comprehensive plans are an essential component of the process.

This document is divided into a number of distinct parts, although there will be some overlap. The first part will provide some of the context under which this activity occurs: HIV/AIDS Epidemiological Analysis; Unmet Need (connecting those who know they are positive to the system); and Early Intervention for Individuals with HIV/AIDS (finding

those who do not know they are positive). Next, we will talk about the identification of needs, individually for care and prevention, and in a combined context. The delineation of Comprehensive plans will be based upon the needs identified, again for both care and prevention, and then in a combined context.

It is crucial to note that the concept of constructing a combined *Care and Prevention* needs assessment and comprehensive plan was initiated relatively recently. There is no joint federal guidance available as to how to do this, and no successful examples of others having done so (we have recently been informed that the CDC and HRSA are developing guidelines for a combined Care and Prevention process and document, which is expected to be available in time for the next comprehensive planning process which will begin in 2015). This effort was undertaken with the realization that we would be working without a proven methodology, but with the intent that we would be learning as we go along, and would be ahead of the curve when such activities become more widely mandated.

Several of the comments provided for this Update addressed this issue of integrating prevention and care more closely. It should be noted that this is really a recent process, and still has quite a ways to go. Thus, for instance, the HIV/AIDS Prevention and Care Advisory Committee (HPCAC) has recently come into being. Derived from the AIDS Care Unit Advisory Committee (ACUAC) and the State Planning Group (SPG), it is this group's mandate (in conjunction with State staff) to develop and implement the processes and methods to realize this goal.

It should be noted that two grants provided to the State will have a bearing on this. The NC-LINK project, a Special Project of National Significance grant funded by HRSA, is in the process of developing initiatives which will more closely link care and prevention activities. And the CAPUS grant, funded with Minority AIDS Initiative funds from CDC, has a specific emphasis on creating close coordination between prevention and care.

HIV/AIDS Epidemiologic Analysis

(NOTE: Before comparing HIV/AIDS reporting data from 2012 to that from 2011 it should be noted that any variations may be due to changes in reporting methodology and may not represent true variation between the two years. In late 2012, HIV disease reporting was fully incorporated into the North Carolina Electronic Disease Surveillance System (NCEDSS) utilized for all communicable disease reporting in North Carolina. As a result, for approximately one month no cases were reported into the system. Although the backlog in reported cases has mostly been resolved, there may be a small proportion of cases, primarily those diagnosed in late 2012, for which the backlog had not been resolved by the time the data used for these analyses were generated. Interpretation of comparisons should be made with caution.)

See Attachment 1, Epidemiology Table

Prevalent HIV/AIDS Cases

As of December 31, 2012, there were 27,068 persons living with HIV/AIDS (PLWHA) in North Carolina. Most prevalent HIV/AIDS cases were male (70.7%) and adult/adolescents (99.8% 13 years of age or older) with 50.9% between the ages of 45 and 64 years. African Americans comprised 65.6% of living HIV/AIDS cases, compared to 25.3% among Whites and 6.0% among Hispanics. Men who have sex with men (MSM) represented 35.7% of all PLWHA in North Carolina as of December 31, 2012, while 16.0% of prevalent cases were the result of heterosexual exposure, 7.5% were due to injection drug use (IDU) and 37.3% of prevalent cases had no identified risk/no reported risk of exposure (NIR/NRR).

The gender and racial/ethnic distributions of prevalent HIV/AIDS cases in 2012 were similar to that of 2011 although there was an increase in the proportion with Multiple or Unknown race/ethnicity (1.8% in 2012 vs. 1.0% in 2011) and as a result a slight decrease in the proportion reported to be African American (65.6% in 2012 vs. 66.3% in 2011). The proportion of prevalent HIV/AIDS cases among adults/adolescents was the same in both 2012 and 2011. The proportion of prevalent HIV/AIDS cases among MSM rose slightly in 2012 (35.7% vs. 34.9% in 2011), while the proportion decreased slightly in 2012 among IDU (7.5% vs. 7.9% in 2011) and among heterosexuals (16.0% vs. 16.3% in 2011). The proportion of PLWHA with NIR/NRR exposure remained the same between 2012 and 2011.

Of the PLWHA as of December 31, 2012, 15,835 (58.5%) had HIV disease (non-AIDS) and 11,233 (41.5%) had received an AIDS diagnosis. Compared to 2011, the proportion of PLWHA with an AIDS diagnosis as of December 31st was slightly higher in 2012 than in 2011 (41.5% vs. 41.0%, respectively). Among those living as of December 31, 2012, AIDS cases were more likely than HIV non-AIDS cases to be male (73.0% vs. 69.1%), Hispanic (6.7% vs. 5.6%) or African American (66.0% vs. 65.4%), and exposed through IDU (9.4% vs. 6.1%) or heterosexual contact (17.5% vs. 14.9%). Prevalent HIV non-AIDS cases were more likely to female (30.9% vs. 27.0%), White (25.7% vs.

24.6%), and have a mode of exposure of MSM (37.5% vs. 33.3%) or NIR/NRR (38.1% vs. 36.2%) than prevalent AIDS cases.

HIV/AIDS Cases Newly Diagnosed in 2012

There were 1,409 newly diagnosed HIV-infected individuals (regardless of disease status, HIV or AIDS) in North Carolina in 2012 (14.6 per 100,000 population). Of these, 1,399 were adult/adolescent cases (aged 13 years or older), with 29.7% of new adult diagnoses occurring among persons between 45 and 64 years of age. Males represented 77.8% of adult/adolescent newly diagnosed cases in 2012. African Americans represented 64.9% of all adult newly diagnosed HIV-infected individuals and were disproportionately affected by HIV disease in North Carolina. The rate of HIV disease among adult African Americans was over three times the rate among Hispanics (53.2 vs. 17.5 per 100,000 population) and nearly nine times the rate among Whites (53.2 vs. 6.0 per 100,000 population). Among adult women, African Americans were diagnosed and reported with HIV disease at 11.2 times the rate among White women (24.6 vs. 2.2 per 100,000 population). MSM represented 89.2% of newly diagnosed adult males with known mode of exposure; 30.3% of adult males had no known mode of exposure. Among newly diagnosed adult females, 64.3% had no known mode of exposure. Among females with a known mode of exposure, 88.3% (98/111) acquired HIV disease through heterosexual contact.

Males constituted a similar proportion of adult newly diagnosed HIV disease cases in 2012 as in 2011 (77.8% vs. 76.9%, respectively). African Americans comprised 64.9% of newly diagnosed adult HIV-infected individuals in 2012, which is a decrease over the previous year (67.2% in 2011). The proportion of cases reported among Whites increased slightly (23.3% in 2012 vs. 21.4% in 2011) while the proportion of HIV/AIDS cases reported among Latinos was similar relative to 2011 (7.2% in 2012 vs. 6.6% in 2011). Compared to 2011, MSM represented a larger proportion of adult males newly diagnosed with HIV disease in 2012 (89.2% vs. 86.5% in 2011) and more adult males had no known mode of exposure (30.3% vs. 28.4% in 2011). Among newly diagnosed adult females, the proportion with no known mode of exposure was smaller in 2012 than in 2011 (64.3% in 2012 vs. 72.8% in 2011). Among newly diagnosed adult females with known exposure, the proportion with heterosexual exposure was higher in 2012 (88.3%) than in 2011 (82.8%).

There were 798 AIDS cases diagnosed in 2012, which represents a rate of 8.3 per 100,000 population; this rate is similar to that of 2011 (8.4 per 100,000 population) although there was a slight decrease in the number of AIDS cases diagnosed (798 in 2012 vs. 811 in 2011). Compared to 2011, AIDS cases diagnosed in 2012 were more likely to be male (72% vs. 70% in 2011) and African American (69% vs. 67%) or Hispanic (7% vs. 6%).

Unmet Need Estimate for Calendar Year 2012

See Attachment 2, NC Unmet Need Estimate, 2012

Unmet Need has long been a requirement of HRSA/HAB for RW programs. At its core Unmet Need is the proportion of HIV-infected individuals who know that they are positive, but are not considered to be in care, as indicated by one of three factors: a CD4 count within the last year; a viral load within the last year; or evidence of antiretroviral medications being prescribed and taken. HRSA has maintained this definition for a many years, but it applies equally to prevention activities, which seek to ensure care for all HIV-infected individuals as a means for preventing transmission.

The Surveillance Unit of the Communicable Disease Branch maintains the public health surveillance system for all morbidity and laboratory reports for HIV and AIDS in N.C. All HIV/AIDS cases reported to the state are stored in a central electronic HIV/AIDS surveillance system (eHARS). eHARS records are updated with additional information, including laboratory results, changes in address, diagnostic information and viral status, as available. eHARS is estimated to represent 85-90 percent of all HIV-diagnosed persons in North Carolina, and eHARS was used to identify persons eligible to be considered for the unmet need estimate. The eligibility criteria to be included in the estimate of unmet need was 1) only individuals reported to the Surveillance Unit with current residency or last known address reported in North Carolina, 2) vital status was living as of 4/01/10 and, 3) not diagnosed through the Veterans Administration. The Veterans Administration (VA) does not consistently report HIV/AIDS cases to the state health department, nor do they publish demographic level data for the total number of persons living with HIV disease by state. Additionally, the VA Center for Quality Management in Public Health does not use the CDC definition of AIDS for the care data that are published by state, thus we are unable to include VA patients residing in N.C. in the estimate of unmet need.

Individuals meeting the definition of "in care" were initially identified based on the available laboratory information collected within the surveillance system (eHARS). North Carolina does not mandate universal reporting of all laboratory tests associated with HIV disease but laboratories are required to report positive antibody, PCR, RNA and DNA results that indicate HIV and CD4 test results that signify a possible AIDS diagnosis (i.e., CD4 lymphocytes count less than 200 or less than 14%). All cases that had a CD4 or viral load test performed in 2010 and reported to the Surveillance Unit were identified as "in care". The HIV/AIDS surveillance system (eHARS) captured viral load and/or CD4 tests for 37 percent of persons with HIV (non AIDS) and 54 percent of persons with AIDS in 2010. The eligible population was then linked to ancillary datasets via deterministic matching to further assess met/unmet need. These data were limited to calendar year 2010 and included: Medicaid claims for CD4 and viral load laboratory tests, Ryan White funded CD4 and viral load laboratory tests recorded in CAREWare and, antiviral drugs dispensed through the AIDS Drug Assistance Program (ADAP).

The estimated number of persons living in North Carolina with HIV Disease was 27,978. Of these, 21,435 (76.6%) were estimated to be "in care" during calendar year 2010. The remaining 6,543 (23.4%) were estimated to be not "in care", and thus represent those with unmet need. The estimated number of persons living with HIV (PLWH) with unmet need was 4,301 (27.4%), as compared to 2,242 (18.3%) persons living with AIDS (PLWA).

Private Pay Estimation methods:

Estimates of "private pay" were made to account for persons living with HIV/AIDS who are in care and receiving HIV-related laboratory tests that are not reported to the state, either because their CD4 lymphocytes counts are greater than 200 or 14%, or due to noncompliance with state reporting requirements by private or hospital laboratories. The estimates of "private pay" are made by comparing the proportional relationship of persons whose care was identified through public data sources *only* (Medicaid, ADAP and CAREWare) with persons whose care was identified through *both* public data sources and through private laboratory reporting in eHARS. The estimates of persons in private care who were not captured through laboratory reporting in eHARS ("X" in the equation) were then redistributed by disease status and geographic region, demographic and HIV risk group. The calculation was performed separately for HIV (non AIDS) and AIDS cases using the following equation:

$$\frac{\text{Government sources only}}{\text{eHARS captured government payer}} = \frac{\text{"Private pay" only (X)}}{\text{eHARS captured private payer}}$$

The methodology used to calculate "private pay" is valid as long as our capture of persons who receive their care through public funding is complete. The assumption that there is no laboratory reporting bias for government and private payer groups must be true for the proportional relationship that is applied to eHARS data to calculate "private pay" estimate to be valid. The principal benefit of this method to calculate "private pay" is that it relies on centrally maintained databases which are generally consistent. The methodology used to calculate private payer healthcare has been used since the 2007 estimations of unmet need, so comparisons of unmet need in N.C. for the 2007-2010 time periods should be valid.

Assessment of unmet need:

The demographics and location of PLWHA not in care

There are proportionately more males in the unmet need population (25%) versus females (19%). By race and ethnicity, the highest proportion of unmet need was among Hispanics (34%), compared with 21 percent of white, non-hispanics, 24 percent of black, non-hispanics and 24% of other racial groups (including non-Hispanic

American Indians, Asians, and Pacific Islanders). Specific subpopulations that experienced improvements in access to HIV care from 2009-2010 were females with AIDS, blacks living with AIDS, all PLWHA ages 45 and older, and all white, non-Hispanic PLWHA. The highest proportion of PLWHA with unmet need by transmission category was among IDU (27%) followed by MSM/IDU (25%), MSM (21%) and Heterosexuals (20%). All persons living with AIDS, regardless of transmission category, experienced improvements in access to HIV care from 2009-2010. However, IDU living with HIV (non AIDS) did experience an increase in unmet need from 29 to 33 percent from 2009-2010.

Geographically, most regions have experienced improvements in meeting the needs of persons living with HIV/AIDS. The greatest improvement areas were Region 2, where PLWHA with unmet need went from 18 percent to 10 percent from 2009-2010, Region 9 where unmet need improved from 34 percent to 30 percent from 2009-2010 and, Region 10 where unmet need improved from 23 percent to 19 percent from 2009-2010. The regions experiencing the highest burden of unmet need are the Charlotte TGA (which includes the N.C. counties of Mecklenburg, Gaston, Union, Cabarrus, and Anson), where 29 percent of PLWHA are estimated to have unmet need, and Region 9 which is comprised of northeast counties that border Virginia, where 30 percent of PLWHA are estimated to have unmet need. These higher estimates of unmet need in bordering regions of the state may reflect gaps in service data for people residing in N.C. but receiving medical care in the neighboring states of South Carolina and Virginia.

Trends over the past 5 years regarding Unmet Need

The estimate of persons in care in N.C. living with HIV (non AIDS) has increased 26 percent since 2007. In 2007, only 58 percent of persons living with HIV (PLWH) were estimated to be in care; the number of PLWH in care increased to an estimated 73 percent in 2010. The estimate of persons living with AIDS (PLWA) in care has increased nine percent since 2007. In 2007, 75 percent of persons living with an AIDS diagnosis were estimated to be in care; the estimated number of PLWA in care increased to 82 percent in 2010.

There are many potential reasons for this welcomed increase in PLWHA accessing primary medical care in N.C. The increase in persons accessing HIV care may be the result of the Communicable Disease Branch's increased efforts to link persons newly diagnosed with HIV through active referrals to HIV medical care and support services by Disease Intervention Specialists and Bridge Counselors. Also, as the economy and unemployment has worsened in N.C., persons living with HIV/AIDS may be relying more heavily on publicly funded services through Medicaid and the Ryan White program, thus making them easier to track. The increases could also be an artifact of increased data collection in eHARS as the Surveillance Unit has become more active in the solicitation of HIV/AIDS case reports and laboratory test results from providers who are treating HIV patients.

Efforts to find people who have dropped out of care and to re-engage them in care

North Carolina has several strategies for re-engaging people who have been lost to care. Each of the 10 Ryan White Part B Regional Networks of Care has one or more Bridge Counselors who provide active linkages to care for newly diagnosed individuals and/or Case Managers who are tasked with helping people stay in care and identifying people who are lost to care so that they can be found and reengaged in care. The CDB's Field Services Unit has recently hired four additional DIS/Bridge counselors who will work with clients and providers to provide active linkages to care in the Winston Salem, Raleigh, western (Black Mountain) and Greenville areas. In addition, all of the Regional Networks of Care participate in the NC Regional Quality Council, and are working in conjunction with an NQC/HIVQUAL Consultant to implement regional retention in care projects and are participating, along with the State RW Part B Program, in the HRSA *in+care* Campaign with the focus of retention in care over the coming year.

In addition, a SPNS grant awarded to the CDB in September 2011 will further enhance and strengthen Bridge Counselor activity. Operating in partnership with the UNC-Chapel Hill HIV Clinic and the Duke University Center for Health Policy and Inequalities Research, the 4-year NC-LINK program intends to show increased efficacy in retaining HIV-positive individuals in care through enhanced Bridge Counselor activity.

Early Identification of Individuals with HIV/AIDS (EIIHA)

Both HRSA's and the CDC's current focus is on Early Identification of Individuals with HIV/AIDS (EIIHA). This legislatively mandated effort focuses on individuals who are unaware of their status, and how best to identify who to test, bring those found positive into care, and refer those who are negative to services which will help them to remain negative. This has been a priority of the Communicable Disease Branch's care and prevention programs for a number of years.

As part of its annual Part B application process to HRSA, the AIDS Care Program has been required to specifically address the EIIHA requirements for the last three years. The material which follows is the EIIHA Strategy and Plan portions of the FY 2014 RW Part B application.

Strategy

Description of Strategy

(a) Overall strategy North Carolina's strategy to identify individuals who are unaware of their HIV status is comprehensive and includes both public and private partnerships across a full continuum from initial HIV testing to enrollment in primary medical care

and support services. The four major components of the NC EIIHA Strategy include: (1) increase the number of individuals who are aware of their HIV status through increased, targeted nonjudgmental and culturally sensitive testing, (2) increase the number of HIV positive individuals who are in medical care and support services, (3) reduce racial/ethnic and MSM health disparities through a combination of targeted HIV prevention efforts and the Minority AIDS Initiative and, (4) increase the number of HIV negative individuals who know their HIV status and are referred to counseling and health care services that support their HIV negative status. The NC EIIHA Strategy is consistent with National HIV/AIDS Strategy (NHAS) goals and is compatible with the aim of helping individuals to become aware of their HIV status. These goals are as follows:

- **Reducing the number of people who become infected with HIV by increasing the number of individuals who are tested and know their HIV status.** We plan to increase the numbers of high risk individuals tested for HIV, particularly among minority men and women and young MSM, and to increase routine HIV testing across North Carolina. Research has demonstrated that when people know their HIV status, they modify their behaviors to reduce contracting the virus if they are negative or of transmitting the virus to others if they are positive. Therefore, we are helping to reduce the number of people in NC who become infected with HIV.
- **Increasing access to care and optimizing health outcomes for people living with HIV.** Research also demonstrates that when HIV positive individuals receive appropriate antiretroviral treatment, this reduces the viral load in their body and decreases their ability to transmit the HIV virus by up to 96%. We plan to decrease the number of people in NC who test late in their disease process and experience a worse prognosis and lower chance of survival by increased testing in high prevalence areas and among subpopulations with demonstrated unmet need.
- **Reducing HIV-related health disparities.** Once people have been identified and informed of their HIV positive status, our goal is to reduce the barriers that prevent PLWHA from receiving high quality HIV care that can reduce their viral load and transmissibility, and increase their chances of survival. Our populations of interest are racial/ethnic minorities and sexual minorities (MSM and transgender women) which is consistent with the NHAS goals.

(b) Coordination

Collaborative efforts were undertaken with various entities in planning and implementing the EIIHA Plan. Below is a summary of these collaborations:

SCPG and ACUAC Input- The CDB EIIHA plan required participation among a broad-based collaboration of stakeholders to include the HIV Statewide Community Planning Group (SCPG) and the AIDS Care Unit Advisory Committee (ACUAC). These groups have since combined into one statewide advisory committee called the HIV Prevention and Care Advisory Committee (HPCAC). The membership of these bodies were given the opportunity to inform the EIIHA plan in a combined face to face meeting of these groups in the Spring of 2013. All EIIHA goals, objectives and outcomes were approved by these two committees.

CDC PCSI Collaborations- the NC CDB is funded through CDC for a Program Collaboration and Service Integration (PCSI) demonstration project that enables us to support the implementation of a syndemic approach to the prevention of HIV/AIDS, viral hepatitis, STD's and TB through collaborative and service integration related programs and activities in four NC counties. These activities include comprehensive integrated testing in community non-traditional testing sites.

CAPUS/SPNS- the NC CDB is also the recipient of a CDC CAPUS award (Care and Prevention in the US) and a HSRA SPNS-LINK award (Special Projects of National Significance). These awards are increasing testing of at-risk people, developing bridge counselors' protocols for linking and retaining clients in care, and assuring that issues of stigma, barriers to care and the impact of a rural epidemic on minorities are all addressed in a collaborative and best-practice based environment.

HIV/STD Prevention Program Supported Agencies- The HIV/STD Prevention Program works with over 150 local health departments, state correctional facilities, jails, hospital emergency departments, community health clinics, CBOs and other entities in their efforts to plan, implement and evaluate HIV/STD Prevention activities in North Carolina. These agencies are vital in conducting the HIV screening, education, and linkage to care and support services among our identified high priority populations.

(c) Incorporation in RFAs The operational aspects of the NC EIIHA strategy and plan will be incorporated in all RFAs for HIV/STD counseling and testing issued by the HIV/STD Prevention Program.

(d) Cost Containment North Carolina's ADAP no longer has the cost containment measures which were in place in previous years. Qualified clients (including those with incomes up to the legislatively mandated limit of 300% FPL), are admitted to the program, and no waiting list currently exists (nor is there an expectation that one will be needed to be implemented). A great many medications have been reintroduced to the Program's formulary, and new antiretrovirals are being added as they are approved. These improvements have been achieved through the exercise of thoughtful controls on program expenses, and the reintroduction of the State pharmaceutical Assistance Program (SPAP), which has significantly reduced the costs of medications for participants.

(e) Needs of Vulnerable Populations The NC EIIHA Strategy attempts to address the respective needs of vulnerable populations in historically underserved communities in order to enable individuals to use the full continuum of health and supportive services funded by HRSA, the CDC, SAMHSA, HUD and the State of North Carolina. The NC EIIHA strategy includes expanding our rapid HIV testing program and a new targeted outreach effort directed at young MSM of color, coordinated jointly through the Minority AIDS Initiative and the NC MSM Task Force. We plan to increase the numbers of high risk individuals tested for HIV, particularly among minorities and young MSM by expanding nonjudgmental and culturally sensitive nontraditional testing in high prevalence areas, and HIV prevention projects and testing offered at fixed sites including homeless shelters, jails, substance abuse centers, migrant health centers, CBOs, mental health facilities, nightclubs, and college campuses.

(f) Challenges There are programmatic, systemic, financial and logistical challenges associated with making individuals aware of their HIV status. The NC Communicable Disease Branch (CDB) currently supports over 80 agencies and partners with local health departments to conduct HIV testing. These funded agencies are encouraged to follow the CDC recommendations that HIV testing be done on an "opt-out" or routine basis for individuals between the ages of 13 and 64 years and that individuals with ongoing risk factors should be screened yearly. There are major challenges, however, to fully implementing those recommendations in NC.

One logistical challenge is that our ability to expand HIV testing is limited by the amount of testing that can be performed by the State Laboratory for Public Health (SLPH). With the funding from a CAPUS grant, the SLPH purchased fourth generation HIV assay equipment. This will allow us to provide approximately 400,000 tests annually which is a significant increase from our previous capacity of 240,000, but is still a constraint. To work around these testing limitations, the CDB expanded our HIV rapid testing program by over 6,000 tests in 2012 and used these funds to support HIV testing among persons at increased risk for HIV, specifically testing sex partners and syringe sharing partners of newly diagnosed HIV positives. However, a programmatic challenge to making individuals aware of their HIV status is that we have a limited number of DIS positions and as more unaware individuals test positive, we will have difficulty assuring that all partners can be notified of their possible exposure and offered testing.

Health insurance reimbursement of routine HIV screening is a major systemic barrier for private, non-government funded providers and the state will continue to work with these partners to reduce this barrier by encouraging insurance policy changes. In April 2013, the US Preventive Services Task Force (USPSTF) issued a final Grade A recommendation statement on Screening for Human Immunodeficiency Virus (HIV). This final recommendation statement applies to all people aged 15 to 65, including pregnant women. This means that all health insurance providers must cover the

screening for their insured population. Medical care providers should follow this recommendation, although it may take several years to fully implement and see results. In addition to expanding government funded testing events, the CDB will partner with non-governmental entities with the capacity to increase HIV testing and to reach at-risk populations, specifically: hospitals (inpatient and ED), private physician offices and Community Health Centers. Another systemic challenge to our efforts to test, identify, refer and link people to HIV care is that there are multiple RW Parts (A, B, C, D, Dental Support, SPNS activities and the AETC) in the state, which must be coordinated. The administrative complexity and different mandates can sometimes confound our best efforts to get everyone on the same page.

It is also challenging to access MSM populations in order to increase testing levels among them. The CD Branch focuses on educating funded agencies on the need to conduct HIV and STD testing among targeted populations, including MSMs.

Another systemic challenge to outreach and testing for IDU users and commercial sex workers is the paraphernalia laws in NC. Syringe exchange is not legal in NC and syringe users can be arrested for possession of syringes. Commercial sex workers in some areas of NC are also at additional risk of arrest because possession of multiple condoms is considered evidence of illegal sex work. This makes it difficult to operate harm reduction programs for injecting drug users and commercial sex workers who may not come forward for fear of arrest.

(g) Support for National recommendations Ryan White funded agencies are encouraged to follow the CDC recommendations that HIV testing is done on an "opt-out" or routine basis for individuals between the ages of 13 and 64 years and that individuals with ongoing risk factors should be screened yearly. Part B subgrantees are to promote testing among sex partners and syringe sharing partners and contacts, and Part B supports Prevention with Positives activities where partners are encouraged to be routinely tested for HIV and other STDs.

(h) Cooperation with Other Ryan White Providers. RW Part C providers are encouraged to routinely test the partners and contacts of their clients. The Part B program in NC encourages all subgrantees and partners to use other funding sources (Part C and Part D, Medicaid, Medicare, private insurance, other) to conduct HIV outreach and testing in their respective regions. The Part B program in NC contracts directly with 9 of the 12 Part C programs and indirectly with 2 others. The Part B program also contracts directly with 2 of the 5 Part D programs (that are not also Part C grantees). A new Part D grant has been awarded to a private agency in Mecklenburg County (C.W. Williams Community Health Center, Inc.), and efforts are under way to involve that organization in statewide planning and program activities.

See Attachment 3, EIIHA Matrix

(This is a tabular representation of the particular populations which the EIIHA effort will focus on during the coming year, and is a required component of the EIIHA Plan.)

Plan

A revised EIIHA Plan was submitted as a component of the 2014 Ryan White Part B application.

(1) Barriers which obstruct awareness of HIV status

(a) Priority Needs and (b) Cultural Challenges for each target group

Physicians report the following barriers to increased testing: attitudes of physicians about implementing routine HIV testing, competing priorities, lack of time, lack of patient acceptance, need for training so staff can counsel patients who test positive, not knowing about resources to refer patients to when they test positive, perceptions about low risk among patients they serve, and the fact that many private insurers only pay for preventive tests when they are rated highly by the U.S. Preventive Services Task Force which recently (April 2013) changed its rating from a Grade C to a Grade A for routine screening for HIV in all persons 15 – 65 years old. Additional structural barriers that can impede testing for HIV and access to other health services include: access issues related to the physical location of provider offices, clinics or testing sites and lack of transportation resources, being younger (18-19 years), older (over 50 years), lower educational levels and rural residence. Social barriers assume a critical role for the most vulnerable to HIV infection. These include: lack of education about HIV and a misperception of risk of HIV transmission, community denial, poverty, unemployment, unstable housing, addiction, depression and other mental illness, partner violence, stigma, and racism.

Men who have Sex with Men (MSM) experience many barriers to awareness of their HIV status. Fear of testing positive, difficulty maintaining safer sex practices, complacency about HIV and mistaken beliefs about HIV treatment are reasons cited among MSM for not routinely testing for HIV. MSM of color may have a greater resistance to self-disclosure of MSM behaviors and have thus been less visible to service providers than females and non MSM males. MSM of color also report a decreased knowledge of or access to community resources and a lack of culturally relevant and appropriate interventions. Language barriers, cultural norms, poverty and lack of access to health care are barriers to HIV prevention services, particularly for Hispanics. For Hispanic MSM, unique cultural factors may discourage openness about homosexuality. Hispanics are more likely to be late testers in North Carolina, suggesting that they are not accessing testing or health care services through which HIV infection could be diagnosed at an earlier state.

(2) Activities to address barriers that obstruct awareness of HIV status

The CDB will continue to monitor the progress towards the National HIV/AIDS Strategy's goals and intensify HIV testing in the communities where HIV is most heavily concentrated. N.C. will continue to encourage people to learn their HIV status through increasing the availability of nonmedical HIV testing locations like HBCU campuses and correctional settings, substance abuse treatment centers and other non-traditional sites. N.C. will continue to work with Emergency Departments to increase ED testing for HIV, as Emergency Departments are uniquely positioned to detect undiagnosed HIV infection because they often serve as the only source of medical care for disadvantaged populations. N.C. will continue to utilize mobile testing vans that are more likely to reach rural populations at high-risk for HIV who are unable to access clinic-based health departments.

(a) Activities to address (a) Priority Needs and (b) Cultural Challenges

Non Traditional Testing in Substance Abuse Centers, and Expanded HIV Testing Initiatives (ETI), in addition to testing in STD and Prenatal clinics at local Health Department sites allow us to reach other high risk populations including commercial sex workers and substance abusers in addition to MSM. In the next few years we intend to partner with other state agencies to expand our outreach and testing in these communities. NC-LINK plans internet interventions which will target MSM on social networking sites and offer testing at selected venues. In addition, NC-LINK activities will also help us to reach and test more high risk heterosexuals and substance abusers through the collaborations between Ends and HIV clinics and by testing people who accompany individuals to their HIV clinic appointments.

The Prevention and Care program is currently reviewing its Minority AIDS Initiative (MAI) program to develop more effective methodologies for utilizing these funds within the context of the very restrictive RW policies. Additional information will be forthcoming as programmatic concepts begin to take shape.

(3) Actions taken to promote HIV testing in the State

(a-c) The N.C. EIIHA Strategy seeks to reduce the systemic and societal barriers to HIV testing. The CDB will continue to provide routine education and trainings for HIV outreach workers, case managers and clinical staff. All agencies funded by the Branch to conduct HIV Prevention, Testing and/or Care services must undergo a competitive Request for Applications (RFA) process that awards funding to programs that demonstrate cultural competency and Spanish language skills. The Part B program subgrantees are, in most cases, also Part C grantees providing counseling and testing services in their respective regions through their Regional Networks. In attempts to reduce health disparities and to educate persons at risk for HIV who may misperceive their risk as low, the Branch initiated the Get Real-Get Tested (GRGT) media campaign in 2006. The GRGT initiative includes a two-pronged approach: television commercials

which air statewide and targeted HIV and syphilis testing in ethnic, racial and sexual minority communities severely impacted by HIV.

(4) Identifying, Informing, Referring and Linking

(a) Identifying individuals unaware of their HIV status

i - ii) Programs that are funded for HIV testing must provide testing services during non-traditional hours and have nontraditional approaches to reaching those historically underserved communities in N.C. most affected by HIV. The Branch also funds various agencies and Historically Black Colleges and Universities (HBCUs) for Health Education/ Risk Reduction (HERR) activities. Our strategy also includes expanding a new targeted outreach effort directed at young MSM of color.

iii) a-b) Essential activities to identify new cases and link them to care include social networking, social marketing, community-level interventions, agency referrals, bundling of CTR services with other health-care and non-health care related services and the use of incentives. In 2014, we will expand our testing services by expanding our HIV rapid testing program.

iv) The Charlotte Part A TGA consists of five counties in N.C. (Mecklenburg, Gaston, Cabarrus, Union and Anson) and 1 county in South Carolina (York) and partners with the Communicable Disease Branch to test at risk individuals in N.C.

a) The Charlotte Regional Field Services office partners with all local providers including Part A agencies to locate patients that have not been informed of their positive test results. This collaboration includes participation in outreach screening activities and the testing in "high risk" areas. The CD Branch also coordinates an MSM task force in this area which brings members of the MSM community together to guide Branch-funded MSM activities for this area. The Part B program has developed a cooperative working relationship with the Part A TGA to work together on coordination and issues of statewide concern.

v) N.C. will develop clear definitions and guidelines for linkage to care through the bridge counseling program and will ensure the provision of information about accessing HIV care will be provided through the Partner Counseling and Referral Services program. These more active linkages provided through the Bridge Counselor program will lead to better health outcomes for PLWHA.

(b) Informing Individuals of Their HIV Status

i) (a-b) The techniques and the messages that we use in order to inform unaware individuals of their HIV status do not vary by risk group. Each individual is assessed and the DIS staff who do the informing tailor their presentation of the information to assure that the person understands as much as possible given the fact that the

information can be very upsetting. DIS engage in the following essential activities: assess situation, assess person, communicate at level of individual; cultural and diversity sensitivity; confidentiality; control measures; individual risk assessment; partner notification and partner services. DIS also make referrals to the following types of medical and supportive services: primary care and ID care, substance abuse, mental health, housing, potential pregnancy, domestic violence, negotiating health care system, additional health needs, need for education (finish school, GED, etc.).

ii) The Field Services Unit provides DIS resources to support the local health departments in the region and the Part A funded agencies with comprehensive partner notification activities to inform positive individuals of their status and refer their partners for testing and, if necessary, care.

iii) The Field Services Unit provides DIS resources statewide to support local health departments and providers with comprehensive partner notification activities to inform positive individuals of their status and refer their partners into care.

(c) Referring to Medical Care and Supportive Services

i) (a-b) CBOs and other testing agencies are responsible for linking clients to medical care, prevention services and other supportive services for HIV positive clients. CBOs and other agencies that test for HIV should also establish comprehensive memorandum of understanding with partner agencies to make active referrals, and may need to realign their resources to support a linkage/support case manager to provide active linkages. A monitoring and evaluation system should be developed to ensure access to services and verify completed referrals.

Newly identified people are referred by DIS or DIS/Bridge Counselors into care provided through Ryan White Part A or B programs, other RW-funded programs or private or public medical providers. Significant efforts (nursing hotline, bridge counseling services, enhanced internet contact tracing and partner services) will be made to refer people into care through NC-LINK.

ii) DIS/Bridge Counselors refer the newly positive individuals to Part A-funded agencies for care. Patients are provided referrals to any of the funded agencies within the TGA, for medical care and case management. The Early Intervention Clinic, which is housed at the Mecklenburg County Health Department, is often used as a means to stage new patients (receive CD4, viral load and TB test). Upon staging of disease, the individuals are referred to a medical provider who can prescribe medication and provide access to a full range of services.

iii) Newly identified people are referred by DIS or DIS/Bridge Counselors into care provided through Ryan White Part A or B programs, other RW-funded programs or private or public medical providers. Significant efforts (nursing hotline, bridge

counseling services, enhanced internet contact tracing and partner services) will be made to refer people into care through NC-LINK.

(d). Linking to Medical Care

i) a. North Carolina has an increasingly integrated system of service provision. Each Network and the TGA have DIS and DIS/Bridge Counselors who can assist individuals in accessing high quality services. Individuals testing positive are reached by Disease Intervention Specialists (DIS) and bridged to care; medical and support service appointments are made; a bridge counselor follows the new client into care, where a medical provider and case manager picks up to assure that medical, mental health, substance abuse and support services happen. In addition to the Regional Networks of Care funded by HRSA Part B, and one TGA funded by Ryan White Part A, N.C. has five academic medical center teaching hospitals with substantial HIV programs serving large numbers of HIV-infected residents.

b. The NC-LINK project, which began implementation in January 2012, will have numerous activities designed to refer newly diagnosed people into care, including the One Call Nurse Advice line and state level bridge counselors who accept referrals from DIS and medical providers.

ii) Five counties in the Part A Transitional Grant Area are not included in the Part B program, although patients from those counties still participate in the AIDS Drug Assistance Program (ADAP). DIS and DIS/Bridge Counselors can verify access to care/services through CAREWare.

iii) DIS and DIS/Bridge Counselors working in Field Services throughout the State and Part A case managers and Regional Network of Care Bridge Counselors will play increasingly important roles as they “bridge” the gap between identification of newly diagnosed individuals and the care systems available to treat them.

iv) DIS and DIS/Bridge Counselors can verify access to care/services through contact with the Regional Network of Care Bridge Counselor or Part A Medical Case Manager. Both Ryan White Part A and Part B providers can verify that an individual has accessed care services through CAREWare. DIS/Bridge Counselors, Care Network Bridge Counselors, the NC-LINK Internet Bridge Counselor, and DIS will provide linkage to care for clients, to the clients’ local care network or other local medical providers. They will assist HIV-positive clients who have been lost to care to reengage in care and they will track all referrals to assure that they go to their first medical appointment and are connected to a medical case manager if needed.

v) DIS and DIS/Bridge Counselors have knowledge of private HIV care providers in their respective regions and seek opportunities to establish relations with additional

providers as they are identified by colleagues. They can verify access to care services through contact with the offices of any private care provider in their region.

vi) There are few legal barriers to routine testing in N.C. There is no age of consent for HIV testing: a provider determines if a person can understand the meaning and consequences of a test. Therefore, a minor of any age can be tested without parental consent as long as the provider deems them to have the mental capacity to understand what they are doing. Every effort is being made to make testing comfortable, accessible, friendly and non-medical by offering it in a multitude of sites and a variety of different venues in order to reach a diverse population. The N.C. Administrative Code (10A NCAC 41A .0202) related to HIV control measures states that a pregnant woman will be tested for HIV during her first prenatal visit and in the third trimester and if there is no HIV test result on record at the time of delivery then she will be tested during labor using a rapid test and/or the infant will be tested at birth.

4 (c) Data

- a)** An updated estimate of individuals who are HIV positive and do not know their status, including the estimate methodology;

Estimate I (Based on diagnosis in NC)

34,600 (26,583 in eHARS, corrected total (underreporting) approximately 29,250, plus approximately **5, 350 unaware**).

Estimate II (Based on diagnosis anywhere and living in NC)

39,850 (30,587 in eHARS, corrected total (underreporting) approximately 33,650, plus approximately **6,200 unaware**).

Method: The number of HIV/AIDS cases reported in eHARS as living as of December 31, 2012 was determined. We have performed the death certificate match with our local vital records office recently so deaths occurring in NC have been taken into consideration but we have not performed either the match against the 2012 Social Security Death Index or a match against the National Death Index. Both of these could identify deaths for cases that have occurred in other states.

A correction for underreporting was applied to the number of cases reported. We estimate that HIV/AIDS case reporting is 90% (+/- 0.3%) complete based on a CDC-supplied program written to provide that estimate. The final component of the estimate is the most difficult and least accurate at a state level. We have no independent means to estimate the number of persons who are living with HIV and unaware of their infection. The CDC recommends that states NOT use the national estimate of persons unaware of their infection unless they are able to validate the proportion. Our preference is to not include that component in an estimate, but there are undoubtedly individuals who are unaware of their positive HIV status. We have applied the most recent CDC estimate of 18.3% unaware to calculate this component of the total prevalence in NC.

We can provide two estimates based on original diagnosis location. In previous years, we have only provided an estimate based on whether a person was diagnosed in NC and will still living with HIV. Recent changes to the eHARS database design plus a five-year data collection period to ensure that we have an established history of collecting data for persons receiving care in NC regardless of their place of original diagnosis allows us to also estimate the number of people receiving HIV care services in NC regardless of their state of original diagnosis. Readers should be aware that when viewing national data supplied by the CDC, the state-specific data is almost always based on cases originally diagnosed in that state.

(2) Coordination with RW Part A with regard to data collection and sharing

By state law, morbidity reports of HIV and AIDS from health providers are forwarded to the State's Communicable Disease Branch, which maintains the data from all 100 counties in the electronic HARS surveillance system (HIV/AIDS Reporting System). This includes data on HIV cases from counties in the Ryan White Part A region.

(3) Coordination with disease control and prevention/intervention with regard to data collection and sharing.

All positive EIA/WB, HIV RNA and DNA and CD4 tests ≥ 200 or 14% are reportable by law in N.C. to the Communicable Disease Surveillance Unit and to the local health department. Data on all persons tested for HIV through state-funded programs (at local health departments and many state-funded CBOs) is available through the NC State Laboratory of Public Health (SLPH). New HIV cases are entered into eHARS and forwarded to the Field Services Unit for follow up field investigation and are interviewed by DIS, who solicit morbidity case reports from providers and subsequently submit case and field follow up information.

2012 SCSN/Needs Assessment for the State of North Carolina

Process

To some extent, this document is actually a melding of several needs assessments and planning processes. Since the requirements of HRSA and the CDC differ in a variety of ways, this process seeks to include those elements of both that are the same or similar, while allowing for the differences which are necessary to achieve compliance with each set of guidance.

One of the HRSA/HAB SCSN requirements is that all existing local needs assessments be used as a component of the SCSN. As part of the overhaul to North Carolina's HIV care system which occurred with the implementation of the Regional Networks of Care in 2010, each network was required to complete a regional needs assessment. In addition, the Part A TGA was also required to complete a regional needs assessment as one of the requirements of the Part A grant.

Thus, the SCSN portion of this document is based on a compilation of the work done for each of the 11 regional assessments. However, since this is a statewide assessment which needs to account for statewide issues which might not be identified in individual local assessments, and also needs to account for Parts A, C and D program components which might not have been accounted for in local assessments, the State has incorporated additions to the local assessments as necessary.

The Prevention portion of this needs assessment is similar in that it requires participation among a broad-based collaboration of stakeholders to include the HIV Statewide Community Planning Group (SCPG). This document was informed by this group and other stakeholders in a series of SCPG/stakeholders meetings, as well as through participation of HIV prevention stakeholders through the needs assessments conducted by the 10 Regional Networks and the Charlotte/Mecklenburg TGA.

Statewide Coordinated Statement of Need

One of the major requirements of the Ryan White legislation is that the State Part B program must, on behalf of all Ryan White programs funded throughout the State, compile on a periodic basis (defined by HRSA/HAB) a Statewide Coordinated Statement of Need (SCSN) The SCSN serves as a blueprint for all RW providers in the State in defining the needs of the HIV-infected population for care services, and helps to ensure that coordination in the provision of such services occurs.

As noted above, the SCSN must include the results of all individual needs assessments completed by each program. As part of its reorganization to Regional Networks of Care, the AIDS Care Program included completion of a Regional Needs Assessment as a

required product. It is those Regional Needs Assessments, along with input from other Care system components, that form the basis of this SCSN.

Each Network/TGA used its own methodology for obtaining data from clients and providers to complete their individual needs assessments. A summary of the client-based methodologies included:

- Total clients surveyed – 946
- Total clients interviewed – 147
- Clients in focus groups – 264
- Charts reviewed - 92

Methodologies used for providers included:

- Providers surveyed – 155
- Providers interviewed – 31
- Providers in focus groups - 26

One of the things we learned from the initial iteration of this process is that there is a greater need for uniformity in the process to ensure that the data can truly represent statewide needs. Thus, the AIDS Care Program will be developing uniform standards, *in conjunction with our provider community*, for the completion of future needs assessment efforts.

The majority of the needs that were identified in the individual assessments revolved around the provision of services. Frequently, this was couched in terms of needing more of something, or an expanded range of something. This is still useful information because it does identify what people/organizations are identifying as the service needs of infected individuals. Other needs are couched in terms of what an organization needs to adequately perform a function and/or provide services. Lastly, a subset of needs addresses systemic issues, those activities which combine to make the entire system more effective for improving the process by which individual events occur.

It should also be noted that the needs identified through this process, and listed below, closely resemble the needs identified in the 2009 AIDS Care SCSN and the 2005-2008 HIV Prevention Comprehensive Plan. This should not be taken to mean that progress in addressing these issues has not been made; quite to the contrary, significant progress has occurred; however, it means that these needs are on-going and crucial to addressing the HIV epidemic.

As an example, major progress has been made in ensuring access to treatments for those who are HIV infected. However, just because such progress has been made does not mean that provision of medications is no longer a need/priority. Our capacity to maintain access to these medications for those receiving support, and where possible to

extend support to those who currently do not qualify for assistance, is crucial to continuing our progress in combating HIV/AIDS.

System/Infrastructure Needs

AIDS Care

Regional Networks of Care

The prevailing need which came out of the 2009 SCSN was to redesign the HIV/AIDS care delivery system into an integrated mechanism which focused on improving the health outcomes of the infected individuals which it serves. Since the inception of the RW program, North Carolina had worked through an HIV Care Consortia model, which served well during the early years of the program, but which was increasingly demonstrating a lack of capacity to provide an integrated care strategy required by this population (it certainly did not help the Consortia model when the Ryan White Treatment Modernization Act of 2006 mandated that Consortia-provided services could no longer be counted as core services, which needed to account for at least 75% of any State's total service dollars). This recognition had been growing for some time, and the Communicable Disease Branch (CDB) had already begun work on developing a mechanism to replace the Consortia model.

The Regional Network of Care Model, with its focus on improved patient health outcomes, was realized with Ryan White Part B program funding in April, 2010. Ten Regional Networks covering 95 of the State's 100 counties (the 5 counties in the Charlotte/Mecklenburg area were funded separately by HRSA through the Part A TGA program) were officially contracted to provide RW Part B services and associated planning, coordination and evaluation activities. One of the Networks was not able to develop a functional system of care during the first year of funding. Limited services for clients in that Network region were paid for via a contractual arrangement with another Regional Network, and the contract for this Network Region was issued to another provider effective April 2011.

This shift to a comprehensive system of RW HIV Care program management/ service provision continues to be identified as a major need to be addressed. While the system has been implemented, it is still in the early stages of development. Tasks still remain to be accomplished to ensure that the Regional Network concept and the policies and procedures to maintain these new entities are fully implemented (examples include completion of monitoring requirements based on the new HRSA Monitoring Guidelines, standardization of required contractual processes such as local needs assessments, and complete implementation of data sharing throughout the State). Thus, the development of the Regional Network system continues to be an identified need for North Carolina.

Co-Located Services

Both clients and individuals working within the care system have previously identified, and continue to identify, a strong need to bring the provision of a variety of services together in one place (or at least to locations that are very close to each other). Often referred to as a “one stop shop”, this refers to bringing a variety of related services together in a common location. The rationale for this is to enable clients to address a variety of service needs during the course of a single service visit. Examples of such services include outpatient/ambulatory care, oral health care, mental health and/or substance abuse services and case management (both medical and non-medical). The argument for this is obvious: having a variety of co-located services will make it easier for clients to see multiple service providers during a visit, increasing their ability to have these needs addressed. It will also make it easier to arrange transportation, decreasing the cost of providing that transportation.

This is not always an easy goal to accomplish. At times, organizational barriers serve to hamper this effort. Other barriers may include space and other resource considerations. Several providers who had participated in the previous system of care, and who have become part of one or more Regional Networks, have implemented varying levels of co-location for the services that they provide, with very positive results. And during the past year, one Regional Network has managed to begin assembling a variety of services within a common facility. The process has not always been easy or smooth, but the response of both clients and providers to these efforts has been very positive.

Integrated Information Systems

The need for integrated information systems to bolster service provision efforts continues to be evident. Establishing multiple-service appointments for clients and ensuring that current client records are available during these visits are especially important. And while progress has been made, the need for further efforts in this area continues to exist. The SPNS NC-LINK award (previously described) will be addressing this need.

Practice Enhancement

HIV/AIDS care practice has changed very significantly in the nearly 25 years since this epidemic was first identified. In the early days, practice focus was on keeping positive individuals comfortable and alive (usually for very short periods of time). Rapidly improved clinical practice and an emphasis on providing medications have greatly increased the life span and positive existence of PLWHA. And we can only believe that changes in care will continue to evolve at a rapidly increasing rate.

A significant element in these improvements has been a cadre of dedicated practitioners who have kept up with advancements in treatment protocols, and the medications

which have been an important component of this change. And, a key component in ensuring that practitioners are kept aware of these advancements are the RW-funded AIDS Training and Education Centers. In this State, the NCATEC has been an important element in providing necessary information and education to HIV/AIDS care practitioners. The AETC has worked with the State and its many partners to ensure that important and current information is made available to those who serve this population. We recognize the importance of this activity, and the need to ensure that it continues to be available.

Administrative Resources

We have been reminded that there was neglect in mentioning the need for additional administrative resources. This has been a consistent part of our needs assessment for many years, and its omission was indeed regrettable. With federal administrative requirements continuing to expand, the need for increased resources to address those needs is at a critical level. Unfortunately, the RW legislation specifically constricts the use of funds for administrative purposes to 10% of expenditures, a level which has not changed since the program's inception. The State has continually requested that something be done to change this limitation, and we will continue to do so. Our subgrantees are reminded that the RW legislation is due for reauthorization, and suggest that subgrantees contact their federal legislators to educate them on the need to increase the level of funds allowed for administrative purposes.

Service Needs

Medications

Probably the greatest advances in the nearly 30 year history of this epidemic are the changes brought about by the many HIV-specific medications which have been developed and made available. What was once an almost certain death sentence has now been transformed into a chronic disease, and clients are living long lives; often, it is some of the diseases more commonly associated with age (cancer, heart disease and diabetes) that cause their death, rather than the diseases associated with HIV infection.

Congress and HRSA have recognized the importance of medications by allocating a major portion of the Part B program for the purchase of these lifesaving treatments. It is equally important that this document recognizes the crucial role that these treatments play in the lives of clients, and declares that the provision of critical medications continues to be a clearly recognized, high-priority need for the State of North Carolina.

Clients generally do not have great difficulty accessing the State's HIV medications program (ADAP). HIV-positive clients with incomes at 300% or below of poverty level and no other support for the purchase of medications (such as private insurance) currently may be admitted to the program. Those who do not qualify for ADAP are

provided assistance in accessing alternative methods of obtaining medications. However, while clients generally do not have difficulty accessing support for HIV medications (and they do so in great numbers, with more than 6,000 individuals currently accessing ADAP), they do so because this has been recognized in the past, and continues to be recognized, as a great need.

Where there is more of a need, however, is access to non-HIV medications. ADAP can only pay for those medications listed on its official formulary, and these are primarily for the treatment of HIV and some associated conditions. Individual providers try to provide fill-in assistance for the purchase of non-HIV medications as resources allow, but these are generally at levels far below what is needed, and are provided in limited situations. And, per RW rules, there is limited support for over-the-counter treatments. Thus, both clients and providers have identified a need for non-ADAP medications.

Provision of Medical Care

Along with medications, the provision of high quality medical care has become a cornerstone of the Ryan White program. Whether delivered as primary care, infectious disease care or specialty medical care, these services provided in an outpatient setting are a crucial component of the Part B program, are the primary basis of the Part C program, and are vital components of the Part A and Part D programs. HRSA/HAB and the legislation both emphasize the importance of providing on-going medical care to HIV-infected individuals.

Again, clients do not generally acknowledge the need for primary medical care, because it is available to them and they access such care. Providers agree that this is the case, although many providers have acknowledged that they are fearful that resources (which they expect to be cut back in the future) will not be able to keep pace with the burgeoning need caused by ever growing populations of infected persons, and the need to provide increased levels of medical care services.

The situation with regard to infectious disease and specialty care is a different matter entirely. A greater proportion of clients have indicated that there is greater difficulty in accessing these types of care. It is unclear at this point whether this might be a client misperception as to the need for such care, a shortage of qualified providers capable of providing such care, or a scarcity of resources to support such care (most likely, it is a combination of all three). This is obviously an area which will require further study.

Transportation

As has been the case in the past, transportation is one of the highest ranked needs by both clients and providers. North Carolina is a very large state geographically, and much of the state is considered rural, with few if any public transportation options.

Much of the state's transportation is based on the automobile, which is not an option for individuals who are economically challenged.

Clients particularly (both those who are insured and those who are uninsured) have identified transportation issues as particularly problematic, especially in light of more restrictive rules brought about by the increasing scarcity of resources to support this service. Specific issues reported by clients include: increasing complexity around scheduling of transportation services; major increases in the amount of time needed to schedule transportation; and increasing time spent in actual transport as schedules are significantly reduced. Many of these issues are causing clients to reduce the frequency of attendance at medical appointments, with a concomitant decrease in the health status for the affected individuals.

In addition, transportation is designated as a support service, and therefore subject to the maximum 25% limitation allowable for support services. This is far below what the need would dictate. The State of North Carolina again calls for a reevaluation of this legislative language, and requests that transportation to medical care be considered as a core service. In this regard, one of the suggestions to institute mobile care vans as a means of making care more available in the community would far exceed the availability of the limited resources.

Housing

Housing has proven to be an effective intervention strategy for improved health outcomes. An individual who does not have access to adequate housing has a lower chance of being seen regularly in health care, correctly taking their medication, maintaining a proper diet and complying with the many other requirements for maintaining their health.

The resources to address this issue are very limited. As with transportation, housing is a Ryan White support service, with the funding limitations of that designation. In addition, the types of activities which can be supported by RW are limited primarily to short-term emergency types of support. Housing is a very expensive proposition, and not something that the RW program is well equipped to address.

The Housing Opportunities for Persons with AIDS (HOPWA) program, funded by the Department of Housing and Urban Development (HUD), is specifically designed to deal with housing issues for HIV/AIDS-infected individuals. It can assist these individuals with a broader range of services, which do not have many of the constraints of the RW program. However, the resources committed to this effort are not sufficient to fully meet the existing need.

The US Department of Housing and Urban Development (HUD) set a goal for HOPWA that by 2012, 90% of HOPWA clients served should maintain permanent housing and

this goal should increase by 1% each subsequent year. All of our HOPWA Project Sponsors within the Regional Networks of Care are required to provide Tenant-based Rental Assistance and Short-term Rent, Mortgage and Utility Assistance.

NC HOPWA Eligible Activities include:

- **Tenant-based Rental Assistance (TBRA)** – Monthly rental subsidy that pays the difference between Fair market Rent (FMR) and the amount a tenant contributes towards rent. TBRA is tied to the tenant and may be used with private landlords, housing authorities or other rental units. TBRA has less stringent guidelines than the Section 8 program, but Housing Quality Standards still apply and the rent amount is based on client income. Clients with or without income are eligible to participate in the program.
- **Short-term Rent, Mortgage and Utility Assistance (STRMU)** – Payments used to “prevent homelessness. The amount of assistance varies among the Regions depending on the availability of funds, based on tenant needs, and program guidelines. A funding cap per client may be established by the network and is usually equivalent to two monthly rent payments. STRMU cannot be used to pay first month’s rent or security deposits and assistance is limited to 21-weeks in a 52 week period. Assistance can only be paid to a third party such as the landlord, mortgage company and utility company.
- **Supportive Services (SS)** – Services that help clients maintain stable housing. These services include mental health and substance use treatment, case management, food assistance and transportation.
- **Operating Costs (OC)** – Funds used to support licensed facility-based housing such as family care homes or group homes. These funds can be used to cover the following costs: facility maintenance, insurance, upgrading appliances, utilities, rent, supplies and incidental expenses such as repairs.
- **Housing Information (HI)** – Services that include but are not limited to developing directories of affordable housing units in a region and providing referral services to assist an eligible person to locate, acquire, finance, and maintain housing. This may include activities such as fair housing counseling for eligible persons who may encounter discrimination on the basis of race, color, religion, sex, age, national origin, familial status or handicap.
- **Resource Identification (RI)** - Funding for this activity is used to help agencies establish, coordinate, and develop housing assistance resources for eligible persons. Examples of RI are conducting preliminary research to determine the feasibility of specific housing-related initiatives and building

and maintaining relationships with landlords and the local housing community with the goal of placing clients into units.

- **Administration** – Up to 7% of the total amount of HOPWA funds allocated to the region can be budgeted for Administrative Expenses such as programmatic and fiscal oversight, supervision, reporting requirements and assuring adherence to the HOPWA HUD applicable regulations.

Oral Health Care

This is a service that is increasingly being identified by both clients and providers as a high need service, in part because HIV-infected individuals are living longer and healthier lives. The link between oral health and general health has been increasingly stressed, and this linkage has had an impact within the HIV community.

All evidence points to a lack of resources to meet this identified need. Although the Regional Network guidance requires all Networks to assure the provision of oral health care, there appears to be a lack of dental practitioners who are willing to treat this population, particularly in rural areas. Supply is not adequate to meet demand, particularly dentists enrolled in Medicaid (it should be noted that obtaining dental care is a problem for all populations in the State).

Food and Nutritional Care

As infected individuals are living longer and healthier lives, they are becoming increasingly aware of the importance of nutrition as an element of maintaining their health. Thus, clients recognize that nutrition impacts their ability to stay healthy, and they seek information on where and how to get appropriate foods.

Providers are also increasingly aware of this connection, and are seeking ways to provide this information within the context of their program structures. Again, there is a limited amount that Ryan White can do in this regard. Food banks and home delivered meals, as a support service, are limited to the maximum 25% expenditure rate. Additionally, due to the impact of the economic crisis on the availability of alternative resources, the capacity to access this service has become increasingly more difficult. Nutritional counseling services when delivered by certified providers allow for the distribution of nutritional supplements as part of core services, but again scarce resources limit a program's ability to match the need which exists.

Emergency Financial Assistance

Clients at the lower end of the socio-economic spectrum have always had a need for this type of assistance, and this continues to be an identified need. Given the current state of the economy, it is not surprising that this need persists. However, the

limitations caused by the 25% maximum on expenditures for support services greatly constrains the ability to address the level of need which exists.

Effective Case Management

As both clients and providers have gained more experience with Medical Case Management, they have come to see the advantages of this more comprehensive, better coordinated service. Clients want to know that their case managers are doing all they can to ensure that the services they receive are provided in the most complete and effective manner possible. Many now seem to be aware that the case management services they had been receiving under previous systems were not as helpful as could have been expected, and that these revised methods could help to improve their health outcomes.

Providers similarly recognize that they are playing a more central role in the supportive care of the clients they serve, and that these activities can lead to enhanced health outcomes for their clients.

Mental Health/Substance Abuse

These two service needs are often identified together. This is because the two needs are frequently co-identified in clients, the treatments are often considered in a combined context, and in many instances, the practitioner is the same. In addition, while it is very possible for an individual with mental health issues to be free of substance abuse issues, it is highly unusual for a substance abuser to not have a mental health issue.

As has been true for a number of years now, North Carolina's mental health/substance abuse system has been in a state of flux, with the availability of services highly dependent on local systems operated by the State. As is the case with much of health care that is supported through State auspices, services tend to be fragmented and under-resourced, and constantly undergoing change.

But there is no doubt that mental health and substance abuse have a large impact on a positive person's capacity to address their medical conditions. Persons with mental health/substance abuse issues are less likely to maintain medical visit appointments, or comply with complex medication regimens. In addition, they are more likely to engage in behaviors which increase the likelihood of HIV transmission.

Psychosocial Support, including Support Groups and Spiritual Support

Many clients have expressed the need for various forms of psychosocial support, particularly support groups. They have noted that this is one of the only times that they can talk about their disease with people who understand what it is all about. Groups

provide a forum for them to raise the issues brought on by stigma and prejudice, and to get feedback from other clients who may have experience with some of the same issues.

Related to this is the need for spiritual support. As noted above, many infected persons feel alienated from their religious/spiritual institution. At this time when they are particularly in need of support, they believe there is no place they can turn to for the spiritual help they require.

Child Care

Women particularly have identified the need for child care. This would be especially important to a mother who is trying to keep a medical appointment.

Treatment Adherence Counseling

Adherence to increasingly complex HIV medication regimens is critical to ensuring the effectiveness of these medications. Often, this is accomplished within the context of a medical care visit, by either medical practitioners or experienced medical case managers.

The importance of adherence to treatment regimens cannot be stressed enough. Every effort in every possible service venue should be made to communicate this message.

Legal Assistance

The provision of legal assistance to HIV-infected individuals has been a long-term identified need in North Carolina.

Such assistance can take many forms, depending on the need of the person requesting assistance. It may involve drafting a power of attorney for an HIV-infected mother whose children will need care when she is no longer able to provide it, drafting a discrimination action for an infected person who has been denied a job because of his infection, or drafting a lawsuit to obtain SSI/SSDI for an infected person no longer able to work.

Some training on the application of legal concepts as they apply to HIV-infected persons is also an important component of the work performed by many individuals who work with this population, and they need to have the knowledge to appropriately identify issues needing to be addressed.

Special Populations

Frequently during the course of this needs discussion, the issues of the needs of special populations have been raised. These populations span a wide range of sub-groups, including:

- Women
- Infants
- Children
- Youth, particularly those who are aging out of the child care system into the adult system
- Non-English speaking minorities
- Lesbians, gays and transgendered persons
- IV and non-IV drug abusers
- Aging HIV/AIDS infected individuals

Special populations have always presented difficulties in ensuring the provision of services. Many special populations, such as transgendered persons or young MSM of color, do not like to use existing services because they feel that these service providers do not have the knowledge or empathy to deal with them. The State has instituted requirements that all providers must deal with all qualified positive individuals in a competent and caring manner. In addition, every effort is made to engage and encourage all special populations to seek the care they need.

Some of the responses to our questionnaire focused on several special populations, such as the aging, suggesting that not enough emphasis was focused on some of these groups. We have always believed that a focus on special populations should be a response of the local HIV care system (Regional Networks of Care), as what these special populations are and require would vary from region to region. Although we acknowledge that services for women, children, children who are aging out of the youth system and into the adult system, adoptees from overseas countries, immigrant Latino populations and other special groups have differing sets of needs, it is the local regional network which must make the decision on what the specific needs of that population are and how to apportion its scarce resources among the many competing groups vying for those resources.

It is the State's role to say that we recognize that there are many populations which have special needs because of unique characteristics. And we believe that in recognizing all of these special needs groups, we have enabled each region/provider to determine what those special needs are and how to allocate its resources to address these special needs populations as resources permit.

The above listing of HIV/AIDS care needs represents the efforts of a broad range of participants to review the current state of HIV care and help develop future directions for North Carolina.

Although the HRSA needs assessment guidance does not call for prioritization of needs, we asked our participants in this process to provide us with a comparative ranking of needs. The results from the respondents are summarized in the following table.

	Priority Ranking	Services
HIGHEST	1	Provision of Medical Care
	2	Medications
	3	Housing, Mental Health/Substance Abuse, Transportation
	4	Oral Health Care
	5	Effective Case Management
	6	Food & Nutritional Care, Emergency Financial Assistance, Psychosocial Support, Treatment Adherence Counseling
	7	Health Education/Prevention Education
	8	Child Care
LOWEST	9	Legal Assistance

This prioritization is consistent with what our community has been indicating for many years as the most significant care needs: medical care, medications, housing, mental health/substance abuse and transportation.

Each regional Network was required to provide a list of the needs identified in its own needs analysis. Those needs, along with the needs identified by the TGA, are summarized in the two following tables:

Table 1

Service Needs Identified by Clients during Needs Assessment Activities

Region	Needs Identified by Clients										
	1	2	3	4	5	6	7	8	9	10	TGA
Services											
Ambulatory/Outpatient Care			X	X		X			X	X	X
Medications											
Housing	X		X	X			X		X	X	X
Mental Health/Substance Abuse	X	X	X	X		X				X	X
Transportation	X		X	X	X	X	X	X	X	X	X
Oral Health Care		X	X	X	X	X			X		X
Effective Case Management			X		X		X	X		X	
Food & Nutritional Care			X				X		X	X	
Emergency Financial Assistance		X	X				X		X		
Psychosocial Support								X			
Treatment Adherence Counseling											
Health Education/Prevention Education						X	X			X	
Child Care								X			
Legal Assistance			X								
Employment	X										
Vision Care		X	X								
Dialysis											
Jail/Prison Services											
Non-HIV Medications			X			X					
Support Groups			X	X					X	X	X
Outreach											X
Financial Support				X							
Jobs				X							
HIV Medications				X							
Convenient Scheduling										X	
Specialty Care						X	X				
In-patient substance abuse											X

This table details the service needs identified by clients during their participation in Regional and TGA needs assessment processes. As has been noted previously, Ambulatory Outpatient Medical Care, Housing, Mental Health/Substance Abuse Care, Transportation and Oral Health care tend to be priorities for clients. Medications was not identified as a need by clients, but we believe that is because there is an expectation that ADAP is doing the job it is supposed to do, and will continue to be available to serve clients.

Table 2

Service Needs Identified by Providers during Needs Assessment Activities

Region	Needs Identified by Providers										
	1	2	3	4	5	6	7	8	9	10	TGA
Services											
Ambulatory/Outpatient Care			x	x			x			x	x
Medications						x					x
Housing	x	x	x	x			x		x	x	
Mental Health/Substance Abuse	x	x	x			x		x	x	x	x
Transportation	x	x	x	x	x	x	x	x		x	x
Oral Health Care		x	x	x					x	x	x
Case Management			x		x					x	
Food & Nutritional Care		x	x							x	
Emergency Financial Assistance			x				x				
Psychosocial Support											
Treatment Adherence Counseling				x							
Health Education/Prevention Education				x		x					
Child Care					x					x	
Legal Assistance			x							x	
Employment										x	
Vision Care		x	x								
Dialysis		x									
Jail/Prison Services		x								x	
Non-HIV Medications			x								
Support Groups			x			x				x	
Financial Support											
Jobs											
HIV Medications											
Convenient Scheduling					x	x					
Rehabilitation		x									
Medical Case Management/Treatment Adherence				x							x
EIS				x							
Specialty Care						x	x				x
Pharmacy Assistance							x				
Health Insurance								x			
Nutritional Counseling									x		
HIV Testing									x		x
Prenatal Care										x	
Linguistic Services										x	x

This table outlines those needs which service providers selected as being the most crucial for their clients. It appears that their selections were based on their assessment of the most difficult to obtain service needs: Housing, Mental Health and

Transportation. Just as was the case with clients, service providers did not list Medications, probably reflecting a belief that this need is relatively simple to meet.

Barriers to care – Although much has been achieved over the last several years in eliminating/reducing barriers to care, several roadblocks still remain. A significant issue in North Carolina is the requirement that the Medicaid cap for services (where such services exist in Medicaid) must be utilized. This is a particular issue for oral health care. North Carolina has a relative scarcity of dental professionals, particularly in the more rural areas which comprise a significant portion of the State. And many of these practitioners are hesitant to see HIV-infected individuals. When adding in the Medicaid restrictions on reimbursement, there are even more impediments to ensuring the provision of such services. Some recognition needs to be given to the difficulty in finding practitioners who are willing to provide these services, and making it possible to provide incentives to encourage such care provision.

In addition to being a high priority service need, adequate transportation availability can also serve as a barrier to care. Particularly among certain populations (those who live in rural areas and migrant/seasonal workers, for example), inadequate transportation systems not only limit their ability to access care services, but the full range of living activities as well. Although the use of RW funds to address these difficulties is limited both by the service definition and the levels of resources which can be committed to support services, it is important for the service system to recognize them and try to find alternative resources to address those gaps.

Housing needs ranked number 3 in the in prioritizing our community needs and the lack of stable housing contributes as an added barrier to care. It has been proven that housing is an effective intervention strategy for improved health outcomes and the need for affordable housing and housing resources remains a need in North Carolina. With Section 8 waiting lists being 2 plus years long and in some instances closed, the challenges in identifying affordable housing and landlords willing to participate in the HOPWA program are a barrier to care.

Gaps - Many of the providers and infected/affected individuals who participated in this identification process also spoke to the question of gaps. However, this discussion was phrased not so much as specific services being unavailable, but more that there were not sufficient resources to address the various needs which were identified. This acknowledgement of the scarcity of resources takes a number of forms: the importance of a specific set of services over another set of services (HIV medications and direct medical care vs. financial assistance and food assistance); legislative requirements, such as the RW requirement that at least 75% of service dollars must be spent on “core” services vs. a maximum of 25% for support services; and spending for much more expensive care services vs. less expensive prevention efforts. The fact is that we are consistently required to make resource allocation decisions between a constantly expanding set of competing needs.

Overlaps – At this time we have not identified many overlaps in care. Each Regional Network has been asked to review the mix of services and providers in its region to ensure that duplicate services are identified and minimized. Obviously, many clients will try to maximize the levels of service they receive, and “shop around” in order to do so. We expect to minimize a client’s capacity to do so by improving our data dissemination capabilities. By implementing regional data sharing, it will be possible for any provider to see what services have been provided to any client, and thus curtail the likelihood of overlaps in service.

Similarly, by opening up data sharing on a statewide basis, we are seeking to minimize the possibility that clients may receive duplicative service by crossing into another region. Obviously, any individual’s ability to obtain services in another area is lessened by their capacity to travel to that area to obtain a service. But we know that highly motivated individuals find ways to get around obstacles. By ensuring that statewide data sharing is operational, we expect to minimize the possibilities that this can occur.

Underserved populations – As noted previously, North Carolina’s RW Part B program, as well as all other programs in the State funded by RW, are open to all individuals who otherwise qualify to receive services (provided, of course, that the resources are available to offer those services). Although there may be a number of reasons why we have underserved populations (lack of knowledge about service availability; stigma; prejudice), information presented by clients and their advocates would seem to focus on two particular issues: these individuals are reluctant to participate in the care system; or the resources are not available to provide the non-core services they are looking for. In regard to the latter, we strongly encourage and work with providers to develop and implement more cost-efficient methods for service provision so they can provide more service with the available resources; and to seek out additional resources to assist in covering the cost of needed additional services. The Branch’s increased emphasis on Bridge Counseling will focus on those who are not receiving care, whether or not they know their HIV status. Bridge Counselors will be looking for those who are known to be positive but not known to be receiving care, and focus on activities designed to engage/reengage these individuals in care. Another component of their work will be to determine persons at high risk, get them tested, and bring those who test positive into the care system.

Health care work force – We believe that the most significant work force issue is the difficulty in attracting qualified individuals to work in rural areas. HIV care has been a specialized area for many years now, and there is still a scarcity of individuals who have the requisite skills to provide such services. And rural areas have even greater difficulty in attracting and keeping such individuals. More assistance is needed in getting qualified individuals to agree to work in these areas, and in providing the specialty training needed to improve and maintain their skills.

As noted previously, provider education is a critical component of ensuring that clients receive the best possible care. But current, up-to-date knowledge is not only important for the medical care practitioners who serve our clients. Individuals in all components of the HIV/AIDS workforce require improved education and practice skills so that their clients can get the best possible service to keep them healthy and functioning at high levels for as long as possible.

One respondent suggested that emphasis needed to be placed on identifying and training peer educators, both MSM and non-MSM. Peer educators are an excellent mechanism for engaging community-based individuals in working with the populations we serve. Attention will be given to determining whether any mechanisms can be established to achieve this goal.

A recently completed needs assessment update by the Region 10 care program reported that the most frequently utilized client services were: substance abuse/mental health treatment, medical case management and nutritional counseling; services identified as being needed the most were dental care and provision of eyeglasses. Stigma continued to be an important issue for patients, signified by the desire to change the clinic's name to something avoiding the use of HIV and AIDS. The tightening of Medicaid transportation availability was cited as a barrier to care.

The Charlotte-Gastonia-Concord TGA conducted an Access to Care Needs Assessment study earlier this year. More than 100 TGA clients were asked to assess their service needs, and the following represent the needs most frequently cited:

- Medication adherence
- Medical care
- Housing
- Healthy lifestyle/overall wellness
- Employment/income

In addition, these clients were asked to cite service barriers, and the following represent the barriers most frequently cited:

- Housing
- Medical care
- Medications
- Insurance
- Dental health service
- Health insurance

Not surprisingly, many of these needs and barriers have been consistently identified as such over the course of many years throughout the State; this speaks to the complexity

of these issues, and the on-going need to bring a variety of resources together to effectively address the needs of our clients.

HIV Prevention Needs Assessment

HIV Prevention Resources

North Carolina HIV/STD Prevention & Care aims to:

Eliminate morbidity and mortality due to sexually transmitted diseases - syphilis, gonorrhea, Chlamydia, and HIV/AIDS; and assure that an up-to-date continuum of care services is available for all HIV-infected individuals residing in North Carolina.

Overview

The North Carolina Communicable Disease Branch supports free HIV/STD testing, linkage to care services, health education and risk reduction activities, as well as treatment in many diverse settings, including community-based organizations (CBOs), Local Health Department (LHD), substance abuse centers (SAC), Historically Minority Colleges and Universities (HMCUs), hospitals and correctional facilities. Funding from the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMSHA) and State appropriated funds supports CD Branch partners in implementing these activities.

Programs and Services

PCRS, Surveillance and Field Services:

The Branch employs 35 Disease Intervention Specialists (DIS) across the state to provide partner counseling and referral services (PCRS) for HIV and syphilis. DIS activities are intended to intervene in the spread of disease through the follow-up of individuals infected or exposed to HIV or syphilis in order to facilitate timely testing and treatment. Disease Intervention Specialists assist newly diagnosed STD- and HIV-infected individuals with informing their partners of their status and encouraging those partners to seek counseling, testing, treatment and related prevention services. Additionally, following the findings of the HPTN 052 study which showed that treatment is prevention, the DIS prioritize linkage and/or reengagement to medical care for all HIV-positive clients. The N.C. HIV/STD Prevention program staff also administers the STD/TB drug shipment program to assure availability of appropriate drugs for STD or TB treatment at no cost to all local health departments in North Carolina.

In North Carolina, all persons diagnosed with HIV or syphilis are reportable by law and are referred to DIS for follow up to include PCRS services. The North Carolina Administrative Code — 10A NCAC 41 .0202 (13) and .0204 (c) (3) — requires the Division of Public Health to conduct partner notification programs for both HIV and syphilis. To support local health departments in this effort, specially trained DIS staff from the Communicable Disease Branch's Field Services Unit work with local health

departments to perform HIV and syphilis PCR services. This is done through seven HIV/STD Regional offices across the state.

Once notified of a laboratory-confirmed case of HIV or syphilis, a Field Services DIS works with the county health department and, under the authority of the local health director, performs HIV/STD PCR and disease intervention case management services to include locating infected patients and exposed partners and providing assurance that patients are referred to proper treatment and examination. The Disease Intervention Specialists also conduct screening activities, ensure proper reporting from providers, conduct provider training on HIV and STD issues and follow up on control measure violators. Another important activity of the HIV/STD regional offices is insuring that HIV-positive individuals receive HIV initial care visits. There are seven State Field Service regions, and all but one have a dedicated HIV Bridge Counselor, who assure that all persons newly identified with HIV in their regions attend their initial HIV care visit (the only one without a Bridge Counselor has a DIS who functions in a Bridge Counselor capacity).

The Field Services Unit performs the following activities:

- Interview, notify and counsel patients diagnosed with syphilis/HIV as mandated by North Carolina Public Health Law;
- Ensure treatment to patients diagnosed with syphilis and other sexually transmitted diseases;
- Provide consultation to local health care providers about sexually transmitted disease control measures;
- Maintain effective disease intervention-based collaborations with community partners; and
- Ensure that newly diagnosed HIV clients are linked into care and refer those who have fallen out of care back into care services.

Data used in lawful disease investigation and notification executed in DPH duties is confidential and protected as described in the monitoring and evaluation section of this document.

HIV RNA Testing Program:

The Screening and Tracing Active Transmission (STAT) program is a continued Branch initiative in collaboration with UNC Hospital. The purpose is to improve HIV prevention and care by enabling the State Laboratory for Public Health to detect individuals who likely are newly infected with HIV via HIV RNA testing and to provide this information to disease intervention specialist (DIS) with the Field Service Unit of the Communicable Disease Branch. From January 1, 2011 through December 31, 2011, 28 STAT cases, plus 11 false positive cases were identified. DIS were able to locate, interview and

follow up all but 1 STAT Acute HIV patient to seroconversion. Plans are to continue this project into 2012 and for the next three years.

Local Health Department Agreement Addenda:

The Communicable Disease Branch provides funding for all 88 NC Local Health Departments to support their HIV/STD education and testing activities. These funds are outlined in local agreement addenda that require LHDs to provide annual reporting on various HIV and STD clinical related outcomes as well as to provide free STD and HIV service. All local health departments in NC will be given these funds in 2012 through LHD agreement addenda and for subsequent years dependent upon CDC funding.

HIV/STD Prevention Community Planning:

The CD Branch merged the Statewide Community Planning Group and the AIDS Care Unit Advisory Committee (ACUAC). The newly formed group is called the HIV Prevention Care Advisory Committee (HPCAC), and serves as the statewide advisory board to provide community oversight and input into CDB HIV/STD Prevention and Care activities. This group is composed of community members, HIV providers, representatives from funded agencies and HIV positive persons who meet on a quarterly basis to provide input into CD Branch's HIV Care and HIV/STD programming. The mission of this group is to provide advice, support, and communication regarding HIV/STD prevention and care issues to the HIV/STD Prevention and Care Unit and community at large. They also seek to integrate HIV/AIDS Prevention and Care programs to develop a more coordinated continuum of HIV Care and Prevention services throughout the State.

HPCAC will continue to play a vital role in guiding programmatic decisions and activities in 2013 and subsequent years. HPCAC plans for 2013 include recruiting new members, strengthening the subcommittee roles, and continued input into the HIV Prevention jurisdictional and comprehensive plans.

Evidence Based Intervention Services (EBIS):

The N.C. Communicable Disease Branch's HIV/STD Prevention and Care Unit funds twelve agencies to conduct Evidence Based Intervention Services (EBIS) activities. The activities provided by those grantees include client centered and group level interventions, and prevention with positives that are done through CDC approved evidence based interventions. They also fund historically black colleges to provide peer education, outreach and testing services to the students on campus. The goal is to raise awareness, educate, foster dialogue, and provide technical assistance and capacity-building support to address individual and collaborative HIV/STD prevention needs through the most effective means. Participants learn about the impact of HIV/STD on

young adults, especially in communities of color, and identify needs and community resources that enhance HIV/STD prevention activities on two HBCU campuses. During 2013, 7,190 students received HIV/STD information through this project and 655 were tested for HIV/syphilis and 432 for gonorrhea/Chlamydia.

All funded EBIS intervention activities related to HIV/STD prevention should contribute to and complement the overall goal of reducing high-risk behaviors. Ultimately, health education and risk reduction aims to increase positive changes in behavior. In the first half of 2013 January-May, 326 participants/clients completed the following evidence based interventions; CLEAR - 38 participants, Hermanos de Luna y Sol – 6 participants, SISTA – 21 participants, VOICES/VOCES – 91 participants, RESPECT – 74 participants. New agencies were funded in June 2013 for the grant cycle 2013-15. Beginning in June 2013, the new agencies had 223 participants complete the following evidence based interventions: Mpowerment- 53 participants, VOICES -122 participants, Focus on Youth + Impact -20 participants, and SISTA - 28 participants. EBIS activities will be continued into 2015 dependent upon CDC funding. The CD Branch monitors and provides capacity building, TA and support services to funded agencies which are detailed in the HIV prevention comprehensive plan.

HIV/STD Testing

The North Carolina Communicable Disease Branch supports confidential free testing and treatment in many diverse settings, including community-based organizations (CBOs) and correctional facilities, as well as in local health departments. Maps of where all supported testing locations are located are available upon request. The programs below constitute North Carolina's public HIV testing strategy:

Integrated Targeted Testing Services (ITTS) Project

The North Carolina ITTS project was created to address barriers to HIV/STD testing through collaboration with community-based organizations (CBOs) and the integration of expanded HIV/STD services outside of traditional public health settings. This project provides HIV/STD counseling, testing, linkage to care and referral services to at-risk populations in easily accessible community settings – public housing developments, homeless shelters, substance abuse centers, nightclubs, colleges, and detention centers – during non-traditional hours such as evenings, nights and weekends. Funds from CDC and N.C. Communicable Disease Branch provides support to twenty-two agencies for conducting confidential HIV, syphilis, chlamydia, gonorrhea and hepatitis C testing. These agencies provide testing in sites that are frequented by people at high risk for HIV/STDs or by members of populations with high HIV/STD prevalence. ITTS projects educate people about the risks of hepatitis C and refer them for testing. They also ensure that people who are HIV-infected are successfully linked with HIV medical care and psychosocial services through active follow-up and referrals through local or regional care coordinators who can make calls to providers, arrange transportation and/or provide

other support. The CD Branch released an RFA in November of 2012 and twenty-two agencies were funded for ITTS activities for three years beginning in June of 2013. The CD Branch monitors and provides capacity building, TA and support services to these funded agencies that are detailed in the HIV prevention comprehensive plan. See 2012 ITTS outcomes below.

**Chart 1
ITTS Testing Outcomes 2013 (preliminary data)**

	TESTS	POS	NEW	PERCENT POS	PERCENT NEW
HIV*	19,875	130	61	0.7%	0.3%
SYPHILIS	15,662	188	-	1.2%	
GC	5,483	77	-	1.4%	
CT	5,483	434	-	7.9%	
HEP C	3,089	134	-	4.3%	

HIV Rapid Testing:

The Rapid Testing Program was created to increase the number of high-risk individuals being tested for HIV and to disclose preliminary test results to individuals who might not return for a traditional blood test result. Rapid tests can be processed in 10-20 minutes, making it possible to provide HIV education, preliminary HIV test results, and linkage to care in the same day. The Rapid Testing Program, which is supported by both state and federal funds, provides HIV test kits for thirty agencies. The N.C. Communicable Disease Branch provides free rapid-test kits to CBOs, local health departments, federally qualified health centers, and universities to conduct confidential HIV testing in both clinical and non-clinical settings. These sites submit a standardized data set on all those tested and maintain protocols determined by the CD Branch on use of these kits to maximize the efficient and appropriate use of the kits. Preliminary data for 2013 show that an estimated 15,941 persons were tested with rapid HIV kits, 164 were confirmed positive and 77 were new. The overall positivity rate was 1% (0.5% new). The CD Branch will continue to support HIV rapid testing sites in NC and will attempt to add more sites as funding allows. Plans to monitor and provide capacity building, TA and support services to funded agencies are detailed in the HIV prevention comprehensive plan.

HIV Counseling and Testing in Substance Abuse Centers:

The N.C. Communicable Disease Branch provides funds to 9 CBOs and local health departments across the state to conduct HIV/STD testing in over 50 substance abuse facilities. The substance abuse centers across North Carolina are supported by funds from the Substance Abuse and Mental Health Services Administration (SAMSHA). The CD Branch will continue to support SAC testing sites in NC and will attempt to add more sites as funding allows. The CD Branch is pursuing more funding through the state block grant to enable us to add more SAC sites to our program and to identify funding to conduct

more Hepatitis C testing in these sites. Plans to monitor and provide capacity building, TA and support services to funded agencies are detailed in the HIV prevention comprehensive plan. See below for 2013 SAC testing outcomes.

Chart 2
SAC Program Testing Outcomes 2011
(preliminary data)

	TESTS	POS	NEW	PERCENT POS	PERCENT NEW
HIV	4,462	15	7	0.3%	0.2%
SYPHILIS	3,120	23		0.7%	
GC	405	2		0.5%	
CT	405	12		3.0%	
HEP C	1,681	269		16.0%	

Department of Corrections and Jail Screening:

The Communicable Disease Branch has partnered with the N.C. Department of Corrections to ensure that all inmates receive HIV opt-out testing at intake into the state’s prison system. This testing began in the fall of 2008 and since then, over 24,000 inmates have been tested annually through the program. The Communicable Disease Branch also supports HIV/STD testing in thirty-two jails and day reporting centers across NC by funding community-based organizations (CBOs) and local health departments to provide testing for HIV, syphilis, gonorrhea, Chlamydia and hepatitis C in selected jails throughout the state. See below for 2013 outcomes.

Chart 3
Jail Screenings 2013

	TESTS	POS	NEW	PERCENT POS	PERCENT NEW
HIV	17,026	97	40	0.57%	0.23%
SYPHILIS	16,766	224		1.34%	
GC	1,951	23		1.18%	
CT	1,951	119		6.10%	
HEP C	1,214	109		8.98%	

The CD Branch will continue to support jail testing sites in NC and will attempt to add more sites as funding allows. Funds are being sought to increase the amount of Hepatitis C screening done in jail settings. Plans to monitor and provide capacity building, TA and support services to funded agencies are detailed in the HIV prevention comprehensive plan

Hospital Emergency Department Testing Program:

The CD Branch funds HIV testing in three hospital emergency rooms in the state. These sites – UNC-CH, Vidant and Wake Med – conduct HIV risk-based testing. The Branch also provides technical assistance and training to other hospitals throughout North Carolina to make them aware of the need for such testing in their emergency departments. See below for 2013 ED testing program outcomes.

**Chart 4
Emergency Department Testing Outcomes 2013**

	TESTS	POS	NEW	PERCENT POS	PERCENT NEW
HIV	1,734	45	5	2.6%	0.3%

The CD Branch will continue to support ED testing sites in NC and will attempt to add more sites through collaborations with UNC and Dr. Peter Leone who coordinates the UNC and WakeMed ED testing programs and functions as the Medical Officer for the HIV/STD Prevention and Care Unit. Vidant Hospital, which was added to the ED program in July of 2013, also tests for syphilis in addition to HIV.

North Carolina MSM Task Force:

Many of the events and activities in support of the minority MSM community, the MAI/MSM Task Force and Safe Spaces that would have normally taken place, were put on hold indefinitely since the MAI/MSM Community and Provider Education and Training Conference, that was hosted by the Branch in 2012, This was due to some of these activities no longer being approved by our federal funders. The absence of this impaired our ability to expand our efforts to reach out to and continue to build solid partnerships and relationships with the minority MSM community.

During this same period of time we experienced the loss of (MSM community) leadership, advocacy and partnership, however the community has approached CDB Staff recently and expressed their desire to have us assist them to re-establish the Regional Task Force Teams. With new HIV programs and initiatives aimed at reducing HIV infection, linking consumers to care and treatment and decreasing viral loads among positive individuals, the community is anxious to get involved. They have agreed to take a more active role working to impact positive health outcomes for their community.

In mid-December 2013, Branch staff met with several representatives of the minority MSM and Consumer community to discuss future plans and strategies that target minority MSM and are aimed at identifying newly diagnosed HIV positive persons,

getting individuals connected to care and minority MSM having greater visibility and input regarding HIV program implementation.

Get Real. Get Tested:

“Get Real. Get Tested. Get Treatment” is a statewide HIV and STD educational, testing and treatment campaign to encourage everyone to get tested and treated for HIV and other sexually transmitted diseases. The project includes television commercials and a toll-free HIV/AIDS Hotline, 1-866-883-1836. This project is a collaborative effort involving the N.C. Communicable Disease Branch, WRAZ/FOX 50 and other industry partners, with the cooperation of community-based organizations and local health departments. The goals of “Get Real. Get Tested. Get Treatment.” are to test people for HIV, identify people living with HIV/AIDS who need care, and provide HIV and STD prevention and education messages to the general public. The clear message is that if you are sexually active, you should know your HIV and STD status and know the status of your partner(s). GRGTGT activities will continue into 2014 and the near future as funding allows.

North Carolina Latino HIV/AIDS Initiative:

Throughout 2011 and 2012 the CD Branch partnered with the Latino Commission on AIDS and the CDC to bring capacity building and expanded capacity building to some of our local Latino community based organizations, to assist them in implementing culturally proficient HIV prevention behavioral interventions and HIV prevention strategies. There have been few requests for similar capacity building activities since that time.

During the spring of 2012 the Latino Commission on AIDS named Erik Valera (who assisted the Branch with the launch of the 2008 North Carolina Latino HIV/AIDS Initiative, served on the Latino HIV/AIDS Task Force, the Latino Health Advisory Group, the State Community Planning Group and the State’s MAI/MSM Task Force) as its new “Latinos in the Deep South” director. The Commission has since then moved their “Deep South” headquarters to North Carolina. As of 2013 Branch staff still served on the Latino Commission on AIDS “Deep South Project” Planning Committee, and the CDC Health Disparities Work Group.

Policy Initiatives:

The North Carolina CD Branch regularly conducts policy, regulations and procedure reviews to ensure that NC has a legal atmosphere that is beneficial for HIV prevention. We have recently made several policy changes to make routine HIV counseling more accessible across NC. We currently have no plans to change existing public health policy and procedures. The outcome for 2012 in terms of policy initiatives is to review all HIV Prevention related statutes to ensure their compliance with HIV program goals. The

inability to conduct harm reduction that includes syringe exchange also continues to be reviewed by the CD Branch.

Prevention Needs

The CD Branch obtained input from agency staff, the SCPG and well as some of our funded agencies to identify needs and service gaps. Below are specific recommendations from our partners for statewide prevention and care efforts to address these needs and/or gaps.

Prevention for Positives

Increasing prevention for positives programming is an identified need. More funding is needed to support evidence based programs that work with HIV positive persons. Efforts to reduce HIV transmission by reducing risky behavior by those infected with HIV is seen as a valuable service, and currently there is limited funding and programming available for these activities. Transportation for these populations to access care was also identified as a need of this population. The Branch will fund four agencies in 2014 to conduct HIV prevention for positives services using either CDC approved interventions or local interventions with data showing that they are effective.

Bilingual Services

With the increase in non-English speakers in NC, more bilingual services are needed in testing venues, social marketing campaigns and in the provision of HERR, case management and clinical services. In order to effectively reach high risk populations, bilingual, especially Spanish, services are important.

Stigma/Prejudice

The reduction of stigma around HIV was identified in the needs assessment process. Stigma was seen as a major barrier to clients getting tested and using venues associated with HIV. Many clients refuse to get tested in their areas or travel out of their jurisdictions to get testing or HERR services. Social media and other training of the public, church leaders and health care providers are needed in order to increase the likelihood of high risk persons receiving HIV prevention services. Training health care providers on cultural competence was specifically stressed as important for providers serving men who have sex with men and IV drug users.

Condom Distribution Services

During the needs assessment process an increase in condom distribution services was identified as a need. Condom use is one of the best ways to decrease HIV transmission and increasing the amount of condoms available to high risk populations is seen as an

effective intervention. Sites in which high risk persons can access condoms should be identified and effective condom distribution sites should be created where knowledgeable personnel are provided with free condoms to distribute. Special consideration to reducing barriers in areas in which condoms have been difficult to distribute (jails, schools, churches) is needed.

Health Education/Risk Reduction/HIV Prevention Education

There is a greater focus on the part of both clients and providers on learning about techniques to avoid spreading HIV infection, and how to employ them. Clients need to be more aware of the consequences of their actions, and that there are risk reduction techniques that they could adopt to avoid some or all of those consequences.

Similarly, there are many providers whose responsibilities could include providing health education, risk reduction education and/or HIV prevention education to infected individuals or those who are at high risk of contracting HIV. It is important to identify who these individuals are, and ensure that they have the knowledge, skills and resources to provide these services.

There is also a need to ensure that appropriate sexual health education is being taught in NC public schools and that students have access to sexual health information to include HIV and STD prevention messages. CD Branch collaboration with the Department of Public Instruction is important in ensuring that these services exist. Every effort will be made by the Branch to encourage increased educational efforts on sexual health information throughout the public education system in North Carolina.

Increased Testing Services

A need to increase HIV testing programs was identified through the needs assessment process. There is a clear need for more funding to support local health departments and nonprofit organizations in conducting testing among persons at risk for HIV. Increased testing should be done in jails, hospital emergency rooms, substance abuse treatment centers, community health centers and other venues in which high risk persons can be located. Usage and availability of rapid HIV testing methodologies should be increased and nontraditional testing hours and services should be increased. Transportation for these populations to access testing was also identified as a need of this population.

Increased Social Marketing Efforts

A need to develop statewide social marketing strategies to address stigma and to increase testing behavior targeted to priority populations with emphasis on African American males, (especially MSM) as well as Latinos. Internet interventions should be

included. Social marketing campaigns geared towards increasing healthy behaviors for people living with HIV/AIDS should be developed.

HIV Prevention Needs by Population

Persons Living with HIV/AIDS (PLWHAs):

- Increase providers that are bi-lingual and bi-cultural; i.e., medical, case managers, bridge counselors and priority to rural counties;
- Increase training opportunities for agencies conducting HIV prevention activities; i.e., DEBIs, cultural sensitivity, stigma, disclosure, STD 101, recruitment and retention of clients;
- Increase and improve access and coordination of services for care, prevention, mental health and substance abuse services, condoms, transportation, and housing;
- Increase and improve services targeting Latino's. Services should be inclusive of early diagnosis, outreach, interventions designed for Latino communities, and representatives of Latinos at all levels; i.e., State, CBOs.

Men who Have Sex with Men (MSM):

- Increase providers that are bi-lingual & bi-cultural to implement HIV prevention intervention; i.e., program staff;
- Identify funding for interventions that are tailored for MSM/transgender populations;
- Increase/identify education and testing in jails and prisons;
- Increase/identify funding for Social Marketing/Social Media to address MSM HIV Prevention needs; i.e., homophobia, stigma;
- Improve prevention and care services for MSM ages 15-30 years old;
- Increase safe spaces for MSM community to address HIV Prevention needs; i.e., LGBT centers, support groups and task force;
- Increase usage of condoms within MSM community;
- Increase mental health and substance abuse services for MSM community.
- Increase testing for MSM in bars, clubs and other areas in which MSM congregate

Heterosexual

- Increase intervention/education/prevention messages for men, commercial sex workers, African American women, pregnant women, youth and 50+ year olds;
- Increase condom usage;
- Improve comprehensive sex education within the school system;
- Increase testing during nontraditional hours and at nontraditional sites;
- Increase prevention messages and funding for social media;
- Improve cultural sensitivity and barriers to education and testing among heterosexuals; i.e., church involvement, religious beliefs.

IV Drug Users

- Increase access to clean equipment; i.e., bleach kits;
- Increase targeted testing among IVDUs;
- Increase access to primary health care, mental health and substance abuse services for IVDUs;
- Increase sensitivity of medical providers on IVDUU issues;
- Improve collaboration and education with law enforcement; i.e., paraphernalia, syringe use;
- Increase advocacy and legislative and policy support for IVDUU issues;
- Improve hepatitis C provider care;
- Decrease drug, syringe and pharmacist stigma;
- Increase harm reduction acceptance among drug rehab programs.

Care and Prevention Needs

As we have begun this process of looking at both care needs and prevention needs, it is interesting to note how the two perspectives are coming closer together.

On the care side there has been an increasing recognition that there needs to be more comprehensive testing to determine who is positive, and get them into care much more quickly. This is important not only to maximally maintain the health of these individuals, but to decrease the likelihood that they will spread their infection to non-infected individuals, thereby reducing the future burden on the care system.

Similarly, those on the prevention side recognize that the provision of care services is important to maintaining the health status of those who are already infected, and will be a key mechanism in reducing the numbers and rates of future infections.

Therefore, it is essential that we develop combined care and prevention plans to make maximum use of scarce resources, and have the greatest impact on the lives of those we serve, both infected and uninfected.

COMPREHENSIVE PLANS

As in the needs assessment portion of this document, this comprehensive plan section will actually contain three parts: a care plan; a prevention plan; and a summary which brings both parts together. This is necessary for two reasons: to satisfy the differing mandates and guidelines of each respective authorizing source (HRSA and CDC), and to demonstrate the similarities and differences in the plan perspectives of care and prevention. It is important to note that all plans and activities must be driven by accurate and expedient epidemiologic data, which has to be regularly collected, analyzed and disseminated to the community.

HIV Care Comprehensive Plan

Just as the Care needs assessment in this document closely resembles the 2009 Care needs assessment, so too the action plan outlined here parallels the Plan developed in 2009.

I. WHERE ARE WE NOW?

A. Description of local HIV epidemic

See pp. 6-22

B. Description of current continuum of care

The AIDS Care Program, a part of the Communicable Disease Branch, Epidemiology Section, Division of Public Health, Department of Health and Human Services, is North Carolina's designated administrator of the Ryan White Part B program. The AIDS Care Program provides all administrative activities for the program as delineated in the legislation and HRSA policies and procedures, and contracts out the provision of service to a broad range of public and private non-profit agencies; the only exceptions to this are: the AIDS Drug Assistance Program (ADAP); and the placement of Bridge Counselors in selected regions of the State.

North Carolina's HIV/AIDS care system is a broad mix of providers and activities, ranging from large medical care providers serving sizeable populations of infected individuals with a broad range of services (many of whom are also heavily involved in national HIV/AIDS research, including clinical trials) on one end of the spectrum to very small urban and rural organizations serving a much smaller population and providing limited services (often only one service) on the other end of the spectrum; however, the spectrum is not limited to these two extremes, but includes a range of differently sized organizations with a varying mix of service provision.

The current focus of North Carolina's care system is Regional Networks of Care (RNC). The RNC system was initiated in the FY 2010 RW fiscal year, and was developed as a direct result of the 2009 SCSN/CP, which placed its highest emphasis on the development of a client-focused care system to replace the Consortia model which had been operating since the beginning of the RW program in 1991. The emphasis of the Regional Networks is the promotion of the Patient Management Model – ensuring the best health outcome for each individual that is treated within the Network. Thus, the focus has become the individual client, rather than the organizations that provide services.

HOPWA is a part of the Regional Network system, with 11 HOPWA Project Sponsors in the 10 regions (Region 3 has 2 HOPWA Sponsors). These HOPWA Project sponsors are involved in the Regional Network meetings, assist with the development and maintenance of Network Deliverables: Needs Assessment, Network Resource Directory, Standards of Care, Evaluation Plan and Client Satisfaction Surveys.

The ten Regional Networks established during the implementation of this new methodology cover 95 of the State's 100 counties (the 5 remaining counties are served by the Part A Charlotte-Mecklenburg TGA). Each Network is comprised of one or two lead agencies, who not only provide services directly to clients, but also perform a variety of other important functions – development of regional needs assessments and action plans; funding and monitoring of subcontract agencies who provide RW-funded and non-RW-funded services to clients; coordinating care and service activities in the region; developing and maintaining resource directories; program evaluation; data management; and all other activities required for RW funding. The Infectious disease Clinic at UNC-CH is funded to provide services to some of the sickest clients from at least three regions around the State. In addition, the Part A TGA is closely involved with all State RW activities (including ADAP and the development of this needs assessment/comprehensive plan).

Each Regional Network is comprised of a number of Part B funded and unfunded service providers. All Networks are required to include RW Part C and D grantees in their Network, and indeed many of those providers serve as the lead agency for their respective regions. In addition, each Network is expected to involve all HIV service providers in their Network activities, as well as those who are infected/affected.

There are other activities which are supported through RW funding that need to be accounted for. While the majority of client services are provided through the Regional Networks of Care, the State has elected to maintain some services on an extra-regional basis. Thus, we have funded primary medical care at the University of North Carolina-Chapel Hill. This clinic sees some of the most complex clients from primarily three Network regions.

Similarly, the Duke University Legal Assistance Project provides legal assistance on matters pertaining to HIV for clients in the project's 34-county service area. They also train legal and non-legal practitioners to provide education and consultation about legal issues related to HIV.

The Emerging Communities program was designated by the RW legislation to provide additional support for services to HIV-infected individuals residing in the Raleigh SMA (Wake, Johnston and Franklin Counties). The Emerging Community does not have sufficient cases to qualify as a Part A TGA, but nonetheless has been recognized as requiring additional support for a large HIV-infected population.

Finally, the Minority AIDS Initiative (MAI) provides separate funding to provide education and outreach to at-risk minority populations to bring them in to care, and particularly to maximize their enrollment in ADAP.

At this time, budget cuts have not been a significant issue with RW funded providers, but have been an issue where State and local resources are a significant part of the funding mix. For example, the need to control Medicaid expenditures may have a growing impact on the RW-funded system of care, but we will need to see how this develops. Similarly, the State's mental health/substance abuse services have realized significant cuts, but the impact on our system of care is still to be determined. Some State funding for prevention efforts has been cut in recent years.

One of the requirements of the Regional Network RFA mandated that each Network prepare an inventory of HIV care resources available to HIV-positive individuals within the Region. The first round of inventories have been prepared and made available to the providers and clients within the Region.

North Carolina must now move this process forward. We need to ensure that these inventories are being kept updated, and that both providers and clients have ready access to this information. In addition, methods need to be developed to disseminate this information on a statewide basis, so that providers and clients have knowledge of the resources that could be available to all clients if they travel outside of their home region. This is entirely in line with making client data available to providers throughout the State, and the concept of a Statewide coordinated continuum of care.

C. Description of Need

See pp. 23-41

D. Description of Priorities/Allocation of Funds

In the RFA to implement the Regional Networks of Care, allocation of funding was based on an analysis of the funding to each of the regions which had been in place

under the previous system of organization, the numbers of persons living with HIV/AIDS in each of the regions, and the number of persons served by Part B funds within each of the regions (two regions received supplements to ensure that they would be able to provide the full range of necessary activities as required under the RFA).

This Plan encompasses all allowable Ryan White services, subject to any program limitations (such as the requirement that only a maximum of 25% of service dollars may be expended on non-core services). Thus, all Regional Networks (including Parts C and D-funded programs which participate in Network operations) can elect to fund any allowable service that they deem to be a priority within their approved area, again subject to service limitations imposed by HRSA/HAB. The truly limiting factor as to what each region can provide is the level of resources that are available; this is the major factor which affects what priorities are addressed, and the level of resources committed to addressing them.

All regional Networks were required to provide a listing of services to be offered in the Region. The following table outlines those services and those of the Part A Program.

Table 3

RW Services Provided by Regional Networks and the TGA

Region	Services Provided										TGA	
	1	2	3	4	5	6	7	8	9	10		
Services												
Outpatient/Ambulatory Care	x	x	x	x	x	x	x	x	x	x	x	x
Oral Health Care	x	x	x	x	x	x	x	x	x	x	x	x
Mental Health Services	x	x	x	x	x	x	x	x	x	x	x	x
Medical Case Management/ Treatment Adherence	x	x	x	x	x	x	x	x	x	x	x	x
Substance Abuse- Outpatient	x	x	x	x	x	x	x	x	x	x	x	X
Emergency Financial Assistance	x	x	x	x			x	x		x		
Transportation	x	x	x	x	x	x	x	x	x	x	x	x
Pharmacy	x		x									
Early Intervention Services	x						x	x				
Referral to Specialty Services	x					x	x					
Non-medical Case Management	x			x				x		x		x
Food Bank/ Pantry Assistance		x	x	x		x	x	x				
Linguistic Services		x	x	x			x	x				
Legal Assistance		x	x	x								
Psychosocial Support		x	x			x	x	x				x
Home and Community-based Services			x	x			x					
Medical Nutrition Therapy		x	x	x	x	x	x		x	x		
Health Insurance Premiums/ Cost Sharing Assistance	x		x				x					x
Other Non-Part B Services	x						x		x			
APA (Local)				x			x					
Substance Abuse-Residential				x			x					x
Treatment Adherence Counseling			x	x	x	x	x		x			
Health Education/Risk Reduction				x	x	x	x					
Referral for Support Services			x	x		x	x					
Home Health Care							x					
Hospice Services			x				x					
Respite Service							x					
HIV Testing			x	x			x					
Counseling							x					
Rehabilitation							x					
Outreach Services			x				x					x
Counseling & Testing in Jails									x			
Bridge Counseling/ Peer Counseling		x	x	x	x	x	x	x	x	x		
Medications (HIV and non-HIV)												x

As can be seen, regions have elected to primarily provide those services which have previously been identified as most important to patient care: Outpatient/ambulatory care; Oral health care; Transportation; Mental Health services; Substance Abuse

services; and Medical Case Management/Treatment Adherence (medications are already provided through the State, although some Networks provide limited support for non-HIV medications through Outpatient/ambulatory care). A second tier of services which many providers offer include: limited Emergency financial assistance; Medical nutrition therapy; and Psychosocial support.

It is crucial to remember that populations to be served and services to be provided remain a local decision. The State has ensured that this plan allows coverage for all populations and all allowable services. And for subgrantees funded under Part B Regional Networks of Care, the State has mandated that each network ensure the provision of certain crucial services – outpatient/ambulatory care, oral health care, mental health and outpatient substance abuse care, medical case management, transportation and treatment adherence counseling, although it does not mandate that Part B funds be used to pay for those services (as long as they are provided through some other mechanism). However, it is entirely within the purview of each Network to select the services that will be provided, and the mechanism by which they will be provided; thus priority setting is left to those at the local level who best know what the problems and resources in that region are.

E. Description of Gaps in Care

The primary gap in the AIDS Care system is the lack of adequate resources to fully fund needed services. For instance, ADAP is only adding those with incomes at or below 125% of FPL to the program, although the State's official cap is 300% of FPL. However, limited resources would lead to early closing of ADAP services if we continue to enroll those individuals between 126% and 300% of FPL in the program. So we assist those who fall within that range to obtain resources to pay for their medications from other sources. In the meantime, we continue to look for ways to decrease program costs so that we may be able to add additional individuals to the program.

Similarly, many medical care providers have told us that they cannot serve all of those who need medical care because they do not have the resources to do so. This can result in delayed entry into medical care, not being able to get appointments as frequently as might be desired, or even having to curtail acceptance of new patients. As we know, failure to receive quality medical care is likely to result in an increase in Community Viral Load, and thus a concomitant increase in HIV transmission.

This scarcity of adequate resources also affects the range of services that providers are able to offer. Even though the Ryan White legislation limits funding for support services to no more than 25% of total service expenditures, North Carolina Part B subgrantees have, for several years now, been limiting such expenditures to less than 15% (13.1% in 10/11 and an estimated 14.2% in 11/12) of their total available service dollars in order to provide more core services. Thus, assistance for those support services which

help keep clients in medical care (transportation, emergency financial aid, support for food and housing, etc.) can no longer be provided to the extent they once were.

F. Description of Prevention Service Needs

See pp. 42-53

G. Description of Barriers to Care

North Carolina is fortunate in that there are few, if any, legislative barriers to care. Routine testing is not a barrier, since counseling and testing requirements allow for individuals to be tested at local health departments and a variety of other traditional and non-traditional venues. HIV testing has been made a part of many medical care activities, unless the individual “opts out” of being tested. The State and its institutional and community partners have made HIV testing a cornerstone of both the care and prevention systems, and have gone to extraordinary lengths to ensure its availability

Stigma/Prejudice

Stigma and prejudice are probably the largest barriers to HIV testing, and thus to getting infected individuals into care. In fact, many community members felt so strongly about this issue that they wanted it to be identified as a need. It is remarkable that nearly 30 years after this epidemic began that stigma and prejudice could still be attached to infected persons. And yet this is precisely the case.

Many clients, particularly those in rural areas, continue to regularly express these concerns. Many refuse to get care in their regions, preferring to wait until they can go somewhere else, or they are too ill to avoid going for care. Many HIV-positive individuals still feel very uncomfortable telling their friends, their clergy and even their families about their illness, preferring to live almost in isolation.

Paraphernalia Laws

North Carolina has strict laws against allowing the sale of drug paraphernalia. This can act as a barrier to treatment for IDUs. In addition, Federal legislation now prevents the use of federal funds for such activities as syringe and syringe exchange; thus, if the State laws did not ban such activity, federal restrictions would not allow the use of federal funds to support these activities.

H. Evaluation of 2009 Comprehensive Plan

The primary focus of the 2009 Comprehensive Care plan was the development and implementation of the Patient Management Model through implementation of Regional Networks of Care, and in this respect the Plan must be considered to have been very

successful. As noted previously, this new system of care provision was implemented at the start of the FY 2010 RW Program Year. RFAs were received for all 10 designated regions, and selection of lead agencies was made, contracts were developed and Regional Networks were established.

However, this implementation process was not consistent throughout the State. One Regional Network was not able to come together during the first year of funding. The designated lead agency did not have the expertise or resources to bring together all of the necessary participants. After working with this group for nearly a year, it became evident that another lead agency needed to be found which had the skills and resources to make the system work (clients in this region were able to obtain Part B assistance because an adjacent Network provided services). Fortunately, the Part C/D provider in this Region volunteered to assume the lead agency role and, although it has taken some effort, now appears well on its way to successful service provision.

The other nine Networks have been fully operational since April 1, 2010. Some of the Networks started out with strong internal structures, and have been moving forward steadily since. Others have encountered some difficulties along the way, but with assistance have managed to overcome these challenges and continue moving forward.

The new system has resulted in the development of strong continua of care, which are focused on maximizing health outcomes for the clients being seen within that care system. One of the biggest changes has been less of a concentration on the needs of individual agencies themselves, and more on how they need to work together to improve services and health outcomes. This is a concept which has taken time to develop and operationalize, but better service for clients and improving health outcomes have helped to foster this recognition.

In addition, service improvements have also occurred. ADAP enrollment and utilization has grown, as has our capacity to use these funds more efficiently and effectively. One major improvement has been the implementation of a State Pharmaceutical Assistance Program (SPAP), which allows Medicare-eligible clients to have the Program pay for insurance fees and co-pays, decreasing the amount of ADAP funds used to pay for these clients as only ADAP clients, while simultaneously increasing the level of benefits these clients receive from Medicare payment for other healthcare services and access to a wider range of prescription medications.

Another requirement which the State initiated was to connect Medical Case Management (MCM) closely to medical care. MCM can only be provided when medical care providers manage what goes on in the case management process. This means that most case management services are no longer provided separate and apart from medical care, but that the two components are working together to ensure maximum effectiveness for the client.

II. Where Do We Need to Go?

The system that we implemented two years ago is now beginning to show real evidence of improvement in patient care, and we must ensure that we continue this progress. The increasing use of CD4/Viral Load results to assure provision of quality care and to track the progress of those in care will become an integral part of the client care process.

In addition, the health care arena is changing at an ever increasing rate. This is particularly true with regard to health care reform and major changes to Medicaid eligibility, which is due to take place in 2014. Although no one knows how much or precisely which parts of this reform will be enacted immediately, we must be prepared to coordinate our systems with the new changes, whatever they might be.

A. Plan to meet 2009 challenges

We will be continuing our efforts to ensure that the Regional Network system maintains forward momentum. When it becomes time to renew support for the RNCs, we will review our progress to date to determine if any changes need to be made. In addition, we will endeavor to include impacts from any proposed changes to the health care system that are being proposed. However, we are also aware that the ramifications of many of these changes are currently unknown (in fact, many of the possible changes are still unknown), so that a great deal of flexibility will be necessary.

Participants in the needs assessment and planning processes contributed well-conceived ideas about how to improve Regional Networks of Care. Some of these ideas included: sharing of information on how networks are operating, including dissemination of best practices; increased utilization of quality management concepts and strategies to improve service delivery; encouraging greater participation by various segments of the community (clients, jails and prisons, local and regional hospitals and other medical providers, social service institutions, HIV prevention and field service partners, and religious institutions); general information sharing among all members of the community; and more education. The Communicable Disease Branch has already initiated some of these activities, and will continue to explore ways to implement strategies to address the delineated needs.

Critical to ensuring this forward momentum is linking individuals to the care system. It is one thing to have services for clients available, but this availability means little if the clients are not receiving them. Thus, we will continue to stress linking people into care: finding those positives who have dropped out of care, and getting them back into care; finding those who never got into care, despite knowing of their positivity, and getting them into care; and finding those who are not aware of their status, getting them tested, and getting them into care if they are found to be positive.

One of the most significant challenges is the insufficiency of resources to meet all client service needs. We are well aware that there are never enough resources to address client needs. However, it is essential that we learn to use the resources we have in the most efficient and effective manner possible. ADAP has made significant strides in this direction, instituting policies and procedures which ensure that all other payee sources are utilized before the Program pays for medications. In addition, intensive efforts are being made to streamline all of the processes required to process clients and provide medications in order to serve the maximum number of individuals with available resources.

The Regional Networks of Care are the primary mechanism to accomplish the same task with regard to all other client services. Greater coordination between service providers helps to ensure that clients receive the services they require with a minimum of duplication. However, more can certainly be done in this regard, and every opportunity will be taken to realize this, particularly through data sharing and integration of health information systems regionally.

One idea that is favored by both clients and practitioners is the establishment of "one-stop shops," whereby clients can get many or all of the services they need in one location. This results in more efficient use of transportation resources, and means the client is more likely to have his/her service needs met. This can be a very difficult challenge, particularly given the requirement of large changes in infrastructure, both physical and organizational, to bring this about. Several of the Regional Networks have begun to implement this concept with excellent results, and we will continue to encourage this development as we move forward in the ongoing development of the Regional Network system.

B. 2012 proposed care goals

North Carolina's HIV/AIDS care goals for 2012 and beyond are focused on ensuring that a comprehensive continuum of care is available for all infected individuals throughout the State. This does not necessarily mean that it is the State's responsibility to actually provide those services to all impacted persons, but rather to ensure that the services which individuals need are available and accessible to them, whatever their situation.

Our efforts to restructure the care system through implementation of the Patient Management Model (PMM) and the Regional Networks of Care (RNC) were an important first step in this process. The premise behind PMM was to focus attention on the patient and his/her health status, rather than on the service providers, and to develop closer coordination between the Ryan White and HOPWA programs in each region. We believe that if providers focus on improving and maintaining the care of their clients, then client health outcomes will improve.

The change to Regional Care Networks was the mechanism through which this shift in focus was to take place. The RNCs were envisioned to be a comprehensive mechanism through which the activities of all providers within the Network serving HIV-positive individuals could be coordinated to provide those services most effectively and efficiently. This would maximize the ability of positive persons to get the range of care services they need in order to lead full and productive lives.

Thus, one of our primary goals is to maintain and improve the regional Network of Care system. The networks have now been operating for more than 2 years, and anecdotal evidence points to improvements in care. It is now important for us to more meaningfully identify the specifics of these improvements, and to spread knowledge of the best of these changes to enhance the operations of all networks, and thus to increase the health status of all infected persons.

Quality medical care provided by knowledgeable and caring providers has increasingly been shown to be an important factor in patient health outcomes. Particularly in regard to its Ryan White program, North Carolina has emphasized the provision of and retention in quality medical care over the past years. This focus will continue over the coming years, and increasing attention to clinical quality improvement will help to reinforce the importance of medical care.

Nothing has had a greater impact on improving health outcomes for infected persons than increasing utilization of effective antiretroviral medications. These drugs have turned what was once considered an almost certain death sentence into a highly manageable chronic illness. Many individuals who were expected to die are now living longer and better lives, while others have not seen the disease progression that characterized this illness in the early years of this epidemic. And recent scientific evidence has been mounting that early use of medications can significantly decrease the transmission of HIV to the uninfected population.

But these medications are both expensive and difficult to take correctly. The AIDS Drug Assistance Program (ADAP) has helped to defray the costs for uninsured populations who meet the program qualifications, for several years the resources to meet current and expected future need were insufficient, despite commitment of significant Federal and State resources. However, careful management and development of alternative sources have enabled the Program to provide services to qualified individuals without any of the restrictions which had been in effect, not only in this state, but across the country as well.

North Carolina's ADAP has provided access to medications for a steadily increasing population, and will continue to emphasize this support in future years. This support will not only help to maintain and improve the health status of infected persons, but may very well serve as important mechanism for preventing the transmission of HIV to uninfected populations.

The CDB recognizes the importance of clinical trials research in advancing knowledge about this disease. To this end, we have for many years encouraged our funded providers to get their clients involved in such programs. The significant participation of Parts C and D providers in the Regional Networks of Care has further encouraged this effort. It is important to emphasize this activity here, since these programs can serve as an additional support for getting clients the medications they need.

As noted above, antiretroviral medications are not only very expensive, but are also difficult to continue taking correctly. Thus, treatment adherence assistance is crucial in ensuring that these medications can have maximum impact. North Carolina has always supported the provision of treatment adherence counseling to assist patients with maintaining appropriate utilization of medications, and will continue to do so.

C. Goals regarding Unmet Need

It is crucial that those who know that they are HIV-positive but are not in care (whether they have never been in care or dropped out of the care system) be located and linked to care. This is important not only to maintain the health status of these individuals, but also to minimize their capacity to spread HIV infection to the uninfected.

In order to achieve this goal, we have required that each Regional Network establish "Bridge Counseling" capabilities within their Networks. These Bridge Counselors are specifically tasked with identifying positive individuals not in care, finding them and attempting to get them involved in the care system. But this is not a task which can be accomplished by the Networks alone. Therefore, the State has established Bridge Counselor positions within its regional Field Service offices. These Bridge Counselors have the capacity to work across Regional Network borders, and thus may be able to trace this increasingly fluid population. In addition, the State's Surveillance system is increasingly being brought to bear to assist in tracking the many individuals who have eluded efforts to engage them in care.

While these efforts have been developing over the last several years, the State and several of its partners have been awarded a 4-year, \$4 million SPNS grant to coordinate and enhance this process. NC-LINK, which is currently operating throughout the state, has helped to routinize these engagement activities and provide enhanced information to make the activity more likely to succeed.

D. Goals regarding EIIHA

It is equally important that those who do not know their HIV status be identified, and when found to be positive, brought into the care system. The activities described for "Bridge Counselors" as noted in C. above are applicable to this description as well. However, this goes beyond the above description because it further involves the work

of prevention as an integral partner in the process. It is important to not only identify the likely populations at-risk (injecting drug users and their sex partners, gay and bisexual black men, gay and bisexual Hispanic men, young [13-24] gay and bisexual men, black women in high prevalence/low wealth areas, and commercial sex workers and their partners), but also to get them counseled and tested. Once this occurs, prevention activities can help to guide those found to be positive into the care system, while continuing to work with negative high-risk individuals to maintain their negative status.

E. Proposed solutions for closing gaps in care

The North Carolina HIV care system provides a broad range of services (both core and support) to the population it serves. As previously noted, the primary gaps in the system are fiscal, as opposed to programmatic – there simply are not enough resources to support all of the need which exists.

Both the State and its program partners are required to make difficult decisions (some of which are imposed from outside the system - such as the legislative requirement that at least 75% of RW service dollars need to be spent for core services) regarding how to distribute limited resources among a broad range of competing interests. Clients are not necessarily interested in hearing about such requirements – they only see that they cannot access assistance for particular services.

The only thing we can do is to ensure that the mix of services being provided fits within the local prioritization scheme, and addresses the most crucial identified needs. They should be provided in the most effective and efficient manner possible, so as to maximize the amount of service that can be provided with the resources available.

In addition, all providers are strongly encouraged to leverage additional resources to enhance their programs. Whether these resources are financial (which generally means they can be used for a broader array of activities) or non-monetary, these additions can help to extend the ability of the provider to assist its client population.

F. Proposed solutions for addressing overlaps in care

All programs are strongly encouraged to continuously monitor their program activities to uncover duplications or overlaps in care. Two important methods in this regard are continuous budget monitoring, and ongoing review of client services.

Budget monitoring can help to determine if resources are going to support the same services in two different places. We know that administrators can sometimes lose sight of the existence of duplicative services. Careful monitoring of budgets can often help to uncover this, and eliminate such duplication.

Continuous review of services being provided to clients can do the same thing, from another perspective. Clients often receive services from a variety of providers, and the possibility exists that two providers can sometimes offer the same (or similar) services to a client. This can often be avoided if a gatekeeper system exists, where a single entity has an overview of all the services being provided to a client.

The methods above work well within a single entity (such as a Regional Network), but not necessarily a wider area, such as the State. However, data sharing capabilities being established through NC-LINK will enable information to be shared on a statewide basis, and thus improve our capacity to eliminate duplication.

G. Proposed coordinating efforts

As has been the case for many years, the AIDS Care Program has coordinated with a wide variety of organizations and providers that work with the HIV population.

The Part A TGA located in Charlotte/Mecklenburg County has been a partner with the State since it began operating. The TGA participates in the Statewide Coordinated Statement of Need and Comprehensive Plan, and its own needs assessment and plan are incorporated within the State's. In addition, the Part A program participated in development of State priorities and Quality Management activities, and the TGA's clients are participants in the State's ADAP, which relieves the Part A program of significant costs for the provision of medications and the administration of those services.

Requirements of the Regional Networks of Care mandate the participation of RW Parts C and D programs within each network program. In fact, eleven C and D providers receive Part B funding as well, and seven of the Networks have such providers as their lead agency or co-lead agency. In addition, the AIDS Care Program meets quarterly with all Networks and Part A, C and D providers. Part C and D providers have always been an integral component of the State's AIDS Care system, and this participation has only strengthened over the years.

As noted in C. and D. above, the State is an active participant in the new SPNS grant just recently announced. In fact, the State has always worked closely with any of the SPNS projects which have been funded. In addition, the Part F Dental Reimbursement Program is also a participant in the Needs Assessment and Planning processes.

The Regional Network system requires each Network to involve non-RW funded service providers in the region, and to offer them every opportunity to participate in the Network system. Many such providers actively participate in their local process, and each Network continually works to draw in any provider who does not currently participate. Of course, we cannot compel non-RW providers to participate, but we do strongly encourage every opportunity for this to occur.

The State's Prevention Program is a part of the same Unit as the Care Program, and we have been working together for many years now. Care and Prevention are now considered complementary activities, with each being considered as a critical component of the other. The increasing closeness of the two programs is best demonstrated by this document, which is a combined care and prevention needs assessment and comprehensive plan.

Substance abuse and mental health programs are primarily a State prerogative, and have been undergoing reorganization for some time now. Each Regional Network is required to maintain contact with its local coordinating agency to ensure the provision of substance abuse and mental health services for its clients, and this requirement will be maintained, particularly since substance abuse and mental health services are considered as high priority components of this plan. We continue to encourage participation by substance abuse/mental health providers in both State and local needs assessment and planning processes.

STD programs are a function of the Communicable Disease Branch, and coordination occurs as a result of intra-unit ongoing discussing concerning common problems and activities, and the continuation of this combined needs assessment and planning process.

Medicare is a major provider of HIV medications through the Part D program. ADAP has worked closely with Medicare to establish and continue operating the State Pharmaceutical Assistance Program (SPAP). We will continue to look for additional opportunities to collaborate with the Medicare system.

Medicaid is the largest single payer in the State for services to HIV-infected individuals. The AIDS Care Program continues to maintain close contact with the Medicaid program to ensure coordination of services. RW Part B clients are required to apply for Medicaid annually, or when their situation changes, to ensure that RW remains the payer of last resort. Medicaid is likely to be a central element of any future health care system changes pertaining to this population, so it will be necessary to maintain close ties in order to optimize service to our clients. Medicaid and the Division of Public Health meet regularly to discuss issues of mutual concern, and HIV/AIDS has and will continue to be one of the common issues for discussion.

The Children's Health Insurance Program is also part of the Division of Public Health, and so coordination primarily occurs at the Division level. Those providers who serve children are the most likely to have contact with this program.

Community Health Centers in North Carolina, with some notable exceptions, have traditionally not served the HIV population. Several of our current sub-grantees and provider agencies are FQHC's. However, a renewed emphasis by HRSA may lead to

more participation by this sector of the health care system. In addition, future health care reform may increase these possibilities, and we are prepared to work with these organizations to assist in their integration into the established health care system. In fact, efforts have begun to survey the ability and preparedness of Community Health centers to serve HIV-positive clients.

Many participants involved in generating ideas for this document indicated that advocacy is an important component in bringing about improvement. The Communicable Disease Branch takes every opportunity within legal bounds to advocate on behalf of its clients to improve the AIDS Care system and the services it provides. However, it is important to remember that advocacy needs to be performed by the entire community. Therefore, although RW resources cannot be used specifically to conduct advocacy, we will continue to work closely with our entire community to advocate for improvements to systems and services.

III. How will we get there?

A. Closing gaps in care North Carolina's care system covers the full gamut of care activities. Where gaps may exist, they are due primarily to a lack of resources to address identified needs, rather than the complete absence of necessary services. Our planning and program development system focuses on a constant and consistent review of what these needs are, efforts to develop programs to address these needs, and "tuning up the system" where possible to make resources available to address additional needs.

We will continue to work with our Regional Network partners to identify gaps in local and statewide care systems, and to develop and implement strategies as needed to close those gaps. All Regional Networks are required to prepare Regional Service Delivery Plans. These Plans can be used by AIDS Care Program staff and Regional staff to ascertain possible service gaps, and to develop strategies to address those service gaps.

B. Addressing the needs of individuals aware of their HIV status. Our care system is, in part, predicated on finding those who know that they are positive but are not in care. As previously noted, State Field Services staff have been adding Bridge Counselor capabilities to their Regional offices. A major component of each Bridge Counselor's responsibilities is to identify and find positive individuals who are not in care (either have never been in care or have disengaged from the care system) and bring them back in and maintain them in comprehensive care activities.

In addition, each Regional Network is contractually mandated to ensure the provision of these same activities in their region. Bridge Counseling (whether through specific staff or staff designated to perform this function) are mandated activities for each network,

with a special emphasis on finding those who have left the care system and bringing them back in.

Part of the problem in trying to identify individuals who know they are positive but are not in care is alerting those responsible for this function to know who those individuals are. The State's Surveillance program (a unit of the Communicable Disease Branch), is in the process of trying to determine if data in the electronic HIV/AIDS Reporting System (eHARS) can somehow be made available to help facilitate this activity. Certainly, DIS currently have access to this data, but they represent a small proportion of the personnel committed to this activity. But other Bridge Counselors at this time do not have such access, complicating their ability to identify this population. We continue to encourage the development of a workable methodology which protects clients' rights, and will update this report as further developments occur.

The NC-LINK SPNS Project will assume a central role in this regard. Over the next three years, they will be developing and implementing methodologies to mold State and local Bridge Counselors into a complementary system for finding positive individuals not in care and bringing them into treatment. The on-going development of data sharing through the State's CAREWare system will be one of the primary methodologies through which this will be achieved.

C. Addressing the needs of individuals unaware of their HIV status Bridge Counselors (both State and local) also have similar responsibilities for finding persons who do not know they are positive, and getting them into care where applicable, or getting them into alternative programs to assist in maintaining their negative status. Again, State Bridge Counselors have a decided advantage here because they can do HIV counseling and testing when they come across high risk individuals.

But RW-funded Bridge Counselors do not generally have this capability due to Program rules. Thus, this is an area where care and prevention programs can work synergistically, with the prevention component helping to identify (through outreach and testing) those who are positive and the care people working to ensure their entrance into and continuation in care. This would also enable the prevention programs to address the issues of keeping non-positives from becoming infected, which care providers paid for by RW Part B funds are not allowed to do. The activities noted in B. above apply equally to this endeavor.

D. Addressing the needs of special populations. Dealing with special populations is a complex task which needs to have a local focus. Adolescents are generally served through Medicaid, and the local practitioners who serve this population must be familiar with Medicaid regulations and the peculiarities of the local adolescent population. Similarly, injection drug users have their own unique set of requirements, and local practitioners are in the best position to know the nature of this population and the

resources that are available to assist them. In short, it is crucial to locally identify what special populations need to be served and how best to serve them.

As indicated previously all care and prevention providers have intimate knowledge of the needs and resources within their Region. The State will continue to work with all of its partners to evaluate the needs of identified special population groups, and ensure that resources are made available (within systemic constraints) to address those needs.

E. Activities to implement proposed coordinating efforts. As noted previously, the AIDS Care Program and the Communicable Disease Branch have established close relationships with a very broad group of providers. All RW-funded programs participate in statewide needs assessment and planning activities. All other providers, whether private or governmental, also participate in a variety of activities, whether on a State or local level. It is our belief that, since services are most likely to be provided locally, it is absolutely essential that relationships between providers have a local focus. That has been the guiding principle in the development of the Regional Networks of Care, and will continue to be the focus of state activity in regard to HIV care.

The State will continue to ensure that all interested parties have a place at the table. All Regional Network providers, State and local agencies, and community-based organizations shall be a part of the needs assessment/planning process, and will always be welcome to participate in any and all activities to improve the system.

F. Addressing Healthy People 2020 objectives The Healthy North Carolina 2020 (HNC2020) program has, as one of its objectives, "reduc(ing) the rate of new HIV infection diagnoses (per 100,000)". According to recently released statistics from the State Health Director's office, this challenge is currently being met, with a reduction to 19.7 in 2009 from a level of 24.7 in 2008. In addition, other HNC2020 objectives have an impact on the HIV-infected population: reducing the percentage of positive results among individuals aged 15-24 tested for chlamydia; reduce the rate of mental health visits to emergency departments; and decrease the percentage of adults who have had permanent teeth removed due to tooth decay or gum disease.

The State is required to address its compliance with HNC2020 in its annual Part B application. As can be seen from the plan, the Communicable Disease Branch is already closely aligned with HNC2020, and will continue this close association.

G. Reflecting the Statewide Coordinated Statement of Need This Plan follows from the Statewide Coordinated Statement of Need, and is thus closely aligned with it.

H. Coordination with and adaptation to implementation of the Affordable Care Act As noted previously, there are many changes forthcoming to the healthcare system by virtue of the Affordable Care Act. And although we do not yet know how the implementation of that legislation will impact the RW program and those who are HIV-

positive, we stand ready to ensure that North Carolina will adjust to this new reality and continue to provide high quality, comprehensive services to those who depend on us.

The Department of Health and Human Services, the Division of Public Health and the Epidemiology Section are all well aware that the Affordable Care Act will have a significant impact on the way we do business, and the populations we serve. Given the uncertainty which still surrounds implementation of this legislation, we can only commit that we stand ready to address the many issues that are sure to arise as implementation occurs.

I. Addressing the goals of the National HIV/AIDS Strategy North Carolina has wholeheartedly embraced the NHAS goals. As noted above under the Healthy People 2020 description, reducing the rate of new HIV infections is a primary objective of our program, and one which we take very seriously. Our HIV prevention activities are heavily focused on reducing HIV transmission, as is our Minority AIDS Initiative, which has recently been concentrating on preventing the spread of HIV to young minority MSMs.

Our implementation of the Regional Networks of Care system was developed specifically to increase access to care for the many people who utilize RW services, and to improve health outcomes for each and every infected individual. We are placing a major emphasis on reducing viral loads in our patient population, which will not only increase the health status of these persons, but reduce the likelihood of their transmitting the virus to uninfected persons.

J. Strategy to respond to additional or unanticipated changes resulting from State or local budget cuts. The current economic situation has meant diminishing support for many State-funded services. One of the primary targets for such cuts is Medicaid, which provides the most significant share of funding for HIV-related services in North Carolina. Although the Ryan White program cannot hope to provide support for all of the resources which Medicaid may lose, it is the CDB's intent to closely monitor the situation with regard to Medicaid, and if possible to supplement the resources of our local Part B providers to assist in maintaining services to their clients who are negatively impacted by these cutbacks.

IV. How will we monitor progress?

Monitoring has always been a key component of North Carolina's Part B program. Our monitoring activities involve a mix of office-based and field-based strategies, which have become more detailed and time-consuming as both State and federal requirements have increased. Office-based activities include review of budgets and contracts, review of monthly expenditure reports and quarterly progress reports, discussing and responding to issues raised by subcontractors, and review of CAREWare-generated statistical reports and quality management reports and activities. The State's

Subrecipient Monitoring Plan requires that each subcontractor receive at least two on-site visits per year. During these visits, AIDS Care Program staff conduct detailed reviews of fiscal reports, including matching expenditures to source documents. Staff also do detailed chart reviews to ensure that services are being appropriately provided and recorded. Additional site visits may be made to subcontractors if issues arise which cannot be settled over the phone or through email, or if technical assistance needs to be presented to Provider staff.

The latest round of Federal requirements has caused us to again evaluate our monitoring program, and we expect to develop new methods, activities and materials to comply with the new standards. This will require a whole new commitment on the part of both our staff and subgrantees to continue providing quality services, and to demonstrate that we are doing so.

The initial step in this process will be to ensure that we meet the technical aspects of the monitoring requirements. This will involve making certain that we fully understand what is being required, and then that we have the capacity to meet those requirements. This is likely to involve training of both State staff and subgrantees on what the requirements entail, and developing the methods and tools to collect and report on the required information. We are hopeful that this will essentially be completed during FY 2012.

The next step in the process will be to improve utilization of the data which is currently available to us, particularly the client level data which we are required to collect and report to HRSA. Fortunately, the RW program has required all of its Part B subgrantees to use CAREWare for a number of years. Further, the majority of our Parts C and D grantees also utilize CAREWare. In addition, this data is maintained on a central State server, which increases its availability to us and our subgrantees. We will also need to find methods to review data quality, and improve our data quality as necessary. We have already begun this process, and hope to be well on our way to meeting this goal by the end of the current calendar year.

The last part of the process is by far the most difficult and complex – using the data to evaluate program operations, and measuring and improving clinical outcomes. It will be necessary to first define what our expectations are or should be. The next step in the process will be to determine what measures can enable us to make that determination. We will then need to analyze these outcomes in light of our expectations to see if we are on the correct track, or if changes need to be made. We realize that this is a difficult task, particularly in regard to clinical outcomes, but we will continue to work with all of our partners to achieve this end.

HIV Comprehensive Prevention Plan

New Prevention Interventions and Strategies to be implemented

Health Education Risk Reduction (HE/RR)/Prevention for Positives: The Branch will continue to fund HERR and prevention for positives activities throughout the State, the CD Branch currently funds 12 agencies for HERR activities, five of which are prevention for positives interventions. These agencies are scheduled to be funded for these activities for up to three years beginning July 1, 2013. The CD Branch will focus on achievable outcomes for HERR and prevention for positives and monitor these sites per the NC subrecipient monitoring policy (available upon request). The CD Branch will also continue to require all HIV Regional Networks of Care to provide HIV prevention for positives activities for their clients.

Condom Distribution Activities: The Branch encourages all its community partners to expand the availability and accessibility of condoms in their neighborhoods and among their target populations by distributing them to non-public health locations, such as bars, clubs, restaurants, laundromats, convenience stores, liquor stores, barbershops and other venues; this will continue into 2014 and 2015. The methods community partners use to identify targeted areas include: needs assessments, outreach, state epidemiologic data analysis and disease intervention specialist information. Once sites are identified and set up, documentation of sites and condoms distributed will be collected by supported agencies through condom distribution log sheets and memorandum of agreements. All sites funded for NTS and syphilis elimination by the CD Branch will be contractually required to operate condom distribution sites. This strategy aligns with the NHAS by making condoms more accessible in high risk populations thereby reducing the risk of HIV transmission in these communities. There are no state laws that prohibit this. At least 40 of the 50 condom distribution sites will be in non-health care settings.

Testing: The CD Branch will continue to support the State Laboratory for Public Health as well as all local health departments to conduct HIV testing among NC identified priority populations with special emphasis on young African American MSM. In 2007, the North Carolina Administrative Code was changed to allow for opt-out HIV screening in clinical settings. Pretest counseling for HIV is no longer required in the state and post-test counseling is only required for patients who test HIV-positive. These changes facilitated routine HIV testing in healthcare settings under the Expanded HIV Testing initiative that was fully implemented in 2008. All supported sites will continue to report data quarterly on the numbers of persons tested, the number testing positive, the number given their test results, and the number that have made an initial care visit. Sites are held accountable for standards on each of these elements. The CD Branch will work to expand the number of jails participating in the jail testing program and will continue funding UNC and WakeMed hospitals to conduct HIV testing in their Emergency Departments (EDs). The CD Branch will also continue to support agencies to conduct CTR across NC through our non-traditional test site programs as well as our

testing in substance abuse treatment facilities program; all of which are provided TA and capacity building from CD Branch monitors as well as funds or rapid HIV test kits (22 Integrated and Targeted Testing sites, 32 rapid sites, 21 jail sites, 9 Substance abuse sites, and 2 emergency departments). The CD Branch will continue to work with these agencies to build their capacity to conduct effective CTR services to include efforts to recruit bilingual and bicultural testing staff. In addition, the CD Branch will continue to provide free HIV rapid test kits as well as capacity building and TA to over 5 federally qualified community health centers and over 30 additional HIV rapid test sites. The preliminary positive rapid HIV tests are confirmed with a Western Blot or an RNA test processed at the NC State Laboratory or by a partner hospital or other private lab. In either case, for all positive patients who do not return for their confirmatory results, DIS will find the patient and perform prevention counseling in the field.

Efforts will be made to promote sustainable testing where possible. One jail facility currently uses regular clinic staff to provide testing, rather than a parallel model of health department staff coming into the jail for testing. STD clinics, the NC State Laboratory of Public Health and community health centers currently bill Medicare, Medicaid and other insurers. Approximately half of all patients at community health centers are uninsured and the Branch provides rapid HIV test kits to these facilities.

The CD Branch staff will continue to work closely with Women's Health, the North Carolina Medical Society and the Get Real, Get Tested campaign to educate private providers on the need to conduct HIV testing. Our Medical Director, Dr. Victoria Mobley, also will continue to conduct regular education sessions to public and private providers which include the importance of routine HIV testing via grand rounds in hospital settings, in quarterly statewide webinars, and in an annual "HIV/STD Update" session which is broadcast to over 400 providers.

Continued efforts will be made to identify high-prevalence, nontraditional venues and identify a positivity rate of at least 1.0%, and confirm linkages of care for 85% of their clients. Branch staff will work with funded agencies to discuss program operations and needs, successes and weaknesses, and make recommendations for improvement. Analysis of counseling, testing and referral patient data will be used to guide agencies to make adjustments to their programs.

Service Integration: North Carolina has always had a policy of integrated testing for HIV and syphilis when conventional serum testing is conducted. This means that all STD clinics in local health departments will test for syphilis when they test for HIV and the vast majority of agencies funded for HIV testing will also test for syphilis. For the jail testing program, eighteen agencies conduct testing in 32 jail and day reporting centers. Of those, all but two agencies offer HIV and syphilis tests (the other two use HIV rapid test kits). Three agencies integrated Hepatitis C testing and four agencies incorporated gonorrhea and chlamydia testing into their programs. All local health department STD clinics offer Hepatitis A and B vaccines and all agencies providing STD,

hepatitis and TB testing offer or refer out appropriate linkage, treatment and evaluation services. STD clinics, the NC State Laboratory of Public Health and community health centers currently bill Medicare, Medicaid and other insurers. The state will continue to collaborate with clinical sites and Medicaid regarding billing practices. Quarterly report data is reviewed with agencies at each bi-annual site visit.

Data Sharing/Communication: Efforts to share best case practices across HIV prevention and care agencies will be increased as will the use of new technology across program areas. HIV prevention and care data will be included in the CD Branch website for review by the public as well as funded and supported agencies. Increased communication between DIS staff and Bridge Counselors with HIV prevention and care agencies will be pursued as will increased attendance of HIV prevention agencies in the regional HIV network of care quarterly meeting. HIV network of care meetings will include HIV prevention agenda items and will allow time for HIV prevention discussions and updates.

Program Description/Goals:

The CD Branch has developed annual and five year objectives in order to guide HIV prevention program efforts for the near future. These objectives are based on HIV prevention programming detailed on attachments 4-11 in this document.

Monitoring and Evaluation description:

Program Monitoring - CD Branch staff monitor all funded and supported agencies through the NC subrecipient monitoring policy which requires regular monitoring of their activities. This NC Department of Health and Human Services policy is on file and available upon request. Through this policy, CD Branch staff monitors ensure that the most effective technologies and strategies and methodologies are used to maximize HIV testing, HERR and PCRS services. Program Monitors conduct at least two site visits during the contract period. Monitors ensure that all agencies report data and outcome measures required of each agency at least quarterly and ensure that these outcome measures are met or plans are made to achieve unmet outcomes. Monitors ensure that project staff have current knowledge of HIV and STDs and are able to provide appropriate counseling, testing, referral, PCRS and HERR services by ensuring staff attend trainings provided by the Communicable Disease Branch. In addition, they observe project staff conduct counseling sessions and educational presentations and ensure that staff provide participants with prevention intervention activities in a respectful manner compatible with their cultural health beliefs, practices, and preferred language. Monitors ensure that all services are delivered in a manner consistent with the CDC 2006 Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings.

Not all agencies supported by the CD Branch receive funding or enter into contractual agreements with the Branch. Thirty four agencies in NC participate in the NC HIV Rapid Test Program. The NC HIV Rapid Test Program supplies HIV rapid test kits to eligible agencies to use in testing high risk populations. These agencies must complete and submit an application to the Rapid Test Program and meet certain criteria including training on HIV CTR and the use of rapid test technologies, an HIV Testing Certificate, a CLIA Waiver, Standing Orders from a physician licensed to practice medicine in North Carolina, and they must enroll in the CDC's Model Performance Evaluation Program. Eligibility Requirements for the NC HIV Rapid Test Program are on file and are available upon request. CD Branch monitors ensure that these sites submit required data and use supplied test kits appropriately. All 53 agencies participating in our rapid HIV testing program sign MOUs with the CD Branch detailing operating procedures and outcomes expected which are assessed by program monitors.

Continued efforts are made to identify high-prevalence, nontraditional venues and identify a positivity rate of at least 1.0% in non-clinical settings, and confirm linkages of care for 80% of their clients. Branch staff works with funded agencies to discuss program operations and needs, successes and weaknesses, and make recommendations for improvement. Analysis of counseling, testing and referral patient data is used to guide agencies to make adjustments to their programs and monitors require improvement plans for sites realizing positivity rates of below 1%. Clinical sites supported by the CD Branch are monitored via the same contractual agreements as non-clinical sites and report testing data on a quarterly basis. This data is analyzed by CD Branch staff and clinical sites with an HIV positivity yield of less than .1% are required to work with program monitors to develop a plan to increase their positivity rates.

PCRS and bridge counseling (linkage to care) services are monitored by the Field Services Branch and are conducted by DIS in seven regional offices across the state. HIV linkage to an initial HIV primary care visit is coordinated by Bridge Counselors assigned to five HIV/STD regional offices. Monitoring for these activities consists of quarterly STD/MIS reports detailing all PCRS outcomes and monthly data reports from Bridge Counselors that capture linkage to care for all newly report HIV positives reported to those regions. DIS and Bridge Counselors are held accountable to state standards for these activities which are available upon request. DIS and Bridge Counselors not meeting state objectives are counseled and provided additional training or capacity building to increase their productivity.

Data Monitoring - The HIV Prevention Program collects data on HIV testing performed by entities and agencies supported by the Communicable Disease Branch (CDB). All data is reviewed on at least a quarterly basis and is used to assess program activities as well as progress towards both overall program and agency specific objectives. Here is a brief list of data sources:

- Self Report – CBOs, health departments, and other agencies who receive funding under certain testing programs (including Non-traditional Test Sites and Expanded Testing) send in quarterly self-reports for the number of tests performed and the number of positives. These can later be verified against other sources.
- NC State Laboratory of Public Health – Health departments in 100 counties and many CBOs send their samples to the SLPH in Raleigh for testing. The required HIV testing data is collected right on the laboratory submission form and is entered at the SLPH. North Carolina has its own HIV testing data forms and data entry system. The forms are scanned using Teleform and then verified by data entry clerks at the SLPH. The HIV Prevention Program receives data directly from the lab once per quarter. This data is converted to a SAS dataset and is cleaned and processed by Epidemiologists in the HIV Prevention Program. This data is also converted to a csv file and submitted to CDC via Evaluation Web.
- Rapid Testing – Agencies that receive rapid testing kits from the CDB fill out a separate form that comes directly to the Prevention Unit for data entry. The CD Branch has a similar Teleform scanning system for these forms but all are handled directly within the HIV Prevention Program. North Carolina is currently making revisions to the forms sent to the SLPH. The new form will accommodate both conventional blood tests sent to the SLPH for processing and rapid tests all on the same form. All of this data will be entered at the SLPH and there will no longer be a need for separate rapid testing forms or a separate database. These changes are slated to take place in the Fall of 2012.
- Clinical Datasets – One of the challenges in working with clinical settings under the HIV Expanded Testing Initiative (ETI) was reducing data burden. For most of the Community Health Center and Emergency Department sites, we agreed to let them send us a quarterly spreadsheet exported from their clinic database rather than filling out paper forms. These spreadsheets are managed in MS-Excel and in SAS by HIV Prevention Program Epidemiologists.

Surveillance Data

In North Carolina, both medical providers and laboratories are required to report positive HIV test results to the Health Department. At this point, a majority of reports reach us via electronic laboratory reporting but medical providers sometimes use paper forms as well. The Surveillance Unit at the DHHS Communicable Disease Branch processes all reports to determine whether or not they are already in the system. Any new diagnoses or previous diagnoses that are new to North Carolina will be forwarded to the geographically appropriate Regional Office for Partner Services follow-up.

The HIV case information for surveillance purposes is housed in an EHARS database at the CD Branch in Raleigh. Partner services follow-up data is housed in one of seven separate STD-MIS databases in the seven regional offices. None of these databases is currently linked. However, North Carolina is moving to a single, statewide electronic surveillance system (NCEDSS). The system is currently operating for nearly all infectious

diseases. The last two to be added will be HIV and syphilis in Fall 2012. This new system will replace and combine the function of the 7 stand-alone STD/MIS databases. This system is being designed to better track subsequent referrals to care, medical appointments, etc.

Reporting/Matching Data Sources

HIV Testing data from the SLPH dataset is prepared for quarterly (now biannual) submission to CDC via EvaluationWeb. Data is converted to the required variable formats using SAS software and then the entire file is converted to xml format for upload to EvaluationWeb.

Additional reporting is required under the HIV Expanded Testing Initiative (ETI). In the past this was for PS-10-1038 but this will now fall under 12-1201 Part B. These reports were in the form of tables in the report narrative, rather than as submitted datasets. In order to report on all tests performed under ETI, it is necessary to combine information from SLPH testing, rapid testing, clinical testing datasets, and some of the special datasets. The CD Branch is moving toward doing more of this electronically but for now, most data sources are analyzed individually and results are tallied by hand for the final tables.

The CD Branch matches screening data to surveillance twice a year to determine whether or not HIV positive cases are new diagnoses. This is time-consuming and currently requires a lengthy delay to ensure that surveillance information is up to date at the time of the match. Right now it is not possible to perform this match before CDC reports are due so the "new" vs. "previous" case status is based on patient self-report. The switch to NCEDSS should improve this process. Currently screening data is not matched up to the partner services data at all. It would require a huge time gap and the combination of at least 8 datasets, this problem should be fixed in the move to NCEDSS.

Analysis/Data Use

HIV testing data are analyzed two to four times a year, depending on the tasks required. CDC progress reports (APR and IPR) for Expanded Testing (10-1038) and HIV Prevention (12-1201) require tables that combine data for all sources. We expand on these tables for a second, internal report that is used by Communicable Disease Branch leadership to track HIV testing efforts. Other times, data from a single source is sufficient and that can be examined more frequently. All HIV testing reports are prepared by HIV Prevention Program epidemiologists using SAS software. Program staff use these reports to determine testing priorities both across and within agencies. Data are also used by program monitors to examine the quantity and quality of HIV testing in funded CBOs or other agencies. The program monitor will request data reports for an agency prior to a site visit and use the data to discuss possible changes in screening

programs. They also compare the data reports to self-reported data. If there are discrepancies, it may be a data collection problem that can be resolved.

North Carolina has procedures in place for data security and confidentiality. These procedures are in accordance with the CDC HIV data security and confidentiality guidelines. A signed copy of the MOU regarding use of CDC data systems is available upon request.

NC Division of Public Health Requirements for Safeguarding Confidential Surveillance Data used for Public Health Actions (November 2011), describes how the NC DPH (Division of Public Health) has implemented these standards within its Communicable Disease Branch of the Epidemiology Section. The procedures described in this document apply to all DPH employees with access to HIV, viral hepatitis, STDs and TB surveillance data. This policy also covers the applicable data stored at DPH locations and addresses protections provided to surveillance data in all forms, electronic, paper, and oral. Both the NC DHHS and DPH programs implement the State of North Carolina Security Standards and follow the guidance promulgated by the National Institute of Standards and Technology (NIST) as defined in its special publication series.

- The North Carolina Division of Public Health is fully committed to protecting the privacy of individually identifying health information. The federal standards for the Privacy of individually identifiable health information (IIHI) require that the NC DHHS Division of Public Health provide for the safeguarding and protection of IIHI that is created, received, and maintained in any form or medium by within the Division. The Division of Public Health has implemented an operating infrastructure that will protect the privacy of IIHI.

North Carolina will develop and maintain rules of behavior for data systems that are in accordance to CDC policies and agrees to sign and submit annually the following documents to CDC:

- ROB for the Administration of CDC Data Systems (Agency System Administrators);
- ROB for the Use of CDC Data Systems (Agency Users);
- ROB for the Administration of Non-CDC Data Systems (Agency System Administrators).

The Division requires training in privacy and security procedures for all member of its workforce. All staff (including temporary and contract staff) is required to complete this training when they join the Division and to provide attestation that they have completed it before access is granted to any confidential information. This orientation includes general instruction on the DPH structure and organization. Day one orientation also includes Computer Security Basic Awareness training, Basic Privacy Awareness training, and submission of a signed *Division of the Public Health Confidentiality Agreement*. Documentation of the successful completion of all new employee requirements will be maintained in employees' personnel files. Supervisors will document that each new employee has access to this document for reference and discuss any questions or

specific programmatic concerns about confidentiality and NC security. In the case of temporary or contract employees, documentation will be maintained by the supervisor responsible for that staff. In addition to the required DHHS and DPH new employee security trainings, all Communicable Disease Branch staff with access to confidential surveillance data must attend an annual confidentiality and security training session or complete an approved electronic training that covers the components of such training. A verification of the annual training is maintained in the employee's personnel file. Current training procedures include supervisor lead sessions using training slides approved by the ORP. Training rosters for training session are retained on site by the supervisor leading the training. All newly hired DIS (Disease Intervention Specialist) must attend the two-week Fundamentals of Disease Intervention (FDI) training within two to four months. This FDI training includes specific confidentiality components for DIS procedures for interacting with patients and providers.

All employees with access to confidential surveillance data are charged with challenging any suspected or improper access to confidential surveillance data. All Communicable Disease Branch employees with access to confidential patient data annually sign the Division of the Public Health Confidentiality Agreement at the time of the employee's annual performance appraisal; a copy of the annually signed agreement is maintained along with the performance appraisal in the employee's personnel file. Supervisors with contract employees ensure that these staff annually sign Division of the Public Health Confidentiality Agreement and retain copies.

North Carolina confidentiality and security policies and procedures are formally reviewed and approved each calendar year. This review includes an initial review by the Field Services Unit Head, the Communicable Disease Surveillance Unit Head for any needed policy, procedural, or programmatic changes needed. This review also includes a review by the DPH HIPAA Privacy and Security Office for any needed changes for changes to laws, policies, procedures related to protecting confidential data and to consistency with new or evolving technology issues. Recommended changes based on this review will be submitted to OPR for formal approval and incorporation into North Carolina's confidentiality and security document.

The DPH HIPAA Privacy and Security Office conducts periodic reviews for all related policies and procedures to ensure that they are consistent across the Division and that they reflect all new requirements and standards. The HIPAA Office also conducts periodic review of the practices and methods in place at physical locations and within work units across the Division. The HIPAA Office also conducts periodic security audits for all information systems containing confidential information. When applicable, the HIPAA Office coordinates these reviews with the DHHS Privacy and Security Office. This assessment reviewed the privacy protections and safeguards in place at all Division locations and for all Division programs.

The supervisor at each physical location (central office, regional offices, etc.) for which there is access to confidential surveillance data completes the annual security requirements checklist for that site and its employees each year at a time designated by the ORP. Supervisors retain these checklists as well as training rosters on site for review as needed. Checklists/training rosters may need to be submitted to the central office if an overall certification is required by the applicable funding agencies.

The North Carolina Division of Public Health is fully committed to protecting the privacy of individually identifying health information. The federal standards for the Privacy of Individually Identifiable Health Information (IIHI) require that the NC DHHS Division of Public Health provide for the safeguarding and protection of IIHI that is created, received, and maintained in any form or medium by within the Division. The Division of Public Health has implemented an operating infrastructure that will protect the privacy of IIHI. North Carolina staff shall continually work in consultation with CDC and review security controls and measures to ensure continued compliance with federal information security regulations.

The North Carolina CD Branch collects and submits additional information as required for interim and annual progress reports.

Quality Assurance Description:

The Field Services Unit (Partner Services) and the HIV/STD Prevention Program will continue to use a variety of means to enhance and determine the skills and knowledge necessary to successfully carry out program activities. These programs use state developed training curricula (CTR training, DIS module training, ISTD I etc.) based on, but separate from the CDC training options. After completion of formal training, Field Services and HIV/STD Prevention Program staff evaluates participants to assess the delivery and quality of the training, and provide opportunities for feedback to enhance existing services. Newly trained staff works in tandem with existing staff until management is confident of their abilities to conduct their duties according to state standards and do such in a culturally and linguistically appropriate manner.

The Field Services Unit training team meets quarterly with Field Services management to provide updates on activities and set priorities. Currently, a four person statewide training team consists of one assistant Field Services Manager, the training coordinator, a former DIS supervisor, and a lead DIS. The benefit of having a statewide training team allows the Unit to focus on training needs and not be affected by fluctuation of regional training resources around daily DIS priority work. Also, the training team provides support to the regional supervisor to accomplish training goals of their team. The training coordinator has the primary responsibility for resource assessment and development and is constantly monitoring training needs and ways to most effectively accomplish training needs and is in contact with CDC's training staff and National Network of Prevention Training Centers (NNPTC). Current efforts to reach disproportionately affected populations such as MSMs

and Latinos has allowed the Unit to work with long time representatives of these communities. DIS with special skills, Senior DIS and Regional Supervisors are a part of the local training teams used to present courses for the staff.

The Branch will continue to offer capacity building trainings for HIV prevention service providers and staff throughout North Carolina in 2014. The HIV/STD Prevention Program requires all supported agency staff conducting HIV CTR to complete a two day state sponsored CTR class and also provides evidence based intervention trainings annually based on the unmet needs. The trainings are prioritized per the data collected on regular needs assessments of supported agencies. Other regular trainings include: organizational infrastructure, fiscal management, DEBI interventions, CTR, Rapid Testing, logic models, STD/HIV101, and reaching priority populations, capacity building is also conducted at the contract monitor level. CD Branch staff also work closely with the CDC CRIS system to request needed HIV prevention training for agencies needing it. All sites funded by the CD Branch for HIV prevention and CTR activities receive at least two site visits annually and routine capacity building and TA from their monitors.

CD Branch staff ensures that all positive HIV test reports are reported to the appropriate state and local agencies according to NC statutes. The Division of Public Health, Department of Health and Human Services, is authorized by law (N.C. G.S. § 130A-134 through 130A-143) to collect reports of HIV cases. North Carolina General Statute § 130A-135 requires licensed physicians to report cases and suspected cases of reportable communicable diseases and conditions in persons who have consulted them professionally. Cases of HIV infection and AIDS are reported on the communicable disease report card (DHHS 2124) and the surveillance form appropriate for the age of the patient: adult (DHHS 4114) or pediatric (CDC Form 50.42B.) Physicians forward case reports to the local health department in which they are consulted.

Cases are then reported to the local and to the state health department through a number of mechanisms, including direct communication like phone calls, mail, electronic laboratory reporting, and via a standardized DHHS disease questionnaire and reporting form (DHHS 2124). Once these reports are received they are investigated by CD surveillance and DIS staff to determine if they are new cases and if so are forwarded to the HIV/STD Regional offices for follow up and PCRS services.

HIV Care and Prevention Comprehensive Planning

Just as a combined Care and Prevention Needs Assessment process is a new venture, so too is comprehensive planning, and there is little doubt that we have lots to learn and improve upon. As indicated at the beginning of this document, both Care and Prevention share a common client base and a shared vision of what needs to happen.

Even at the Federal level, there is increasing recognition that Care and Prevention share common aims – identifying those who are positive or at risk of contracting HIV, and

ensuring their entry into care in order to provide the infected with better lives and decrease the likelihood that they will transmit their virus to others. Although our methods may be different, our goals are complementary, and are crucial parts of a continuum. We all support the goals embodied in the National HIV/AIDS Strategy, and we must continue working together to ensure that those goals are realized.

As noted early in this document, the collaboration between Prevention and Care is in its earliest stages, although the programs have been working cooperatively for several years now. Probably the most visible sign of this collaboration is NC-LINK, which draws heavily on both. It is obvious, however, that much still remains to be done, and participants in the development of this document have offered constructive suggestions in this regard.

On a Statewide basis, some of the suggestions include:

- Combining Advisory groups to ensure that all perspectives are accounted for in discussion of issues and development of operating methodologies.
- Combining data systems to ensure consistency of information (may be difficult at this time due to Federal requirements).
- Redefining Regions so that Care and Prevention regions coincide.
- Develop master calendar for coordination of activities.
- Collaboration on grant-writing.
- Statewide cross-training.

On a local basis, suggestions include:

- Collaboration on events, such as health fairs.
- Create local linkages between Prevention and Care.
- Provision of Medical Case Management training.
- Develop regional calendars of events.
- Promote team-building.

It seems obvious that combining HIV Care and Prevention is a logical next step in the evolution of this disease and the methods needed to address the disease. It also seems obvious that providers and advocates are in agreement that combining these 2 formerly distinct disciplines is a positive move. This will certainly not be easy, nor will it happen overnight. But given the positive sentiment expressed in this document, it certainly appears that this is the direction we must follow.

This concept has just been given a major boost. HRSA and the CDC have recently announced that they have begun developing guidelines for joint Prevention and Care needs assessment and comprehensive planning. In fact, this announcement noted that the next official document required to be submitted will be a combined prevention and care needs assessment/comprehensive plan, and will be due to the respective agencies in September, 2016.

List of Participants

These participants represent a broad cross-section of the HIV Prevention and Care community in North Carolina. Affiliations are purposefully omitted to protect confidentiality, but include: Communicable Disease Branch staff; HIV Prevention and Care Advisory Committee (HPCAC) members; prevention and care providers, including RW Parts A, B, C, D and F providers; and HIV-infected and -affected individuals.

Melvinna Adams	Corina Buzard
Liana Addison	Larry Bynum
Sucora Anderson	Carol Caldwell
Jeff Bachar	Paul Camarena
Michele Bailey	Leslie Cameron
J. Michael Baker	Diane Campbell
Kelvin Barlow	Annette Carington
John Barnhart	Heather Carter
Mark Batson	Mary Ann Chap
Rickie Battle	Michelle Chester
Sebastian Battle	Robert Childs
Brenda Beam	Maritza Chirinos
Michael Beard	Patrick Church
Donna Bell	Kristena Clay-James
Lynda Bell	Adria Cline
Stephanie Bell	Jacquelyn Clymore
Denise Belle	Sandra Coley
Mariah Bellello	Juan Colon
Brian Berte	Linda Connor
Karen Best	Lisa Cooper
Michael Best	Alex Cordova
Al Bishop	Janet Cote
Gladys Bonilla	Rita Cozart
Candace Bonner	Luis Cruz
Sandra Boren	Stacy Cuevas
Natasha Bowen	Coleen Cunningham
Jim Bradley	Suzette Curry
Tracy Bristow	Robert Daniel
Jena Britt	Karen Daniels
Corin Brown	Eric Davis
Domonique Brown	Fran DeShazo-Mock
Cherri Brunson	Ricky Duck
Marty Buie	Stacy Duck
Sharon Burwell	Jesse Duncan
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Yvonne Early
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Lauren Boyle-Estheimer
Marquis Eure
Sharon Evans
Nada Fadul
Amy Faw
Brenda Fields
Glenn Filkins
Rasheeka Fogg
Katherine Foster
Tamala Fuller
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Geneva Galloway
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Monique Gary-Porter
Cheryl Gill
Julieta Giner
John Glorioso
Carlos Gomez
Sandra Gomez
Elio Gonzalez
Jessica Goodman
Beverly Greenwood
Kevin Gwynn
Robin Hahaj
Zina Ham
Anthony Hannah
Kevin Harrell
Taylor Harrelson
Brian Harris
Leonard Hay
Lisa Hazirjian
Amy Heine
Artie Hendricks
Ron Higginbotham
Barbara Hinnant
Carolyn Hinton
Jamie Hopkins

Katie Horstmann
Lola Houston-Hager
Renee Huffaker
Harold Hunter
Tara Ilsley
Michael Isler
Arthur Jackson
Solita Jeffries
Dennis Jenkins
Johnathan Jenkins
Jonathan Jernigan
Rob Jiggetts
Mary Jo Hassett
Darrin Johnson
Dee Johnson
Lora Johnson
Marc Johnson
Jennifer Keller
Melicia Laroco-Molter
Sharon Leach
Michael Leonard
Althea Lewis
Christopher Long
Ione Long
Michelle Mace
Jaime Mallory
Dana Mangum
Faye Marshall
Debbie Maye
Carolyn McAllaster
Elazzoa McArthur
Shemeika McEachern
Charlene McKay
Larissa McLaurin
Diane McLawhorn
Mary McLees-Lane
Tilda McMillan
Paula McMillian
Carlotta McNeill
Michael McNeill
Ione McShaw
Julie Meyer
Sandy Michael
Dallas Midgette

Gabriela Montilla-Perez Rhinehart
Pete Moore
Eric Murray
Cheryl Newsome
Marti Nicolaysen
John Niffenegger
Kathy Norcott
Susan O'Brien
Michelle Ogle
Arthur Okrent
Lakecia Owens
Pat Oxendine-Pitt
Scott Parker
Heather Parnell
Laura Parrish
JeaNelle Plummer
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Rusty Powell
Kay Prioleau
Detra Purcell
Byrd Quinlivan
Venika Razemore
Valetta Rhinehart
Allison Rice
Broderick Roary
Esther Ross
Charice Rosser
Theresa Rubin
Tujuanda Sanders
Jan Scott
Tiffany Sewell
Teri Sferlazza
Linda Sheehan
Glenda Sigmon
Sherita Simmons
Delton Smith
Grady Smith

Sandra Smith
Douglas Solow
Cynthia Songs
Beth Stringfield
Andy Sturdy
Hannah Stutts
Carol Suarez
John Switzer
Netha Taylor
Yvonne Torres
Evelyn Troy
Christopher Vann
Salvador Vargas
Kevin Varner
Caree Varughese
Renita Vega
Kimberly Walker
Todd Wallenius
Debbie Warren
Shannon Warren
Dorothy Waterson
Holly Watkins
Paul Weaver
B. Welch
Derrick Whitaker
Barry White
Curtis Williams
Jeff Williams Knight
Sharema Williams
Wayman Williams
Julie Willis
Bob Winstead
Barbie Woods
Rich Wooldredge
Thelma Wright
David Zealy

2014 SCSN/NA/CP Update Questionnaire
Distributed by email April 14, 2014

The Prevention and AIDS Care Programs are in the process of preparing a 2014 update to the combined 2012 Statewide Coordinated Statement of Need/Needs Assessment/Comprehensive Plan (SCSN/NA/CP), and we are requesting that you assist us in this effort.

We have been informed by both the CDC and HRSA that the next required SCSN/NA/CP will be due in 2016, and will be a combined document for both programs. We are awaiting the guidance for this effort, so that we can begin planning preparations. Thus, this will be the last update of the 2012 document. When we complete the 2014 update, we will begin planning for the 2016 SCSN/NA/CP.

Attached is the draft 2014 Update to the SCSN/NA/CP. Based on our initial review of the 2013 updated SCSN/NA/CP, we have already included a number of changes. These changes are located throughout the document, and can be identified by their grey background. We are planning to have a discussion with you about this document at our joint Prevention and Care Providers Meeting on May 16, 2014. We will be sending out the announcement for that meeting very soon. We are requesting that you carefully review the changes that have been made to the attached draft document. In addition, we are asking that you also carefully review the identified Prevention and Care needs, and the activities planned to address those needs, to determine whether they continue to remain appropriate or need updating.

We rely heavily on the input we receive from you, and are asking that you respond to the two sets of questions below by April 25, 2014 (this will allow us time to consider your responses and prepare additional materials for your review at the May meeting).

1. Needs Assessment:

Do the needs identified in this document continue to remain appropriate? Do you believe that any of these needs no longer need to be considered? Are there any needs which you consider important that are not addressed in the needs assessment? Are the priority rankings still appropriate, or are changes needed?

2. Comprehensive Plan:

Are the priority program areas identified still appropriate? Are any of these activity areas no longer needed? Are there any activity areas that need to be added? Are activity areas appropriately ranked, or do changes need to be made to these priorities?

These are all important questions for HIV/STD prevention and care as we plan for the next several years, and for the new process that will be implemented for the future. Therefore, we strongly urge you to review this material carefully, and provide us with the information necessary to assure that we can appropriately plan for the short term, and for the future.

Please email all responses to the above sets of questions to Arthur Okrent at arthur.okrent@dhhs.nc.gov.

Thanks very much for your input and participation.

Attachment 1

HIV/AIDS 2012 Epidemiology Table
Living Persons Diagnosed* in North Carolina with HIV Disease by Demographics and Exposure Category

Demographics and Exposure Category	Disease status				TOTAL	
	HIV non-AIDS		AIDS		Cases	Percent
	Cases	Percent	Cases	Percent		
GENDER						
Male	10,940	69.1%	8,195	73.0%	19,135	70.7%
Female	4,895	30.9%	3,038	27.0%	7,933	29.3%
Total	15,835	100.0%	11,233	100.0%	27,068	100.0%
CURRENT AGE						
Less than 2	3	0.0%	0	0.0%	3	0.0%
2 to 12	60	0.4%	4	0.0%	64	0.2%
13 to 24	1,137	7.2%	218	1.9%	1,355	5.0%
25 to 44	6,782	42.8%	3,927	35.0%	10,709	39.6%
45 to 64	7,246	45.8%	6,537	58.2%	13,783	50.9%
65 and over	592	3.7%	547	4.9%	1,139	4.2%
Unknown	15	0.1%	0	0.0%	15	0.1%
Total	15,835	100.0%	11,233	100.0%	27,068	100.0%
RACE/ETHNICITY						
White**	4,076	25.7%	2,760	24.6%	6,836	25.3%
Black**	10,350	65.4%	7,140	66.0%	17,760	65.6%
AI/AN**	118	0.7%	93	0.8%	211	0.8%
Asian/PI**	98	0.6%	40	0.4%	138	0.5%
Hispanic	886	5.6%	749	6.7%	1,635	6.0%
Multiple/Unknown	307	1.9%	181	1.6%	488	1.8%
Total	15,835	100.0%	11,233	100.0%	27,068	100.0%
EXPOSURE CATEGORY						
MSM	5,931	37.5%	3,740	33.3%	9,671	35.7%
IDU	961	6.1%	1,060	9.4%	2,021	7.5%
MSM/IDU	305	1.9%	277	2.5%	582	2.2%
Blood Products	32	0.2%	49	0.4%	81	0.3%
Heterosexual	2,362	14.9%	1,968	17.5%	4,330	16.0%
Pediatric	203	1.3%	75	0.7%	278	1.0%
NIR/NRR	6,041	38.1%	4,064	36.2%	10,105	37.3%
Total	15,835	100.0%	11,233	100.0%	27,068	100.0%

*Living Persons Diagnosed as of December 31, 2012

**non-Hispanic

Source: North Carolina Electronic HIV/AIDS Reporting System (eHARS)

Attachment 2

Table: North Carolina Unmet Need Estimate, 2012

Input Population Sizes	Value	Data Source
A. Number of persons living with AIDS (PLWA), CY2012	13,867	HIV/AIDS Reporting System (eHARS) Calendar Year 2012
B. Number of persons living with HIV non AIDS (PLWH),	16,814	HIV/AIDS Reporting System (eHARS) Calendar Year 2012
Care Patterns	Value	Data Source
C. Number of PLWA who received HIV primary medical care, CY 2012	10,889 (78.5%)	Surveillance, Ryan White Titles, ADAP, Medicaid, Calendar Year 2012
D. Number of PLWH (aware, non-AIDS) who received HIV	11,653 (69.3%)	Surveillance, Ryan White Titles, ADAP, Medicaid,
Calculated Results	Value	Calculation
E. Number of PLWA who did not receive primary medical care	2,978 (21.5%)	A-C (E/A)
F. Number of PLWH who did not receive primary medical care	5,161 (30.7%)	B-D (F/B)
G. Total HIV Disease (aware) not receiving primary medical care (quantified estimate of unmet need)	8,139 (26.5%)	E+F (G/A+B)

Attachment 3

EIIHA Matrix for 2012

All individuals in NC who are Unaware of their HIV status (HIV Positive and Negative – Tested and Untested)					
Tested in the past 12 months		Not tested in the past 12 months			
Individuals not Post-test counseled (HIV positive or negative)	High risk individuals	Moderate & low risk Individuals			
		Not tested in past 24 months	Not tested in past 48 months		
--- 3 PARENT GROUPS ---					
Substance abusers (IDU)	MSM			High risk heterosexuals	
---- 6 TARGET GROUPS ---					
Injecting drugs users & their sex partners	Gay and bisexual black men	Gay and bisexual Hispanic men	Young gay and bisexual men (13-24)	Black women in high prevalence/ low wealth areas	Commercial sex workers and their partners

Attachment 4

PS12-1201 Category A: HIV Testing Objectives and Annual Targets

HIV Testing Goals:

Approximately 200,000 total HIV tests will be conducted in healthcare and non-healthcare settings. Of these total tests, 30,000 will be targeted testing done in non-healthcare settings in Year 1. In non-healthcare settings, 300 HIV-positive persons that are previously unaware of their infection will be identified in Year One of funding.

By Year 5, approximately 1,221,020 total HIV tests will be conducted cumulatively. Of these total tests, 183,153 will be targeted testing done in non-healthcare settings and approximately 1,832 HIV-positive persons that are previously unaware of their infection will be identified.

HIV Testing Objectives and Annual Targets

In an effort to monitor progress toward meeting the PS12-1201 Category A national objectives, please submit your jurisdictional proposed objectives for number of HIV test events, number of newly-identified HIV-positive test results, and new HIV-positive test rate for years 1-5 of the project period. For each year, enter the projected number of HIV test events that will be conducted and the anticipated new HIV-positive test rate.

Objectives	Targets Per Year					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	# of HIV testing events (TOTAL=HEALTHCARE + NON-HEALTHCARE)*	200,000	220,000	242,000	266,200	292,820
# of HIV testing events (HEALTHCARE)*	170,000	187,000	205,700	226,270	248,897	1,037,867
# of HIV testing events (NON-HEALTHCARE)*	30,000	33,000	36,300	39,930	43,923	183,153
# of newly-identified HIV-positive test results (NON-HEALTHCARE):	300	330	363	399	439	1,832

New HIV-positive test rate (%) (NON-HEALTHCARE)**	1%	1%	1%	1%	1%	1%
# of newly-identified HIV-positive test results returned to clients (NON-HEALTHCARE)	255(85%)	287(87%)	316(87%)	359(90%)	395(90%)	1,613
# of clients with a newly-identified HIV-positive test result linked to medical care and attended their first medical appointment (NON-HEALTHCARE)	240(80%)	274(83%)	301(83%)	339(85%)	373(85%)	1,528
# of clients with a newly-identified HIV-positive test result referred to and interviewed for Partner Services (NON-HEALTHCARE)	255(85%)	287(87%)	316(87%)	359(90%)	395(90%)	1,613
# of clients with a newly-identified HIV-positive test result that received prevention counseling or were referred to prevention services (NON-HEALTHCARE)	255(85%)	287(87%)	316(87%)	359(90%)	395(90%)	1,613

Outcome Objective(s)	Responsible for implementation
Objective 1: From January 1, 2012 to December 31 2016, the Communicable Disease Branch and its partners will conduct a minimum of 1,221,020 HIV tests (1,037,867 HEALTHCARE; 183,153 NON-HEALTHCARE).	
Process Objective 1: From January 1, 2012 to December 31 2016, a minimum of 100 sites will conduct HIV testing in non-clinical and clinical settings.	Funded agencies

<p>Objective 2: From January 1, 2012 to December 31 2016, the Communicable Disease Branch and its partners will maintain a minimum rate of 1.0 for newly-identified HIV-positive clients in non-healthcare settings, i.e., homeless shelters, nightclubs, barber shops, colleges and universities.</p>	
<p>Process Objective 2: From January 1, 2012 to December 31 2016, the Communicable Disease Branch and its partners will review testing data annually and adjust testing venues, as needed.</p>	<p>CD Branch Staff, funded agencies</p>
<p>Objective 3: From January 1, 2012 to December 31, 2016, the percentage of newly-identified HIV-positive clients that are interviewed for Partner Services will increase from 85% to 90%.</p>	
<p>Process Objective 3: From January 1, 2012 to December 31, 2016, Disease Intervention Specialists will interview newly identified HIV-positive clients within 48 hours of receipt of the HIV test results.</p>	<p>DIS</p>
<p>Objective 4: From January 1, 2012 to December 31, 2016, the percentage of newly-identified HIV-positive clients reported to the Communicable Disease Branch that are eligible for Ryan White medical services that will attend their first medical care appointment within 90 days of diagnosis will increase from 85% to 90%.</p>	
<p>Process Objective 4: From January 1, 2012 to December 31, 2016, Bridge counselors will track newly-identified HIV-positive client visits to ensure that they receive their first medical care appointment within 90 days of client notification.</p>	<p>Bridge Counselors</p>

Attachment 5

Comprehensive Prevention for Positives Objectives and Annual Targets

Comprehensive Prevention for Positives Goals:

At least 80% of all Persons testing positive for HIV in North Carolina will be given their test results, linked to HIV primary care and preventative care, will receive partner services and education, and will attend their first care appointment within 90 days of their diagnosis.

Comprehensive Prevention with Positive Objectives and Annual Targets						
Objectives	Targets					Total
	Year 1	Year 2	Year 3	Year 4	Year 5	
Newly-identified HIV-positives						
# HIV-diagnosed clients (new and previous positives) linked to HIV medical care	*302 85%	*335 87%	*368 88%	*404 89%	*445 90%	1853
# of clients with a newly-identified HIV-positive test result linked to medical care and attended their first medical appointment within 90 days of initial diagnosis	284 80%	320 83%	351 84%	386 85%	420 85%	1760
# of newly-identified HIV-positive clients who were referred and linked to prevention services	302 85%	335 87%	364 87%	409 90%	445 90%	1854
# of clients with a newly-identified HIV-positive test result referred to and interviewed for Partner Services	302 85%	335 87%	364 87%	409 90%	445 90%	1854

*This reflects newly diagnosed HIV positives.

Outcome Objective(s)	Responsible for implementation
Outcome Objective #1: From January 1, 2012 to December 31 2016, the Communicable Disease Branch and its partners will increase the amount of new and previously diagnosed HIV positive clients linked to HIV medical care and receiving interviews for partner services from 85% to 90%.	

<p>Process Objective 1: From January 1, 2012 to December 31 2016, agencies funded for HIV CTR will be required to make initial appointments for care for all newly diagnosed HIV positive clients.</p> <p>Process Objective 2: From January 1, 2012 to December 31 2016, agencies funded for HIV CTR will be required to make initial appointments to care for all clients previously positive for HIV who are retested positive and who are not in care at the time of the new positive result.</p> <p>Process Objective 3: From January 1, 2012 to December 31 2016, DIS/Bridge Counselor staff will ensure that all newly diagnosed and previously diagnosed HIV positive clients who are not in care are referred to HIV care.</p> <p>Process Objective 4: From January 1, 2012 to December 31 2016, DIS staff will ensure that all newly diagnosed HIV positive clients will be pursued for interviews and partner services.</p>	<p>Funded Agencies</p> <p>Funded Agencies</p> <p>DIS, Bridge Counselors</p> <p>DIS</p>
<p>Outcome Objective #2: From January 1, 2012, to December 31 2016, the Communicable Disease Branch and its partners will increase the amount of newly-identified HIV-positive clients who attend their first medical appointment from 80% to 85%.</p>	
<p>Process Objective 1: From January 1, 2012 to December 31 2016, agencies funded for HIV CTR and DIS will be required to provide HIV results to at least 95% of all persons testing positive for HIV.</p> <p>Process Objective 2: From January 1, 2012 to December 31 2016, agencies funded for HIV CTR and DIS will be required to make initial appointments for care for all newly diagnosed HIV positive clients receiving test results</p> <p>Process Objective 3: From January 1, 2012 to December 31 2016, funded agencies and DIS/Bridge Counselor staff will verify that all newly identified HIV positive persons referred to care attended their first care appointment.</p> <p>Process Objective 4: From January 1, 2012 to December 31 2016, Bridge Counselor staff will attempt to contact all newly identified HIV positive clients missing their initial care appointment and work with them on reducing barriers to attending this appointment.</p>	<p>Funded Agencies, DIS</p> <p>Funded agencies, DIS</p> <p>Funded agencies, DIS, Bridge Counselors</p> <p>Bridge Counselors</p>

<p>Outcome Objective #3: From January 1, 2012 to December 31 2016, the Communicable Disease Branch and its partners will increase the amount of newly-identified HIV-positive clients who were referred and linked to prevention services from 85% to 95%.</p>	
<p>Process Objective 1: From January 1, 2012 to December 31 2016, agencies funded for HIV CTR will be required to make appropriate referrals to prevention and support services for all newly diagnosed HIV positive clients given their test results.</p> <p>Process Objective 2: From January 1, 2012 to December 31 2016, DIS/Bridge Counselor staff conducting interviews or referrals to care for clients newly identified with HIV will make appropriate referrals to HIV prevention and support services.</p>	<p>Funded agencies</p> <p>Bridge Counselors, DIS</p>

Capacity Building Activities Planned for Prevention with Positives:
Capacity building activities include training for funded agencies, DIS and Bridge counselors to locate, counsel and refer HIV positive clients as well as communication to ensure that these separate entities work together to coordinate services.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
How many clients are newly identified with HIV	HIV positive tests with no previous positive result	NCEDSS	1-1-2013 to 12-31-2016
How many clients receive their test results	HIV positive clients receiving test results	NCEDSS	1-1-2013 to 12-31-2016
How many newly identified HIV positive clients are interviewed for partner notification	New HIV positives with documented interviews conducted	NCEDSS	1-1-2013 to 12-31-2016
How many newly identified HIV positive clients are referred for prevention services	New HIV positives with referrals to prevention services	DIS reports, quarterly narratives from funded agencies	1-1-2013 to 12-31-2016
How many clients make their first care appointment	New HIV positives with verified initial HIV care appointments made	Bridge counselor data	1-1-2013 to 12-31-2016

Attachment 6

Condom Distribution Objectives and Annual Targets

Condom Distribution Goals:

Approximately 500,000 condoms will be distributed statewide. Of these, at least 100,000 condoms will be distributed to HIV-positive clients and 400,000 will be distributed to high-risk negatives or others of unknown status in Year One of funding.

By Year Five, North Carolina expects that approximately 2,500,000 total condoms will be distributed statewide with approximately 500,000 condoms distributed to HIV-positive clients and 2,000,000 distributed to high-risk negatives or others of unknown status.

Condom Distribution Objectives and Annual Targets						
Objectives	Targets					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
# of condoms to be distributed (overall)	500,000	500,000	500,000	500,000	500,000	2,500,000
# of condoms to be distributed targeted to HIV-positive clients	100,000	100,000	100,000	100,000	100,000	500,000
# of condoms to be distributed targeted to high-risk negatives or others of unknown status	400,000	400,000	400,000	400,000	400,000	2,000,000
Additional local objective: <i>Establish and maintain condom distribution sites</i>	100	100	100	100	100	100

<p>Outcome Objective(s)</p> <p><i>Outcome Objective 1:</i> From January 1, 2012 to December 31, 2016, the, CD Branch will support funded agencies to establish at least 100 condom distribution</p>	<p>Responsible for implementation</p>
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sites where 2,000,000 condoms will be distributed to high-risk negatives or others of unknown status and 500,000 will be distributed to HIV-positive clients.	
Process Objective 1: From January 1, 2012 to December 31, 2016, a minimum of 34 CD Branch supported HIV testing and evidence-based intervention agencies will establish condom distribution sites statewide that will reach HIV-positives, high-risk negatives and individuals of unknown status in high morbidity areas in North Carolina.	Funded agencies

Capacity Building Activities Planned for Condom Distribution:

None at this time.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
See Part B Monitoring and Evaluation Plan			

Attachment 7

Social Marketing, Media Mobilization Objectives and Annual Targets

Social Marketing Goals:

North Carolina will maintain a statewide social marketing campaign promoting HIV testing and linkage to care messages to North Carolinians at high risk for HIV and other STDs.

Social Marketing, Media, & Mobilization Objectives and Annual Targets						
Objectives: <i>Implement one Get Real, Get Tested, Get Treatment campaign.</i>	Targets Per Year					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
# of social marketing/public information campaigns to be conducted	1	1	1	1	1	5
# of people to be reached (exposures)	100,000	100,000	100,000	100,000	100,000	500,000
# of media placements for marketing campaigns	TV spots = 250 - 400	TV spots = 250 - 400	TV spots = 250 - 400	TV spots = 250 - 400	TV spots = 250 - 400	12,500-20,000
Additional local objectives	Spanish language campaign	Spanish language campaign	Spanish language campaign	Spanish language campaign	Spanish language campaign	Spanish language campaign
Additional local objectives	Radio campaign	Radio campaign	Radio campaign	Radio campaign	Radio campaign	Radio Campaign

Outcome Objective(s)	Responsible for implementation
Process Objective 1: Develop messaging with local HD and CBOs	CDB staff
Process Objective 2: Work with media partner to implement campaign	CDB staff
Process Objective 3: Work with ADAP staff to monitor outcomes	CDB staff

Capacity Building Activities Planned for Social Marketing, Media, & Mobilization:

Working with local health departments and CBOs on these commercials – using them as the talent for these spots. They can then use them in their organizations.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
How many patients were connected to care?	Number of calls coming into hotline as a result of media / radio campaign	Metrics from call sheets, reports from providers	2012 - 2016
How many patients were added to NC ADAP	Number of patients added to ADAP as a result of media / radio campaign	Metrics from call sheets and ADAP	2012 - 2016

Attachment 8

Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk of Acquiring HIV Objectives and Annual Targets

Goal:

The CD Branch will support at least 8 agencies to provide high quality HIV prevention interventions to high risk HIV negative populations targeting NC's prioritized populations; i.e., PLWHA, MSM, HSC, and IDU in order to reduce risky behavior.

EBIs for High-Risk Negatives Objectives and Annual Targets						
Objectives	Targets Per Year					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
# of high-risk HIV negative clients who will enroll in individual and group level evidence-based interventions (ILIs and GLIs):	470	517	569	626	689	2,871
# of community evidence-based interventions to be conducted	0	0	0	0	0	0
# of people to be reached by community evidence-based interventions	0	0	0	0	0	0

Outcome Objective 1. From January 1, 2012 to December 31, 2016, all agencies funded for HV interventions for high risk negatives will have staff properly trained for their selected intervention	Responsible for implementation
<p>Process Objective 1: By December 31, 2013, the HIV/STD Prevention Program will conduct a needs assessment to assess the agencies capacity to implement the funded interventions</p> <p>Process Objective 2: By September 2014, the HIV/STD Prevention Program will identify resources to address the training needs of the funded agencies</p> <p>Process Objective 3: By June 2016, the HIV/STD Prevention Program will conduct a follow up assessment to identify if training needs were met by funded agencies</p>	HIV/STD Prevention Program Staff

Capacity Building Activities Planned for HIV Prevention Interventions:

The CDC CRIS system will be used to support any identified training needs of agencies needing training for HV interventions for high risk negatives

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
How many agencies have appropriately trained staff for their selected intervention	Number of appropriately trained staff per funded agency	Needs assessment	December 31, 2013

Attachment 9

Policy Initiatives Objectives and Annual Targets

<p>Policy Initiative Goal: NC DPH public health statutes and CD Branch policies will align with the National HIV/AIDS Strategy.</p>

Outcome Objective 1:	Responsible for implementation
<p>Process Objective 1: Between December 31 2012 and December 31, 2016, CD Branch staff will review current public health statutes and CDB policies relating to HIV prevention activities bi-annually to ensure that they align with CD Branch goals and the NHAS.</p> <p>Process Objective 2: CDB Staff will submit changes to public health statutes and CDB policies relating to HIV prevention activities that don't align with NHAS and CD Branch goals.</p>	<p>CD Branch Staff</p>

<p>Capacity Building Activities Planned for Policy Initiative: None</p>

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
<p>Do DPH and CD Branch policies and statutes align with the NHAS and CD Branch goals?</p>	<p>Reviews of current statutes, policies</p>	<p>DHHS public health statutes, CDB policies</p>	<p>December 31 2012 and December 31 , 2016</p>

Attachment 10

PS 12-1201 Category B: HIV Testing Objectives and Annual Targets in Healthcare Settings

HIV Testing Goals:

Approximately 31,711 HIV tests are provided and approximately 55 HIV-infected persons who were previously unaware of their infection are identified in Year 1 of funding.

By Year 5, North Carolina expects that approximately 158,555 HIV tests are provided over this five year period and approximately 275 HIV-infected persons who were previously unaware of their infection are identified.

HIV Testing in Healthcare Settings: Objectives and Annual Targets

In an effort to monitor progress toward meeting the PS12-1201 Category B national objectives, please submit your jurisdictional proposed objectives for number of HIV test events, number of newly-identified HIV-positive test results, and new HIV-positive test rate for years 1-5 of the project period. For each year, enter the projected number of HIV test events that will be conducted and the anticipated new HIV-positive test rate.

Objectives	Targets Per Year					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
# of HIV testing events*	31,711	31,711	31,711	31,711	31,711	158,555
# of newly-identified HIV-positive test results:	55	55	55	55	55	275
New HIV-positive test rate (%)**	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
# of newly-identified HIV-positive test results returned to clients	47 (85%)	48 (87%)	48 (87%)	50 (90%)	50 (90%)	243
# of clients with a newly-identified HIV-positive test result linked to medical care and attended their first medical appointment	44 (80%)	46 (83%)	46 (83%)	47 (85%)	47 (85%)	230
# of clients with a newly-identified HIV-positive test result referred to and interviewed for Partner Services	47 (85%)	48 (87%)	48 (87%)	50 (90%)	50 (90%)	243
# of clients with a newly-identified HIV-positive test result that received prevention counseling or were referred to prevention services	47 (85%)	48 (87%)	48 (87%)	50 (90%)	50 (90%)	243

*The number of test events is not expected to increase due to decreased Category B funding. Also, we do not expect to continue collecting data from unfunded projects as they become sustainable.

** # of newly-identified, confirmed HIV-positive test results (numerator)/ # of HIV test events (denominator) = Target rate for new HIV positivity.

<p>Outcome Objective: From January 1, 2012 to December 31 2016, the Communicable Disease Branch and its partners will conduct a minimum of 31,711 HIV tests in clinical settings annually for a total of 158,555 tests.</p>	<p>Responsible for implementation</p>
<p>Process Objective 1: From January 1, 2012 to December 31, 2016, a minimum of 28 correctional facilities will conduct HIV testing.</p> <p>Process Objective 2: From January 1, 2012 to December 31, 2016, a minimum of 4 hospitals will conduct HIV testing in emergency departments, outpatient clinics and other clinical settings.</p> <p>Process Objective 3: From January 1, 2012 to December 31, 2016, a minimum of 9 federally qualified community health centers will conduct HIV testing.</p> <p>Process Objective 4: From January 1, 2012 to December 31, 2016, a minimum of 102 local health department STD clinics will conduct HIV testing.</p>	<p>Project Coordinator, Agency Coordinators</p>
<p>Outcome Objective: From January 1, 2012 to December 31, 2016, the Communicable Disease Branch and its partners will maintain a minimum rate of 0.2 for newly-diagnosed HIV positives.</p>	
<p>Process Objective 1: From January 1, 2012 to December 31, 2016, the Communicable Disease Branch and its partners will review testing data bi-annually and adjust testing venues as needed.</p>	<p>Project Coordinator, Agency Coordinators</p>
<p>Outcome Objective: From January 1, 2012 to December 31, 2016, the percentage of newly-identified HIV positive results returned to clients will increase from 85% to 90%.</p>	
<p>Process Objective 1: From January 1, 2012 to December 31, 2016, agency staff and Disease Intervention Specialists will notify clients of positive HIV test results within 48 hours of receiving the results.</p>	<p>Agency Staff, Disease Intervention Specialists</p>
<p>Outcome Objective: From January 1, 2012 to December 31, 2016, the percentage of newly-identified HIV positive clients linked to medical care and attending their first medical appointment will increase from 80% to 85%.</p>	
<p>Process Objective 1: From January 1, 2012 to December 31, 2016, Bridge Counselors will track newly-identified HIV positive client visits within 90 days of client notification.</p>	<p>Bridge Counselors' Agency Coordinators, Disease Intervention Specialists</p>
<p>Outcome Objective: From January 1, 2012 to December 31, 2016, the percentage of newly-identified HIV positive clients that are interviewed for Partner Services will increase from 85% to 90%.</p>	

Process Objective 1: From January 1, 2012 to December 31, 2016, Disease Intervention Specialists will attempt to interview clients within 48 hours of receipt of the newly-diagnosed HIV test results.	Disease Intervention Specialists
Outcome Objective: From January 1, 2012 to December 31 2016, the percentage of newly-identified HIV positive clients that received prevention counseling or were referred to prevention services will increase from 85% to 90%.	
Process Objective 1: From January 1, 2012 to December 31, 2016, upon notification of test results to newly-infected HIV clients, agency staff or Disease Intervention Specialists will provide prevention counseling or refer clients to prevention services as needed.	Agency Staff, Disease Intervention Specialists

Capacity Building Activities Planned for HIV Testing in Healthcare Settings:			
None at this time			
Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
<i>Was the program successful in achieving its objective of conducting 51,620 HIV tests in each year of the program?</i>			
1. How many tests were conducted?	Number of tests conducted measured by: <ul style="list-style-type: none"> • Site type • Client demographics 	NCSLPH Quarterly Reports	1/1/12-12/31/12 1/1/13-12/31/13 1/1/14-12/31/14 1/1/15-12/31/15 1/1/16-12/31/16
<i>Was the program successful in achieving its objective of identifying 112 persons with newly diagnosed HIV infection annually?</i>			
2. How many and what percentage of HIV tests were positive?	Number of tests conducted measured by: <ul style="list-style-type: none"> • Site type • Client demographics 	NCSLPH Quarterly Reports	1/1/12-12/31/12 1/1/13-12/31/13 1/1/14-12/31/14 1/1/15-12/31/15 1/1/16-12/31/16
<i>Was the program successful in achieving its objectives for percentage of persons with newly positive HIV tests who 1) receive their test results, 2) are linked to medical care, 3) are interviewed for partner services, and 4) receive prevention counseling or are referred for prevention services?</i>			
3. Among clients with newly positive HIV	• Number of clients who	STDMIS NCEDDS	1/1/12-12/31/12

<p>tests:</p> <ul style="list-style-type: none"> • What percentage received their test results? • What percentage attended first medical care appointment? • What percentage were interviewed for partner services? • What percentage received prevention counseling or was referred to prevention services? 	<p>received their test results</p> <ul style="list-style-type: none"> • Number who were linked to partner services • Number who were linked to HIV medical care • Number who were linked to prevention services 	<p>Bridge Counselor forms Quarterly Reports</p>	<p>1/1/13-12/31/13 1/1/14-12/31/14 1/1/15-12/31/15 1/1/16-12/31/16</p>
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Attachment 11

Service Integration in Health Care Settings Objectives and Annual Targets

Service Integration Goals:

North Carolina Goal:

Approximately four correctional facilities will offer integrated testing for syphilis, gonorrhea, Chlamydial infection and hepatitis C in Year 1 of funding.

By Year 5, North Carolina expects that approximately seven correctional facilities will offer integrated testing for syphilis, gonorrhea, chlamydia and hepatitis C.

Outcome Objective: From January 1, 2012 to December 31, 2016, the Communicable Disease Branch and its partners will increase from four to seven the number of correctional facilities that offer integrated testing for syphilis, gonorrhea, chlamydia and hepatitis C.	Responsible for implementation
Process Objective 1: From January 1, 2012 to December 31, 2016, the Project Coordinator and Agency Coordinators will identify three correctional facilities with the capacity to integrate testing.	Project Coordinator, Agency Coordinators, Jail Administrators
Process Objective 2: From January 1, 2012 to December 31, 2016, the Project Coordinator will collaborate with Agency Coordinators and Jail Administrations to negotiate testing policies, procedures and practices.	

Capacity Building Activities Planned for HIV Testing in Healthcare Settings:

None at this time

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
<i>Was the program successful in achieving its objective of integrating testing programs for HIV, other STDs and HCV?</i>			
1. How many tests for each of the following were conducted in conjunction with HIV testing? <ul style="list-style-type: none"> • Syphilis • Gonorrhea • Chlamydial infection 	Aggregate numbers of tests for each activity conducted measured by: <ul style="list-style-type: none"> • Test type • Site type 	Quarterly Reports	1/1/12-12/31/12 1/1/13-12/31/13 1/1/14-12/31/14 1/1/15-12/31/15 1/1/16-12/31/16

<ul style="list-style-type: none"> • Hepatitis C 			
<i>Was the program successful in identifying positive tests for other STDs and HCV?</i>			
<p>2. How many positive test results for each of the following were identified in conjunction with HIV testing?</p> <ul style="list-style-type: none"> • Syphilis • Gonorrhea • Chlamydial infection • Hepatitis C 	<p>Aggregate numbers of tests for each activity conducted measured by:</p> <ul style="list-style-type: none"> • Test type • Site type 	<p>Quarterly Reports</p>	<p>1/1/12-12/31/12 1/1/13-12/31/13 1/1/14-12/31/14 1/1/15-12/31/15 1/1/16-12/31/16</p>