

Comprehensive HIV/AIDS Services Plan Dutchess County 2008—2010

Dutchess County HIV Health Services Planning Council
Dutchess County Department of Health

December 2008

Acknowledgement

Conducting a Needs Assessment and Comprehensive Services Plan is impossible without the help and support of many individuals. In particular it is important to acknowledge:

Ben Barile, the Chair of the Dutchess County HIV Health Services Planning Council,
Kathleen Murphy, Chair of the Planning and Allocation Committee.

The staff of the Dutchess County Department of Health provided support and guidance for all activities under this plan:

Rana Ali, Epidemiologist
Jay Landolfi, Grants Coordinator
Lisa Cardinale, Quality Management Coordinator
Sabrina Jaar Marzouka, Public Health Information Director

In addition the members of the Planning Council's Planning & Allocation Committee, as well as the members of the Evaluation Committee, the Council's Executive Committee, the Dutchess County Medical Society, Fahad Ahmed and May Mamiya were essential to the needs assessment and comprehensive service plan process.

All funded service providers helped with the distribution of surveys and the recruitment of focus group participants. We wish to express our sincere appreciation for their contribution.

Special thanks to all consumers and volunteers who helped distribute surveys, who completed surveys and who participated in the community forum.



Dutchess County HIV Health Services Planning Council

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February 5, 2009

Mr. Kerry Hill
Grants Management Officer
HAB/HRSA
5600 Fisher Lane, Room 7A-39
Rockville, MD 20857-0001

Reference: Dutchess County, NY
Comprehensive Services Plan
2008-2010

Dear Mr. Hill:

This letter accompanies the Dutchess County 2008-2010 HIV Health Services Comprehensive Services Plan. At its February 4, 2009 meeting, the Planning Council voted to adopt this plan.

As the Chair of the Dutchess County HIV Health Services Planning Council, I am writing to endorse the 2008-2010 Comprehensive Services Plan for submission to Health Services and Resources Administration in compliance with the requirements of the 2006 Ryan White HIV/AIDS Treatment Modernization Act.

The Comprehensive Services Plan presents where we are as a community in our struggle in helping those effected and affected by HIV/AIDS get the best possible health care, including an in depth description of our current system of care. It also describes the plan for the future of our TGA, including how our current system could improve and ways we plan to improve it. The Dutchess County TGA Part A Planning Council, in close collaboration with state and local government health departments, and other HIV/AIDS serving organizations, has participated in the creation of a comprehensive continuum of care that weaves together basic core services with other social supports to optimize the delivery of care to people living with HIV/AIDS. As more people enter the health care system and more people are living longer with HIV/AIDS, the continuum of care is undergoing strains in providing services. The delivery of care is being further burdened by the reduction of resources in our TGA. The Plan presents how the Planning Council will continue its mission of providing comprehensive health care despite the reduction in funding coming into the Dutchess County TGA.

Thank you for the opportunity to provide this endorsement.

Sincerely yours,

Ben Barile
Planning Council Chair

Cc: Sabrina J. Marzouka, Dutchess County Ryan White Part A Project Director

DCHIVHSPC operates with the support of Dutchess County Ryan White Treatment Modernization Act

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INTRODUCTION

Planning has always been a fundamental focus of federal Ryan White legislation and a critical component of Part A programs for individuals infected with HIV/AIDS. A regular comprehensive service planning provides a framework used by Part A grantees to establish service and resource allocation priorities and develop annual service goals and implementation strategies. The federal Health Resources and Services Administration oversees implementation of the Ryan White legislation, and views comprehensive planning as “a road map for the maintenance and improvement of a system of care that is responsive to the changing epidemic and the unmet health care needs of those not currently in care.”

The Dutchess County Department of Health collaborated with the Dutchess County HIV Health Services Planning Council to conduct a comprehensive community assessment and develop the comprehensive services plan (CSP) for 2008—2010. The Health Planning and Education Division of the Dutchess County Department of Health provided consultation and assistance with survey design and analysis.

Funding and service delivery environment is constantly changing and, as a result, planning is viewed as dynamic process. The recommendations that provide the basis of the 2008—2010 comprehensive services plan were finalized with the understanding that the current policies which guide the provision of Part A services as well as present funding may change dramatically pending the outcome of the anticipated reauthorization of the Ryan White HIV/AIDS Treatment Modernization Act. In order to be responsive to the varying nature of the policy and funding environment, the recommendations for the continuum of care will need to be reviewed and updated, as necessary, on a regular basis.

Comprehensive Services Planning Process

Data to assess care needs, as well as gaps and barriers to care for individuals with HIV/AIDS living in Dutchess County was derived from several sources including: Estimates of PLWH/A currently not in medical care, needs assessment survey conducted with consumers of HIV services at service locations throughout the county, a survey targeted at health and human service organizations providing both HIV specific services as well as ancillary services. A CSP focused community forum and facilitated discussion was attended by over 100 individuals.

Throughout the data collection process, the information collected was presented for review to the Planning and Allocation Committee of the Dutchess County HIV Planning Council who provided an additional source of qualitative information throughout the assessment. The Needs Assessment results and the work of the Planning & Allocations Committee were presented to the Full Planning Council for review and participation into the process. Additionally, community members, individuals infected and affected by HIV/AIDS, as well as service providers were invited to a community forum to share their ideas and partake into the development of the vision, goals and objectives of the Comprehensive Services Plan. The Planning and Allocation Committee then used the findings and input to identify goals and objectives that comprise the 2008—2010 service plan.

EXECUTIVE SUMMARY

The Planning and Allocation Committee of the Dutchess County HIV Planning Council developed recommendations for continued enhancement of the continuum of care in Dutchess County based on their review of the epidemiological data, as well as the information collected through consumer and provider surveys, and a community forum. The goals, objectives and activities for the Dutchess County HIV/AIDS service delivery system, as well as the continued planning and evaluation to ensure that the service system remains responsive to changing needs in the community, are described in detail in the following sections.

The committee finalized its recommendations with the understanding that the current policies which guide the provision of Part A services, as well as future funding awards may change dramatically pending the outcome of the anticipated reauthorization of the Ryan White Treatment Modernization Act. In order to be responsive to the dynamic nature of the policy and funding environment, the recommendations for the continuum of care will need to be reviewed and updated, as necessary, on a regular basis.

MISSION, VISION AND VALUES

It is the mission of the Dutchess County HIV Services Planning Council to create an *effective compassionate and comprehensive system of health care* and other support for people living with HIV/AIDS in Dutchess County.

Looking to the future, the Transitional Grant Area (TGA) envisions a *comprehensive, well-integrated system of care* that is characterized by universal, barrier-free service access; that is flexible and adaptable; that is responsive to changes in the epidemic that result in changing needs; and that is comprised of service providers with specific training and expertise in HIV so that they may best serve our communities.

The continuum of care for individuals infected and affected by HIV/AIDS in Dutchess County will be characterized by services that:

- Treat all people with compassion and respect;
- Ensure equity of access to services for all residents of the county;
- Support the right to self-determination for all those infected with HIV;
- Deliver services in a culturally competent manner; and
- Promote accountability as the cornerstone of our service delivery system.

GOALS AND OBJECTIVES

The Planning Council and the Grantee have identified the following goals and objectives to drive the 2008-2010 Comprehensive Services Plan for Dutchess County.

LONG TERM GOAL: Develop and Maintain High Quality Continuum of Primary Care and Support Services for PLWH in the TGA

It is the desire of the TGA to establish and support a comprehensive, coordinated system of HIV/AIDS care, including prevention and treatment services, which facilitate full access to and successful utilization of services for all consumers across the continuum of care. The specific objectives linked to this goal include:

- By December 2009, investigate feasibility of a “one stop shopping” service delivery model by co-locating primary care providers and specialists at accessible locations.
- By December 2009, primary care providers, hospital discharge planners and support services will have established formal linkage agreements to expedite cross referrals.
- By February 2010, ensure implementation of existing standards of care relative to essential staff training
- By February 2010, conduct outreach with non-HIV specific service providers to improve coordination of services and increasing understanding of HIV specific issues

LONG TERM GOAL: Sustain Ongoing Planning For HIV/AIDS Services

The TGA aims to provide a platform for exploring funding opportunities, community input and consumer feedback, regardless of the HIV/AIDS federal funding legislation. Consequently, the TGA will conduct planning activities that respond to changing trends in the HIV epidemic and support the timely and responsive development and implementation of comprehensive, coordinated services along the continuum of care. The specific objectives are:

- By September 2009 inform stakeholders (government, funders, service providers and community at large) of emerging issues related to the RW Part A Continuum of Care and obtain support for its sustainability. Coordinate efforts with Part B Policy Advisory Committee.
- By October 2009, develop a contingency plan to sustain funding for essential services and Planning Council functions if necessitated by the outcome of the re-authorization.
- By December 2009, build linkages with the AIDS Institute Prevention Planning Group (PPG) and other prevention partners for the purposes of coordinating Planning Council activities with prevention planning
- By December 2009, enhance Planning Council membership base to ensure ongoing high level of participation at full council and committees.

SECTION 1: WHERE ARE WE NOW?:
WHAT IS OUR CURRENT SYSTEM OF CARE?

A. DESCRIPTION OF THE TGA

Dutchess County is located approximately 90 miles north of New York City, in the heart of the Hudson Valley, and is primarily a rural county with two urban centers, the cities of Beacon and Poughkeepsie. According to the 2006 American Community Survey census, the county's 801 square miles is home to 292,746 residents and has a population growth of 6%, making it one of the fastest growing counties in New York State. The Transitional Grant Area (TGA) is geographically small, but intensely diverse amongst its communities. Sixty one percent of the population is between the ages of 20 and 64. Whites comprise 77.4% of the population, Blacks 10.2%, and Hispanics 8.4%. The average county household income is \$65,965.

As per the US Census Bureau 2006 American Community Survey estimates, 19,519 individuals (7 % of the TGA's population) live at or below the Federal Poverty Level (FPL). In addition, 78,132 people (28% of the population) live at or below the FPL of 300%. There are significant income disparities, however, between the county's urban and non-urban areas. Although only 7 % of the residents in the county were identified as living in poverty, 22.7% of the Poughkeepsie residents and 11% of the Beacon residents live below the poverty level.

Although Dutchess County experienced a downturn in the economy during the mid 1990s due to downsizing at IBM and the closing of the Harlem Valley Psychiatric Center, it regained strength and vitality during the late 1990s and in early 2000. This growth is reflected in the growing population as well as housing costs and development. The decline of manufacturing jobs in the area forces a greater dependence on lower paying service jobs. The county has seen dramatic increases in rent in the past two years while vacancy rates remain low. Local shelters have a need for beds that far exceeds the current capacity. The average waiting list for subsidized housing in Poughkeepsie is over two years. The Dutchess County Housing Consortium's Mid Hudson Valley Homeless Management Information System (HMIS) reports that in the last 12 months (2007) about 1,035 counts of homeless residents in the county. Of these individuals, 567 (55%) met the Housing and Urban Development definition of "Homeless"

Dutchess County is home to a large institutionalized population. The TGA holds four state prison facilities, three state psychiatric and developmental disability centers, two NYS Division for Youth facilities, four residential substance abuse rehabilitation facilities and three facilities for emotionally disturbed adolescents. In 2006, the distribution of mentally ill patients in Dutchess County was concentrated much like HIV, in the two main city areas of Poughkeepsie (56%) and Beacon (25%).

Dutchess County is home to four hospitals: Vassar Brothers Medical Center (365 beds), Saint Francis Hospital (396 beds), Northern Dutchess Hospital (68 beds), and the Veterans Association Hudson Valley Hospital (299 beds). Vassar Brothers Medical Center and Saint Francis Hospital are located within the city of Poughkeepsie. Northern Dutchess is located in the village of Rhinebeck, and the VA Hospital is located in the southern end of the county.

- **Description Of The Part A Program:**

Dutchess County became an Eligible Metropolitan Area (EMA) in 1995, and has received the Ryan White federal funding to support interventions addressing the needs of people living with AIDS. The 2006 re-authorization of the funding provided a safety net for an area like Dutchess that did not meet the new funding criteria but had received funding for nearly a decade, regardless of how many (or how few) AIDS cases it had. Under the 2006 re-authorization set to expire in October 2009, Dutchess qualifies as a Transitional Grant Area (TGA). If the legislation remains unchanged, Dutchess will no longer qualify for Part A funding starting in FY2011.

The Dutchess County Executive is the formal recipient of Ryan White Part A funds and delegates administration of the funds to the Dutchess County Department of Health (DCDOH). The Administrative Agency, DCDOH, is comprised of five distinct Divisions reporting directly to the Commissioner of Health. The Director of the Division of Public Health Information is assigned as the Ryan White Part A Project Director.

DCDOH provides the administrative support necessary to achieve the goals of the Ryan White Part A program, including the organization of meetings and mailings necessary to solicit applications for proposals, and contracting with the selected agencies that will perform the direct services. The Grant Coordinator, the Quality Management Coordinator and the Project Director review programmatic reports from the subcontractors within the guidelines of Federal Regulations and the County, the standards of care, in compliance with applicable laws/regulations and procedures. The Account Clerk, the Senior Accountant, and the Project Director review the contractors' fiscal reports to monitor their spending and compliance with fiscal guidelines. The Program Assistant provides clerical support to the program staff.

DCDOH personnel provide technical assistance to the subcontractors as necessary to ensure appropriate fiscal and programmatic reporting as well as successful implementation of project activities and work plans. Additionally, the DCDOH Epidemiologist provides in kind support relative to the use of multiple data set, such as HIV/AIDS epidemiology data, comorbidity data, poverty and insurance status data.

The TGA has established an HIV Health Services Planning Council to plan for the use of the Part A funds for the provision of HIV services throughout Dutchess County. The TGA's Planning Council is composed of 18 members who reflect the demographics of those infected with HIV/AIDS in Dutchess County. Each member is trained on the Council's mandated responsibilities and given information necessary for a full understanding and participation in the decision making and planning process.

The established mechanisms within the TGA enable newly infected, underserved, hard-to-reach individuals, emerging populations and/or disproportionately impacted communities of color to access and remain in primary medical care. The implementation of a AIDS Information Reporting System over the past two years has enabled the tracking of referrals, providing specific data to capture and monitor efficacy of the referrals. The referral system has increased the linkages between providing agencies, helping to establish a more effective and efficient *continuum of care*.

B. EPIDEMIOLOGICAL PROFILE

- **Current Epidemic** (see Epi Table Appendix)

1. People Living with HIV (HIV Prevalence):

According to the updated 2007 New York State Department of Health (NYSDOH) estimates, there are 1,141 people living with HIV infection in Dutchess County. The HIV prevalence rate for the TGA is 386.6 per100,000 populations, which is *more than twice the national HIV rate* of170 per100,000 populations.¹

Among people living with HIV, 71% are male and 29% are female. Racially, the burden of HIV infection within the TGA falls on minority populations, with approximately 45% of the cases among Blacks, about 27% Hispanics, 25% Whites and a 3% Multi-Race. There is an increase in the percentage of HIV prevalent cases that are of Multi-Race from 2005 when it was less than 1% to 2007 when it is 3.03%.

As of December 31, 2007, there were seven (7) reported cases of children under the age of 13, and twenty five (25) children ages 13 to 19 living with HIV in Dutchess County. Approximately sixty percent (59.2%) of HIV cases are between 30 to 49 years of age, followed by 33.13% aged 50 and older. The aging trend of HIV prevalence is apparent in the increase in the number of HIV cases seen in the age group 50 years and older, which was 26.64% in 2005.

New York State started reporting of HIV in 2000. According to NYS Bureau of HIV/AIDS Epidemiology data, from 2000 to 2007, the number of people living with HIV in Dutchess County is *steadily increasing* from 26 in 2000 to 495 in 2007. Chart 1 below illustrates the increased HIV prevalence in the TGA.

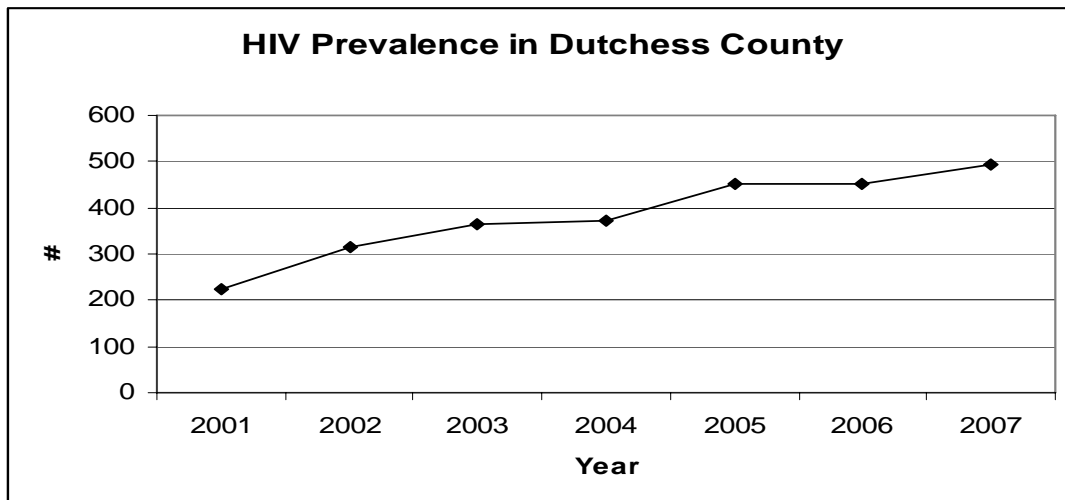


Chart 1 - Source: NYSDOH, Bureau of HIV/AIDS Epidemiology, August 2008

¹ Source: <http://www.cdc.gov/hiv/topics/surveillance/basic.htm#PLWH/A>

2. Number of People Living with AIDS (AIDS Prevalence):

According to data provided as of August 2008, by NYSDOH Bureau of HIV/AIDS Epidemiology, the Dutchess County Transitional Grant Area (TGA) has a total of eight hundred fifty eight (858) prevalent cases of AIDS at the end of December 2007 (See Attachment 3).

The NYSDOH Bureau of HIV/AIDS provided data for AIDS prevalence. Over the past five years, the number of individuals living with AIDS (i.e. prevalence of AIDS) has steadily increased from 536 in 2000 to 858 in 2007. When compared with the national prevalence rate of 150 per 100,000 populations², the prevalence of AIDS in Dutchess County at 291 per 100,000 populations demonstrates the burden of the disease in the TGA.

In Dutchess County, consistent with national trends, AIDS disproportionately affects minorities. Blacks account for 44%, Hispanics 30%, Whites 23%, and Multi-Race 3% of the cases. The prevalence distribution among these racial groups has remained stable since 2006.

As of 2007, 53.26% of AIDS prevalent cases are in the age group of 30-49 years, and 44% are 50 years or older. This reflects an increase from 2006, when 40% were in the age group of 50 years or over. The number of living AIDS cases in the 13 to 19 age group has increased from a single case in 2003, to 6 cases in 2005 and remains at 6 cases in 2007. Among the cases living with AIDS, men accounted for 81.24% of the cases and women accounted for 18.76%.

Chart 2 illustrates that over five years period, from 2002 to 2007, the highest risk factor remained Intravenous Drug Use (IDU), accounting for 46.27% of the cases, followed by Men having Sex with Men (MSM) at 14.8% and Heterosexual contact at 13.4%. In 2007, 4 pediatric patients with maternal transmission and one pediatric patient with no identifiable risk were reported. Over the past three years, about 20% of the cases have no known risk factor identified.

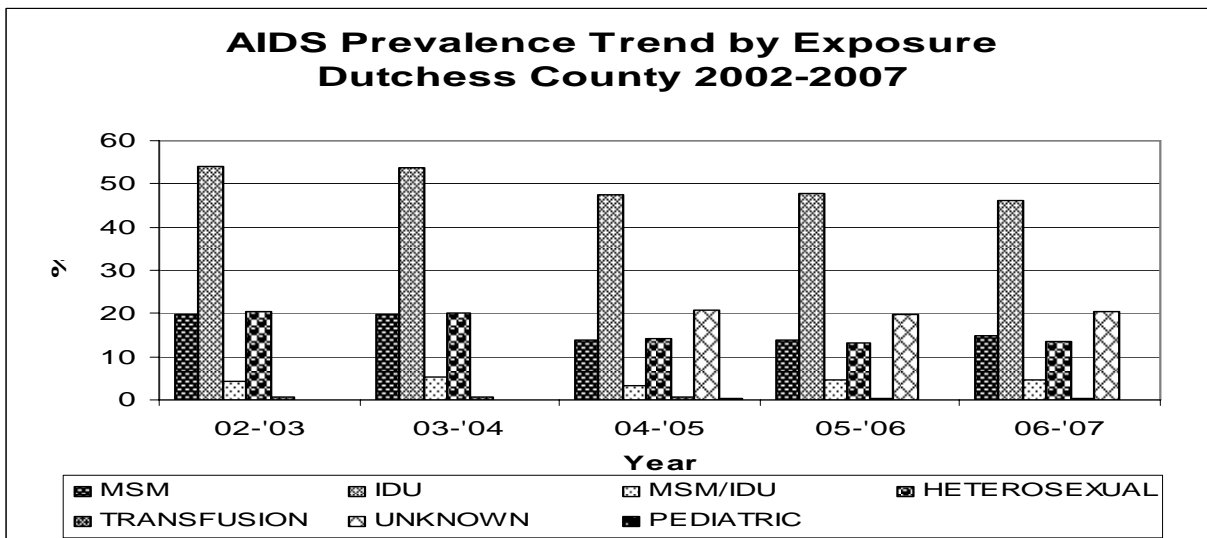


Chart 2 - Source: NYSDOH, Bureau of HIV/AIDS Epidemiology, September 2007

² <http://www.cdc.gov/hiv/topics/surveillance/basic.htm#lwa>

3. Number of New AIDS Cases reported (AIDS Incidence):

Sixty seven (67) new AIDS cases (i.e. incidence of AIDS) were reported in the TGA from January 2006 to December 2007. Men accounted for 80.6% and women accounted for 19.4% of the new cases. Twenty seven 27% of the new AIDS cases were White, 51% were Black, 20% Hispanic and 2% Multi-Race.

Nearly sixty three percent (62.69%) of AIDS incidence cases between January 2006 and December 2007 are 30 to 49 year old, while 29.85% are 50 years and older, and 7.5% are 13 to 29 year old. There were two (2) new cases of AIDS among children aged 13 to 19 years. In that same period, there was one pediatric case with undetermined exposure and another one with maternal transmission. The steady increase in the older category (i.e. 50 years old and older) should be noted. In 2005, the AIDS incidence in the age group 50 years or older was 14.28%; in 2006, it was 21.3%; and in 2007 it has gone up to almost 30%. This pattern may be due to availability of better therapeutics delaying the HIV positive patients from progressing to AIDS.

- **Specific Disproportionate Impact of HIV/AIDS on Populations**

1. Minority Populations

According to US Census Bureau's American Community Survey, 2006 Dutchess population is estimated to be 292,746. Whites comprise 77.4% of the TGA's population, Blacks (10.2%) and Hispanics (8.4%). Yet in this TGA, Blacks are almost 20 times and Hispanics are 12 times more likely to have AIDS as compared to Whites.

As illustrated in Chart 3, in 2007, new cases of AIDS per population (the AIDS incidence rate) confirm the trend seen in previous years in being disproportionately higher in the Black and Hispanic communities.

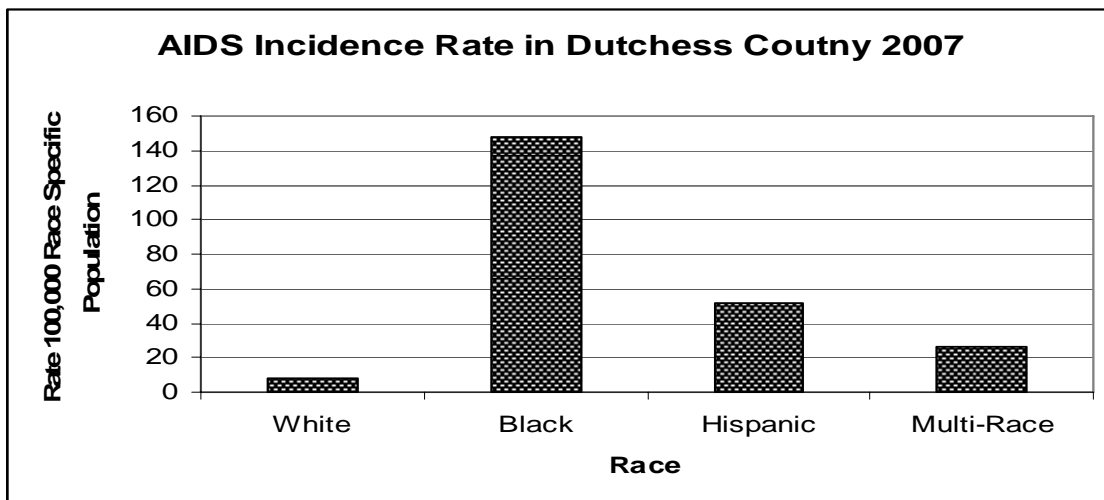


Chart 3- Source: US Census Bureau 2007 & NYSDOH HIV/AIDS Bureau, August 2008

Race and ethnicity specific infection rates indicate a disproportionate impact on minority populations in the TGA. The race specific AIDS prevalence (the number of living AIDS cases per population) for Whites is 86 per 100,000 White population; for Blacks it is 1,690 per 100,000 Black population; and for Hispanics it is 1,033 per 100,000 Hispanic population.

Chart 4 below illustrates the prevalence of AIDS cases per race and ethnicity in Dutchess County, New York State and the nation. As of 2006*, the percentage of Hispanics among the living cases of AIDS is much higher in Dutchess County (30%) than that seen in the nation (21%). Additionally, the percentage of living AIDS cases in Dutchess County who are Black (44%) is also slightly higher than that in the US (43%).³

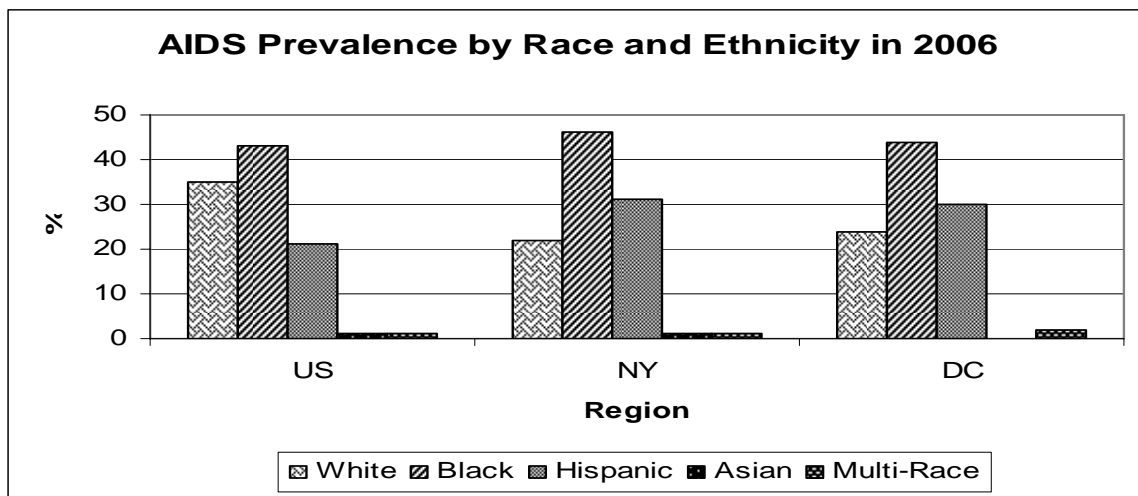


Chart 4 - Source: Dutchess County Data 2006 Provided by NYSDOH 2007, CDC HIV/AIDS Surveillance Report 2006, NYSDOH HIV/AIDS Surveillance Report 2006.

2. Women, specifically Black Women

In Dutchess County, Black women are 21 times more likely to have AIDS compared to Whites, while Hispanics are 6 times more likely to have AIDS as compared to Whites. The race specific AIDS prevalence rate for Black women is 794/100,000, and Hispanics is 29/100,000, whereas for the White women population the rate is only 39/100,000.

Chart 5 demonstrates that *Black women have the highest rate in the TGA*. In 2007, of all women living with AIDS in Dutchess County, about 52% were Black, 15% were Hispanic, and 6% were Multi-Race.

³Source: <http://www.statehealthfacts.org/profileind.jsp?ind=520&cat=11&rgn=34>

*2007 data for the US and New York State are not available for comparisons.

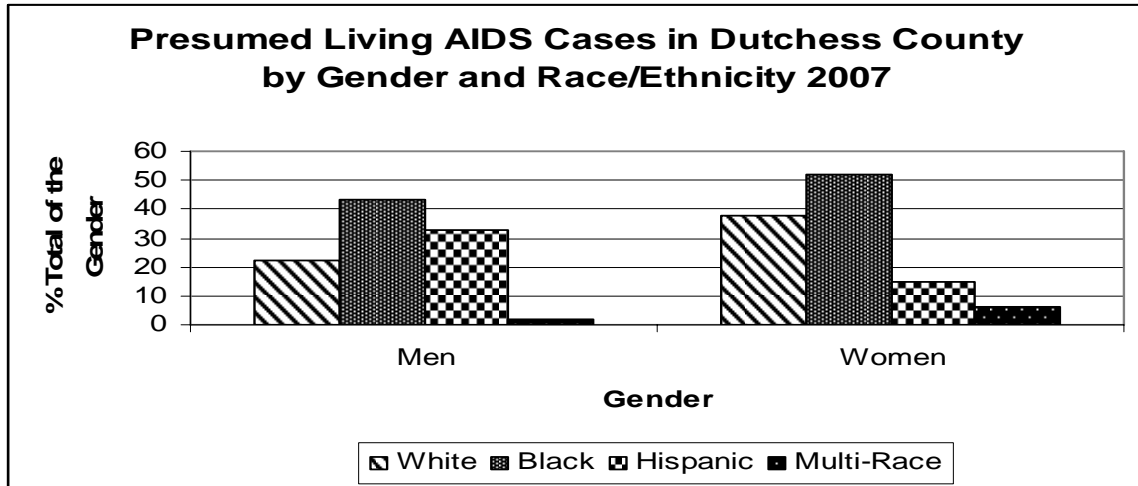


Chart 5 - Source: NYSDOH, Bureau of HIV/AIDS Epidemiology, September 2007

Incidence data from NYSDOH for 2006-2007 provides the following key statistics: Among all female newly diagnosed AIDS cases, 46% are Black, followed by White 23%, and Hispanic 23% which is a disproportionate distribution as compared to the distribution of the race and gender in the general population. As Chart 6 shows, 38% of all women have contracted AIDS by heterosexual exposure; 31% of women with AIDS are injection drug users, and for 31% the risk exposure category is unknown.

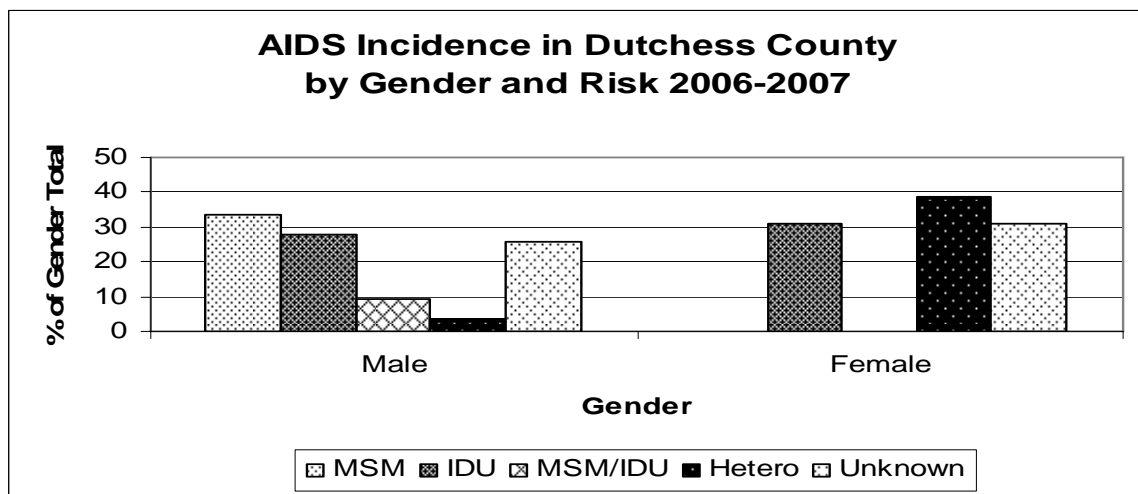


Chart 6 - Source: NYSDOH, Bureau of HIV/AIDS Epidemiology, August 2008

Overall, in Dutchess County prevalence and incidence of HIV/AIDS, Blacks and Hispanics, and in particular Black females, are disproportionately affected by the epidemic as compared to other regions, and require more targeted interventions.

- **Emerging Population**

The TGA's targeted populations are substance abusers, particularly IDUs; women of childbearing age, particularly black women; and the emerging immigrant populations, particularly male Mexican immigrants. These special populations are the most marginalized and vulnerable within the TGA and are at significant risk for HIV infection. Attention to their unique needs is essential in planning for comprehensive interventions and associated costs.

1. *Injection Drug Users and other Substance Abusers*

Substance Abuse may be the primary co-morbidity within the TGA, which lays a significant burden on its resources. HIV-infected substance users often face a health and social services system that stigmatizes them and erects multiple barriers to providing the care they require. As a consequence, their patterns of health care utilization and the quality and continuity of care they receive are far from optimal.

Over 20,000 people in the TGA are estimated to be struggling with substance abuse. According to the Dutchess County Department of Mental Hygiene annual program report, over 8,139 county residents were admitted to alcohol and substance abuse treatment in 2007. In that same year, 275 persons received 54,655 service visits by the TGA's Methadone treatment services. This number is only a small proportion of people struggling with substance abuse. According to NYSDOH SPARCS data, in 2007, there were 1,921 alcohol and substance abuse related hospital discharges in the County with an average charge of over \$14,000 per patient.

In Dutchess County injection drug users make up 46.27% of the AIDS prevalent cases. The results of the recent needs assessment clients' surveys indicate that about 30% attribute their exposure risk to IDU. Many IDUs in the TGA are minorities (39% of all Black and 31% of all Hispanic PLWH/A), living in poverty (29% of all IDU PLWH/A indicated an annual income of less than \$20,000). They reported being without health insurance, and it is estimated that more than half are suffering from some form of mental illness. IDUs have other co-morbidities, such as tuberculosis, HCV, and STI.

According to the needs assessment, substance abuse treatment services, both in and out-patient services are needed by PLWH/A who are already in care. While generalized mental health and substance abuse support services exist in the TGA, HIV and other co-morbidity necessitates a significant portion of the TGA's service allocation go to this category.

Cost and Complexity of providing care include the increased cost of specialized outreach and engagement to find IDUs and link to an already overwhelmed Substance Abuse treatment system. 2003 HIV Cost Resource Utilization data cites the average inpatient cost per day for an IDU is \$5,342.23. If each PLWH/A-IDU were to be admitted to the hospital for just one day, the cost would exceed three times the TGA's Part A award for FY 2007. There are no specialized IDU treatment system in place besides detoxification and methadone maintenance, and hiring just one additional licensed professional to serve this population would cost the TGA an estimated \$50,160.

2. Women of childbearing age – Especially Black women

The 2006 New York Statewide Coordinated Statement of Need and Comprehensive Plan, revealed 18,000 heterosexual AIDS cases; 80% of those cases were women. Thirty six percent (36%) of female AIDS cases attributed to heterosexual contact were due to sex with an injection drug user. Of the 2,320 AIDS cases reported among children under the age of 13 in NYS, 52 % acquired HIV from a mother who injected drugs or who was the sex partner of a drug injector.

Heterosexual women have a higher chance of being unaware of their status. This has major health implications on the risk of vertical transmission. Data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in New York State had a prevalence of 0.30% (n=727), or approximately 1 in 333 women giving birth. In the Mid-Hudson Region (which includes Dutchess County) the prevalence is 0.17% (n=17), or approximately 1 in 588 women giving birth had a positive HIV test result.⁴

In Dutchess County, as of December 31, 2007, women accounted for 18.76% of the living AIDS cases and represented 28.89% of the HIV living cases. Of all women presumed living with AIDS in the TGA, 52% were Black, 15% were Hispanic and 6% were Multi-Race.

New cases of AIDS in women (i.e. AIDS incidence) have fluctuated from 20% in 2005, to 23% in 2006, to 19.4% in 2007 in the TGA. In 2006-2007, 46.2% of the AIDS incident cases (new cases) are among women of childbearing age 13 to 44. According to NYSDOH 2006-2007 data, 45% of AIDS prevalent cases are among women of child bearing age of 13 to 44 years. The majority of reported female AIDS cases in the TGA are from Poughkeepsie (with 44%) and Beacon (with 11%). Historically, HIV+ infants are from Poughkeepsie (70%).

Most women who are HIV positive in the TGA live in poverty. The socioeconomic status of women negatively influences access to health care. When women face unmet subsistence needs (such as housing, food, and child care), they have little time or resources to devote to their own health. The impact on their lives and on the lives of those who may be in their care can be catastrophic.

Service providers report that at-risk women struggle with a variety of issues including substance abuse, mental illness and domestic violence. Women may resort to trading sex for drugs or money, putting them at risk for HIV infection, incarceration or crime victimization. Women of childbearing age, especially women of color who are at higher risk of HIV infection due to substance use or partners who are infected, are identified for special consideration by both HRSA and the TGA.

Cost and complexity of providing care for women include greater specialty care needs, i.e. OB/GYN, metabolic syndromes, and medication adherence. Each one of these specialty categories, particularly specialized OB/GYN and oncology incur a huge cost and add to the complexity of care. The NYSDOH SPARCS data indicates that in 2007, the average cost of hospitalization with HIV/AIDS without any other related diagnosis was \$24,125.

⁴ Source: May 2008 <http://www.health.state.ny.us/diseases/aids/reports/scsn/index.htm>

3. Immigrants – Hispanic Men

While Hispanics represent only 8.4% of the TGA population, the incidence of AIDS cases among Hispanics has risen to almost 20%. As discussed in the epidemiology section of this document, Hispanics are 12 times more likely to have AIDS in Dutchess County than Whites. The migrant worker populations in the eastern and northern sections of the county, who are mostly Hispanics, tend to be disconnected from the traditional service system.

Mexican families in particular are often in the lowest income brackets, usually have language barriers, and are less likely to have access to quality health care than more established residents. Moreover, the DCDOH STD clinic reports it is common for Mexican men seen at the clinic to report contact with sex workers more often than other populations seen at the clinic.

Only ten percent of the respondents in the last needs assessment were Hispanic. This indicates that Hispanic PLWH/A are underrepresented in care and and/or not represented in the survey. Forty percent (40%) of the respondents indicated they first tested positive outside of the TGA. The Hispanic respondents were more likely than Whites or Blacks to report being without health insurance, and most reported a family income below \$10,000. Service providers report healthcare and insurance as the greatest issues for their Hispanic and immigrant clients (re: 2008 United Way and Community Foundation's Hispanic/Latino and Immigrant Communities Assessment)

Cost and Complexity of providing care include intensive culturally and linguistically competent outreach and engagement in a population which tends not to engage in care- trust, fear and stigma, legal barriers, immigration issues, transient nature of clients employment, isolation from current sources of assistance (i.e. Social Services, food and nutrition, ongoing medical care). The typical insurance reimbursement for an office visit is anywhere from \$50 to \$100 on average, and translator fees can be approximately \$75 per hour. (The Business Journal, September 2008).

Currently, Dutchess County is experiencing a shortage of Spanish-speaking service providers at all levels of care. There was a slight decrease in Hispanic representation in primary care, possibly due to staff turn over and the lack of bilingual case managers who assist in maintaining "at risk" clients in care. Capacity of bilingual staff throughout the continuum is essential, but will increase cost of services in the TGA significantly. Beyond language, the subtleties of cultural competency in relation to HIV can greatly impact trust, disclosure and maintenance in Primary Care.

The U.S. Office of Management and Budget also documented \$132 per hour for language line services (contracted, multilingual medical interpretation services provided via telephone). Adding just two Spanish speaking Social Workers in the TGA's Ryan White Part A Care system would cost an additional \$121,750 per year.

C. REGIONAL AND LOCAL RESPONSE TO THE EPIDEMIC

In 1983, the New York State Legislature established a law creating the AIDS Institute with the mission to “promote, protect and advocate for health through science, HIV prevention and assurance of access to a coordinated system of quality care and support services for persons with HIV/AIDS.” In 1987, the HIV Confidentiality Law was enacted in New York State, addressing a major barrier to care.

While some AIDS Institute funds were available, prior to Dutchess County’s designation as an Eligible Metropolitan Area (EMA) in 1995, there was no established continuum of HIV/AIDS care. Many PLWH/A were first diagnosed in hospital emergency room presenting with opportunistic infections or through limited Department of Health testing. With only one local private infectious disease specialist at the time, the common mode of ambulatory care was hospital emergency rooms or out-of-county facilities, requiring an 85 miles trip to New York City or Albany. There were few local support services.

With receipt of Part A funding in 1995, a planning format was established in the EMA to bring together diverse stakeholders. The Planning Council worked toward the development of a continuum of care that is constantly evolving in response to changes in the local epidemic, consumer needs and available resources. Ryan White funds have been the catalyst in drawing together community resources and ensuring a commitment to developing an HIV/AIDS "continuum of care" accessible to all PLWH/A in the TGA.

Currently, the majority of HIV services are located within the cities of Poughkeepsie (central Dutchess) and Beacon (southern Dutchess), the epi-centers of the epidemic. Contracted programs are required to cooperate in promoting access to services for PLWH/A in the eastern and northern regions of the TGA.

The TGA coordinates services with other Ryan White programs and funding streams to avoid duplication, to deliver services that are cost effective and to ensure that Part A is the payer of last resort. Part A is the primary funding for the TGA’s continuum of HIV care because of the limited availability of other resources.

In the few instances where providers have multiple grants across several TGAs, tracking resources is more challenging. The Grantee’s contracting process requires providers to develop MOUs (memorandum of understanding) with all Ryan White funded programs in the TGA and other relevant state, federal and local resources to ensure coordination, access and cost effectiveness as well as to avoid replication of services.

Additionally, numerous strategies are employed to improve the quality of care and monitor progress, including: contract management monitoring, capacity development efforts, and quality management initiatives. These activities are critical in maintaining high quality HIV care and services in Dutchess County.

- **Impact Of Decline In Part A Formula Funding**

Dutchess County became a TGA with the Treatment Modernization Act re-authorization in 2006. Because of the TGA total population number and that of its HIV/AIDS cases, the Planning Council has to face not only the current funding cuts, but also the possibility of no funding within the next two years as the county fails to meet the TGA definition. The total Ryan White funding for the TGA, i.e. Formula, Supplemental and MAI, was *reduced by 14% from FY 2006 to FY 2007*. The table below shows the actual level of decline per funding category from FY 2006 to FY 2007.

FUNDING	FY 2006	FY 2007	FY 2008	\$ Change / % Change
Formula	\$ 698,112	\$ 719,007	\$ 756,120	\$ 58,008 + 8.3%
Supplemental	\$ 556,849	\$ 339,616	\$ 309,278	(\$ 247,571) - 44.5%
MAI	\$ 112,623	\$ 103,571	\$ 112,436	(\$ 187) - 1.7%
TOTAL	\$ 1,367,584	\$ 1,162,194	\$ 1,177,834	(\$189,750) - 13.9%

The impact of the decrease in funding has forced the Planning Council to reduce or flatten its allocation to many of its service categories, such as EIS. The declining award has severely limited Planning Council and capacity development activities. For example, capacity development formerly coordinated a case management round table, bi-monthly meetings to enhance collaboration, coordination and problem solving across all case management disciplines that were stopped due to lack of funding. This loss of opportunity to learn and network has had an impact on the effective referral relations, particularly outside the funded provider network.

Reduction in total Part A funding comes at a time when Part C funding to the only grantee in Dutchess County has declined. Additionally, part B funds to the TGA have been limited. Dutchess County also does not benefit from AIDS Institute funded programs, or Designated AIDS Centers (DAC), as the closest one is located in Albany or Westchester. Patients needing specialty consultations must drive or be transported substantial distances to obtain DAC services.

Another impact of the change in the TGA’s level of funding, and its limitations, remain the funding of the Planning Council’s activities. Traditionally, the Dutchess County Planning Council was allocated 7% of the total award for the support of a dedicated staff, an office space, reimbursement of PLWH/A, and mandated activities, such as needs assessment. About 5% of Formula funds are allocated to the management of the Planning Council’s operations. Consequently, the Grantee took over the fiscal management of the Planning Council’s operation in FY 2008, including hiring the staff and paying for the office rent. The Planning Council has had no funding for contractual support for their essential activities such as Needs Assessment, special projects to identify needs of emerging populations. Additionally, the Grantee had to provide in-kind its epidemiologist to support the needs assessment efforts, including the design of the providers and clients surveys, and analysis of the results.

D. ASSESSMENT OF NEEDS AND SERVICE GAPS

• **Methodology**

The Dutchess County Department of Health and the Planning Council conducted a Needs Assessment to collect information on the needs and service gaps of People Living with HIV/AIDS. Information was collected from both the providers of services and the clients utilizing these services. Efforts were made to also reach out to those PLWH/A not in care through the outreach and early intervention programs.

Dutchess County utilized guidance provided by HRSA to calculate the TGA's unmet need estimate. Unduplicated data was obtained from the New York State AIDS Institute Unmet Need Workgroup, who developed a standardized methodology to collate data for all funded areas across New York State.

Data to assess service care needs as well as gaps in service was derived from survey questionnaires. The Dutchess County Medical Society assisted with administering these surveys, including data collection and data entry. The survey tools and sample sizes were provided by the Dutchess County Department of Health (See Appendix). Throughout the process, the information collected was presented for review to the Full Dutchess County HIV Planning Council. The Planning and Allocation Committee provided an additional source of qualitative information throughout the assessment. Additionally, a Community Forum was held to obtain further insights and feedback.

Assessment of needs and services gaps were derived from several sources including:

- Estimates of PLWH/A not in medical care developed using HRSA's framework;
- Outreach staff working to locate and engage infected individuals not currently in care;
- Survey conducted with twelve health and human services organizations providing both AIDS specific services as well as ancillary services to HIV/AIDS infected individuals in Dutchess County;
- A needs assessment survey conducted with ninety eight (98) consumers of HIV/AIDS services at service locations throughout the county; and
- A community forum conducted with both infected and affected individuals, service providers and community leaders.

The list of service providers to be included in the surveys was developed by the Planning and Allocation Committee of the Dutchess County HIV Planning Council. Service providers assisted in recruiting participants for the consumer surveys. Both sets of surveys were conducted utilizing standard sets of questions differentially developed to collect information from the service provider and consumer perspectives. Outreach efforts were also conducted in an attempt to solicit consumer feedback through individual interviews. These efforts included flyers distributed both to service providers and consumers, and flyers posted at bars known to be frequented by the GLBT communities.

- **Need for Primary Care and Other Services**

A total of ninety eight PLWH surveys, and twelve provider surveys were collected. The demographic characteristics of the 98 participating PLWH were similar to the total affected TGA population with a few exceptions: there were fewer men and fewer Hispanics in the study as compared to the PLWH.

The agencies surveyed included both clinical and non clinical providers. Of these providers, there were five who were receiving Ryan White funding (Parts A and/or B). The number of HIV clients these agencies served in the last 12 months varied from one to 350.

Medical Care

Comprehensive medical care is an essential service that a lot of PLWH lack for one reason or another. The services listed in the table below are a few of those medical care services.

Medical Service Type	Needed (% of total respondents)	Obtained (% of total respondents)
Pelvic Exam	22.5% (% of total women)	77% (% of total women)
Pregnancy/Prenatal Services	7% (% of total women)	9% (% of total women)
CD4/Viral Load Testing	64%	83%
Child Immunization, wellcheck, sickcare	9.2% (% of children)	7% (% of children)
HIV Specialty Care for Children/Adult	24%	34%
Other Specialty Care for children/adults	15.3%	20.4%
Emergency Medical Care	19.4%	25.5%
Home Care Services	12%	11%
Access to Clinical Trial	5%	3%
Pharmacy/Drug Assistance/ADAP	34%	39%

It is important to examine all the services in this category. First, when looking at the few services that all clients should be receiving, the following observations should be noted: *Only 77% of women had received pelvic exam; only 83% of total survey respondents received CD4/Viral Load testing, while only 34% of total obtained HIV Specialty Care.* Other services showed lower utilization probably because they were not needed/required e.g. Home Care Services which shows utilization by only 11%, and Emergency Care Services utilized by 25.5%.

Dental Care

Annual dental care and cleaning is essential to all the PLWH/A, however only 57% of the respondents reported having utilized the service within the past twelve months.

Dental Care	Needed (% of total respondents)	Obtained (% of total respondents)
Dental X-Rays and Cleaning	43%	57%
Denture, Fillings, Extraction	38%	41%

Substance Abuse Services

In Dutchess, 46% of prevalent AIDS cases were attributed to IDU. Substance Abuse related services are essential to successful disease management.

Approximately 22% of the respondents needed counseling and only 19% received it; 15% needed in-patient drug treatment and 12% obtained it; 16% needed out-patient drug services and 14% obtained it. The table indicates that services were not obtained by all who needed them.

Substance Abuse Services	Needed (% of total respondents)	Obtained (% of total respondents)
Alcohol or Substance Abuse Detox	13%	14%
Drug / Alcohol / Tobacco Counseling	22%	19%
In-Patient Drug Treatment	15%	12%
Out-Patient Drug Treatment	16%	14%
12 Step or Recovery Group	13%	13%

Case Management/Counseling

Case Management services are a core component to the continuum of care. Often consumers are not aware of other services available to them. With the exception of mental health services, case management and counseling has been obtained by more than the percentage of those who needed it. Thirty percent (30%) of the respondents needed case management of mental health service but only 21% were able to obtain it.

Case Management	Needed (% of total respondents)	Obtained (% of total respondents)
CM for Medical Services	45%	56%
CM for others (SSI/SSDI)	27%	27%
Mental Health Care	30%	21%
Support Group for Self	36%	30%

Family & Legal Services

Few clients indicated a need for child care services (5%) or legal assistance (19%). Only 2% obtained child care services and 15% legal assistance.

Family & Legal Services	Needed (% of total respondents)	Obtained (% of total respondents)
Child care/ Day Care	5%	2%
Legal Assistance	19%	15%

Food services

Of the food services vitamins and supplements were needed by 26%, food pantry services by 26%, home delivered meals by 20%, food vouchers by 19% and nutrition counseling by 26%. The percentage of those who obtained these services was smaller than the need for each of the above food service type.

Food Services	Needed (% of total respondents)	Obtained (% of total respondents)
Vitamins, Ensure, Sustacal, etc	26%	19%
Food pantry	26%	18%
Meals/groceries	20%	21%
Food Vouchers	19%	10%
Nutrition Education/Counseling	25.5%	20%

Housing Services

Housing has come up at many places in the survey as being an important concern. Subsidized housing for PLWH was needed by 29% and obtained by 23%, housing for those recovering from substance abuse was needed by 13% and obtained by 12% and housing for families was needed by 14% and obtained by 12%.

Housing Services	Needed (% of total respondents)	Obtained (% of total respondents)
Subsidized Housing for PLWH	29%	22.5%
Housing for People Recovering from Substance Abuse Problems	13%	7%
Housing for Families	14%	12%

Benefit/Financial Services

Emergency financial assistance was needed by 29% but obtained by only 18%. Women Infant and Child (WIC) assistance was needed by 8% and only 3% obtained and VA was needed by 9% and obtained by 5%.

Benefit/Financial Services	Needed (% of total respondents)	Obtained (% of total respondents)
Temporary Assistance for Needy Families	13%	15%
Veteran's Assistance (VA)	9%	5%
Women, infant & Children (WIC)	8%	3%
Medicaid/Medicaid HMO	29%	33%
Emergency Financial Assistance (Utilities/rent, medication)	29%	18%

- **Unmet Need Estimate And Assessment**

Using the HRSA/HAB Unmet Need Framework, the Dutchess County TGA calculated a total of 1,141 people living with HIV/non-AIDS who know their status (PLWH/non-AIDS/aware) and 858 individuals living with AIDS (PLWA) as of December 2007.

As per NYSDOH HIV/AIDS Bureau, in 2007, there were 858 individuals living with AIDS in the TGA. Using CDC Methodology, the NYSDOH AIDS Bureau Data was adjusted and the TGA estimated that in the past 12 months of 2007, there are 1,141 people living with HIV/non-AIDS who were aware of their status.

Using the HRSA HIV/AIDS Bureau's tool for Grantees, the TGA was able to estimate that a total of 735 people (64.45%) living with HIV/non-AIDS/aware, and 641 PLWA (74.66%) received HIV/AIDS primary medical care during the 2007 calendar year. The results of the Unmet Need estimate based on the framework definition revealed a total of 217 (25.3%) PLWA, and 406 (35.5%) PLWH/non-AIDS/aware, did not receive primary medical services. The total number of persons not receiving primary medical care services (i.e. the unmet need for primary medical care) was estimated to be 623 (31.2%).

Estimation Methods

To calculate the TGA's unmet need estimate, Dutchess County utilized the HRSA HIV/AIDS Bureau's tool for Grantees entitled 'A Practical Guide to Measuring Unmet Need Unmet Need for HIV-Related Primary Medical Care: Using the Unmet Need Framework.'

The TGA's methodology involved cross program collaboration with the NYS AIDS Institute Unmet Need Workgroup. The NYS AIDS Institute developed a standardized methodology to collate data across NYS. New York State provided the percentage to estimate the number of PLWH/A in care by "other payers". This payer mix was identified through the AIDS Institute Quality of Care Review Program. This utilized a list of almost 60,000 patients from 154 facilities statewide. As per the Unmet Need Framework, data on the number of people in the TGA who are HIV+/aware was used rather than the total number of people with HIV or AIDS (true HIV prevalence). Data is obtained on (1) the total number of people in the TGA who are HIV+/aware and AIDS (non-HIV) from the NYS HIV/AIDS Bureau, and (2) the number of people who are "in care," using the framework's operational definitions of "in care as receiving a CD4, Viral Load test or receiving an antiretroviral." By subtracting those in care from the total number of people who are HIV+/aware and AIDS (non-HIV), the TGA obtained an estimate of the number of people who know they are HIV+ aware and are not in care - those with an unmet need for primary medical care. (See Unmet Need Table in Appendix)

There were several reasons for choosing this methodology. First, it ensured unduplicated data from all sources including ADAP, correctional facilities, Medicaid, Medicare, Veterans Administration and the estimate of other payers. Second, it allowed for standardization of the methodology with other EMA/TGA in the state. Limitations of the methodology include the fact that other payers is only an estimate, and that the number of PLWH/A that have Medicaid and ADAP may be fluid, due to eligibility criteria.

Assessment Of Unmet Need

The unmet need for primary health services among individuals who know their HIV status but are not receiving primary health care demonstrates the severity of the HIV/AIDS epidemic in the TGA. During the comprehensive needs assessment effort, those not-in-care were under-represented in the survey. Hence, the Planning Council analyzed information collected from the on-going “Unmet Need-Out of Care” survey conducted by the Early Intervention Services (EIS) program. EIS staffs follow up with known PLWH/A out of care, and find those at high risk through testing. This strategy is effective in finding high risk clients that are typically homeless, street workers, substance abusers, mentally ill, and otherwise disenfranchised.

Demographics and location of persons with unmet need

Unmet Need data provided by New York State is not able to differentiate gender, race or ethnicity. However, according to local data collected by the Early Intervention’s “Out of Care” survey, through February 2008, there are differences in demographics between those “not in care” and those “in care”. Sixty-three percent (63%) of those “out of care” were Black and 29% were 50 years or older in age. With respect to gender, 50% of those with Unmet Need were women, (of which 75% were black) as compared to the 18% of total living AIDS cases who were women. Additionally, those with unmet need are located in the two cities of Poughkeepsie and Beacon, as well as the north eastern rural area of the TGA.

The data on those ‘not-in-care’ in the TGA also indicates that 46% are uninsured, 88% have annual family income of less than \$20,000, and 29% are either homeless or live in transitional homes. The above characteristics are hallmarks of those who are not in care and the reasons, including poverty, lack of health insurance, and homelessness are compelling.

Service needs, gaps and barriers to care for those with Unmet Need

Based on the EIS surveys, even though those with Unmet Need identify the “need” for basic primary care services (i.e. T-cell and viral load monitoring, an experienced HIV doctor), very few followed through on the referrals that were made. It is safe to assume that PLWH/A who are asymptomatic tend to seek care less often than those with symptoms. Women seek care more frequently than men, consistent with nearly all research regarding health seeking behaviors and gender. Women also tend to list barriers associated with family care giving more than men.

Forty one percent (41%) of the EIS clients indicated a “need” for case management and for financial benefits identically to those “in care.” However, few agreed to access case management services. Early Intervention staff offered to accompany them to services or meet them at the referral agency. Some initially agreed to meet case managers, and EIS staff waited for them at the referral agency; they did not show. This leads us to believe that linking those with unmet needs for care requires intensive services. Qualitative data from the “out of care” surveys identifies common barriers to care. Those clients who refused referrals or assistance with connecting to care identified the need for housing, active substance abuse and non-readiness for substance abuse treatment, stigma and confidentiality concerns, as well as perceived cost and time burden of entering the treatment system as significant barriers to care.

- **Gaps in Care**

The Planning Council, Ryan White Part A funded and non-funded provider and consumer surveys provided the primary source of information about the service gaps and barriers to care that affect the ability of infected individuals in Dutchess County to access needed services. The information relative to gaps in care is presented below, organized according to the HRSA defined core service categories.

1. Core Service: HIV Outpatient Ambulatory Care

All of the consumers surveyed indicated that they could easily access HIV primary medical care. Overall, consumers receiving their primary care in Dutchess County report that they are satisfied with the quality of care they receive.

Of those respondents who needed medical care about 8% did not get CD4 Counts/Viral Load tests, 6% did not get pharmacy/drug assistance/ADAP, 3% did not get child medical care, HIV and other specialty care, emergency medical care, home care services, and access to clinical trial. Seventy three and a half percent (73.5%) had no problems getting medical care. Approximately 9% had issues with transportation, 9% with the waiting period, 5% had problems because providers did not accept their insurance and, 3% were concerned with providers not accepting new patients, and another 3% lacked ADAP and Medicaid.

Key gaps in services related to consumer access to primary care are as follows:

- Specialty care, particularly from specialty care providers with specific training and/or experience treating individuals with AIDS/HIV, is difficult to obtain in Dutchess County. In particular, women report long waits to access gynecological care in the county and having to go outside of the county to obtain care.
- Both service providers and consumers indicate that providing increased training and education about treatment issues related to AIDS and HIV is critical to improving the ability of specialty care providers to respond to the treatment needs of the infected population.
- Consumers and service providers noted the need for ongoing support for treatment adherence. Consumers stressed their preference for support that is provided by their infected peers.
- Hepatitis C is a major issue for many consumers and it is difficult to engage infected individuals in appropriate treatment, as it is complicated, painful, lengthy, and has mixed results. The incidence of Hepatitis C among infected individuals with histories of substance abuse is of major concern, as the treatment is both difficult to undergo and difficult to manage, especially for individuals who are still actively abusing substances.

2. Core Service: Dental Care

About 12% of those needed dental X-rays and cleaning did not obtain it and 16% of those who needed dentures, filling and extraction did not obtain it. Long waiting period (12%), Lack of service providers (6%), Non-acceptance of client insurance (6%) and transportation (4%) were cited as problems in getting dental care.

Ryan White Part C funds dental services in Dutchess County at one site in Beacon, in the southern part of the County. Additionally, dentists are in short supply in Dutchess County, and those who accept Medicaid and/or who have specific training in treating individuals with HIV are in great demand.

The following specific issues were identified around oral health:

- The shortage in supply is exacerbated by the frequent turnover of staff in the dental clinics and “down-times” in service provision necessitated while new staff is recruited. As a result consumers may experience long waiting times for dental appointments.
- Consumers report being uncomfortable utilizing dentists in private practice in the county due to a perception that many dentists continue to stigmatize those infected with HIV.

3. Core Service: Substance Abuse Services

About of survey respondents 7% who needed drug/alcohol counseling did not obtain it, 6% who needed out-patient drug treatment did not obtain it, 5% who needed in-patient drug treatment did not obtain it and 3% who needed 12 step recovery services did not obtain them.

Problems getting substance abuse services included: transportation (2%), and waiting period (2%). The problems faced by infected individuals who need assistance related to substance abuse parallel those identified with regard to mental health services. In addition to the concerns, which have already been identified, the key findings are as follows:

- Individuals enrolled in the methadone maintenance program are ineligible for outpatient treatment services for substance abuse in the county. The methadone maintenance treatment program appears not to be well connected with the HIV service delivery system, with some of its staff reporting that they are not well informed about HIV issues and services in the county.
- Although most substance abuse treatment providers are more tolerant of harm reduction approaches than in the past, harm reduction approaches need to be more widely implemented if consumers are to escape the current structure that prevents them from accessing services from the mental health system unless they are abstinent but requires them to be actively using in order to access substance abuse treatment.

4. Core Service: ADAP

New York State ADAP provides comprehensive medication formulary to eligible people living with HIV/AIDS. The Dutchess County TGA contributes to the ADAP program and does not coordinate a local pharmacy, voucher or co-pay program. All the consumers interviewed as part of the assessment process reported that ADAP is essential to their ability to access necessary medications and supplements and stressed that it must be maintained at least at its present level.

5. Core Service: Case Management/Counseling

Eleven percent (11%) of those who needed mental health case management and counseling did not get it, 10% of those who needed support group help for self did not obtain it, 9% of those who needed Mental Health counseling for family did not obtain it, 8% of those who needed case management for medical care and 8% of those needed case management of other services did not obtain it. Problems in getting case management services included: Transportation (4%), Waiting period (4%), Did not know where to go (2%), Not accepting new patients (1%), not accepting their insurance (1%).

Consumers who have utilized case management services clearly understand its importance as a central component of the service delivery system in Dutchess County. Responses, however, indicate that case management is not always easily accessible, and can be a source of frustration for consumers seeking immediate assistance in crisis situations. The key issues related to the provision of case management services in the county are as follows:

- There are an insufficient number of case managers available to address the high level of need that exists within the community and caseloads continue to be high.
- There is a high rate of turnover within medical case management positions and this presents a major barrier to consumers who report a high level of frustration with having to “start over” with new case managers who are still struggling to learn about the complexities of the service system at the same time they are getting to know the unique individual needs of their clients.

6. Core Service: Mental Health

There are no mental health services specifically targeted for individuals with HIV/AIDS in the county. Additionally, many infected individuals also have alcohol and/or substance abuse histories that present particular barriers to care. The following findings reflect the complexity of accessing mental health care for infected individuals:

- Mental health providers have limited understanding of HIV issues and are not well informed about the HIV services offered in the county, thereby limiting inter-system communication.

- Mental health care is difficult to access outside of the county mental health clinic system as most private therapists do not accept Medicaid. The county funded mental health services operate as a separate care system with its own unique requirements. Consumers with histories of substance abuse face particular difficulties as they are expected to be abstinent prior to accessing county funded mental health services.
- There is a lack of psychiatrists who are trained in diagnosing and understanding AIDS related issues. There is a need for professionals who can determine if symptoms are a result of substance use, side effects from medications, or biological issues related to HIV.
- Mental health treatment approaches may utilize medication as a primary treatment component, which can present difficulties, as there is little understanding about the potential interactions with AIDS drug regimens.
- Mentally Ill Chemical Abusers (MICA) consumers are the most difficult to place in treatment as there are limited services that are able to address the constellation of needs presented by the multiply diagnosed.

7. Non Core Services:

Accessing to all services is closely tied to transportation and availability of child care at the service provider. Three percent (3%) who needed child care services did not obtain it. Transportation has been identified as a big concern; with 38% of the respondents indicating they needed it and only 33% being able to obtain it. Of those who responded that they needed legal assistance, about 11% did not obtain it.

PLWH/A who participated in the survey reported the following problems getting services: Transportation (5%), Waiting period (4%), Did not know where to go (5%), Not accepting my insurance (2%), Not accepting new patients (1%).

- **Prevention needs**

Prevention can be viewed as two targeted activities: 1) Prevention to keep people from becoming infected, and 2) Prevention with positives, to prevent those who are infected from transmitting the virus to others.

Although the TGA receives no Prevention with Positives funding, the outreach, information and referral, harm reduction are built into nearly every service category with objectives related to behavioral risk interventions. Additionally, the Dutchess County Department of Health's Communicable Disease Division STD Clinic, HIV testing and counseling, PNAP and Tuberculosis programs support increased condom use, knowledge of sero-status, HIV education for those in Substance Abuse treatment, HIV, STD and TB education in State Prisons, Counseling and testing in state prisons, HIV testing in TB patients, STD and hepatitis B immunizations.

The last needs assessment survey instrument utilized did not ask participants about sexual practices, injection drug equipment sharing, or about practices that may exacerbate their own infection. Therefore there are no findings to report from the needs assessment. Future surveys should include such questions. However, participants are asked when and where they were diagnosed. When first diagnosed, about 16% of the respondents were already suffering from AIDS. This information provides insight into the long duration between exposure to HIV and diagnosis in the patients who already were in the advance stage of AIDS at time of diagnosis. About 48% of the respondents were diagnosed in Dutchess County, 30% in the State of New York but in an area outside of the TGA, and 16% were diagnosed out of New York State.

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Status at First Diagnosis:	Percentage
HIV	75%
AIDS	16%
Don't Know	9%
Place First Test Positive for HIV/AIDS	Percentage
Dutchess County	48%
New York State (but not Dutchess County)	30%
Outside new York State	16%
Unknown	5%

Just as revealing, only 57% of the survey respondents stated that they received HIV related treatment immediately after their diagnosis; 125 did so within the next six months, and 9% within one year. About 16% received treatment only after they became ill.

During the community forum held in December 2008, those in attendance expressed the need for prevention programs reaching out to the community. Based on these discussions, and other relevant data, the TGA has identified the following prevention needs:

- Implementation of testing at routine medical appointments which includes alternative locations and methods for testing,
- Substance abuse counseling and treatment which includes rehabilitation and on-going care services,
- Continued linking of PLWH/A to medical and social services,
- Working with PLWH/A and their partners to prevent new infections and co-infections, and
- Peer education and outreach to communities.

Since funding for the preventive services are currently not available, reliance on other service categories for prevention will be increasingly important.

E. CURRENT CONTINUUM OF CARE AND FUNDED PROVIDERS

- **Current Continuum**

The organizations that comprise the continuum of care for those infected with HIV/AIDS in Dutchess County are detailed in the Resource Inventory (Appendix C). Linkages to multiple points of entry enable the Dutchess County continuum of care to be responsive to the needs of newly affected and disproportionately impacted communities.

Key points of entry include Dutchess County Department of Health counseling and testing programs, hospitals and emergency rooms, Sexually Transmitted Disease clinics, TB clinics and methadone clinics, community health programs such as Planned Parenthood and Migrant Health Program, substance abuse treatment programs, Community Based Organizations and case management programs, homeless shelters, local social services, NYS correctional facilities and jails, youth facilities and group homes, among others.

Primary Care providers comprise the top of the HIV care pyramid, supported by Community Case Management, Early Intervention Services, and substance abuse treatment services. Additional support services respond to the needs of PLWH/A, the newly diagnosed, “out of care” and consumers established in the Ryan White care system. The TGA allocates funds to ADAP, home delivered meals, peer based adherence services, emergency financial services to maintain equilibrium disrupted by financial crises, a newly implemented health insurance premium program and transportation.

Although Dutchess is a relatively small TGA, it remains a challenge to fully coordinate services. To address service barriers and to reduce disparities, the TGA supports a range of interventions aiming at increasing access to HIV continuum of care. Early intervention services utilize a mobile van traveling throughout the county, using culturally representative outreach workers to locate, engage and test those at risk. Medical case management assists consumers coordinate medical care throughout the TGA. The Part A Substance Abuse program has partnered with inpatient and outpatient clinics in central, southern, and eastern Dutchess. Home delivered meals ensure the nutritional and medical stability of homebound clients. A newly implemented Health Insurance Premium program provides access to comprehensive health insurance coverage. And finally, the Part A transportation program provides rides throughout the TGA, as well as rides for primary and specialty care, and Designated AIDS Centers in Westchester, Albany and New York City. Transportation is critical to nearly every other service due to limited public transportation, geographic disbursement of consumers and the location of HIV specialty services.

Service gaps are identified during the priority and allocation process of the Planning Council. The service inventory indicates that currently peer education and outreach, prevention, legal services, permanency planning, and limited transportation are funded by Part B. Part B also funds a Transitional Case Management program for the county jail, and has recently changed contractors. Part C funds an HIV specific oral/dental program. Part D funds are utilized to enhance primary care, case management services for women, infants, children and families. Special Projects of National Significance (SPNS) are currently not funded in the TGA.

- **Description of Part A Services**

To address barriers to care and reduce disparities, Dutchess County supports a range of interventions aimed at increasing access to and maintenance in the HIV continuum of care. The established mechanisms within the TGA enable newly infected, underserved, hard-to-reach individuals, emerging populations and/or disproportionately impacted communities of color to access and remain in primary medical care. The referral system has increased the linkages between providing agencies, helping to establish an effective and efficient *continuum of care*.

Early Intervention Services (EIS) identify and test high risk clients who may not know their status and track PLWH/A that know their status and have fallen out of care. This field based service makes referrals into medical case management, primary care, and other support services as necessary. The EIS program has targeted points of entry to ensure that newly diagnosed clients who may appear at ERs, homeless shelters, emergency services and testing sites can be linked to care immediately and with the additional support this vulnerable population needs.

Outpatient/Ambulatory Medical care includes three main outpatient HIV primary care settings throughout the central, eastern and southern parts of the TGA and provides services consistent with the NY State AIDS Institute's guidelines. Services include professional and diagnostic services provided by HIV specialists, access to drug and combination antiretroviral therapies, including prophylaxis and treatment of opportunistic infections, as well as on-site laboratory and nutrition services.

The locally funded providers continuously increase their clinical capacity through monthly sessions with physicians from Albany Medical Center. Care providers are available for consultation and emergency care through 24 hour on-call service provision. Each funded care provider has admitting rights to local hospitals for specialty collaboration and continuity of care throughout the disease spectrum. Both male and female HIV specialists are available, as some clients have expressed increased comfort with a practitioner of the same gender. Located in the epicenters of the infection, the providers are accessible to the underserved communities. These services attempt to neutralize stigma as they are housed in community health settings, and are not identified as HIV clinics. Providers are able to provide culturally competent, bilingual services to meet the needs of our diverse population.

The TGA contributes to AIDS Drug Assistance Program (ADAP), the Part B, state administered program which provides medication primary care visits and essential laboratory services to low income clients who have limited or no coverage from private insurance, Medicaid, or Medicare. ADAP enrollment is available at primary care, medical case management and through a field based facilitated enrollment program.

Health Insurance Premiums and Cost Sharing Assistance is a new program that was implemented in FY2008. In collaboration with the state ADAP program, the Dutchess TGA has developed a program to coordinate financial assistance for PLWH/A to enroll in comprehensive, cost effective, private health insurance program. By providing commercial insurance, this program enhances access to specialty providers who may not accept public insurance.

Substance Abuse services interface with points of entry such as detox programs, inpatient treatment and drug court to facilitate access to care. The Substance Abuse program is housed within an inpatient substance abuse treatment facility, operated by a local hospital. In addition to treatment, this field based service provides additional benefit to clients who are at risk of dropping out of care. Services are provided in a readiness & harm reduction model, to keep clients in care that may not be eligible through OASAS models. The program provides individual and group therapy. The program staff participates in case conferencing to coordinate and monitor mental health, substance abuse and primary medical care access.

Medical Case Management services (including Treatment Adherence) coordinate clients HIV, specialty care, and other services essential to stabilize and maintain optimal health. Medical case managers routinely assess and ensure that medically appropriate levels of care are accessed. Two community based organizations and a community health center are contracted to provide these essential services. Through coordination, referral and follow up, medical case management promotes access to and maintenance in primary care and is instrumental in linking the disproportionately impacted populations who tend not to access or maintain care. Treatment Adherence ensures compliance with difficult antiretroviral medication regimens.

Medical Transportation includes the provision of medically appropriate transportation to primary care and other services essential to stabilize and maintain health. Long distance rides are provided as necessary when Medicaid restricts the use of medical transportation and will not provide service to appointments outside the county. Long distance transportation is frequently provided to the designated AIDS centers located outside the TGA. This allows access for consumers seeking specialty and advanced HIV care that is unavailable in the TGA.

Home Delivered Meals program provides nutritionally balanced, cooked meals for medically homebound PLWH/A. Menus have been reviewed by nutritionists to meet dietary guidelines for HIV and other co-morbidities such as hypertension, diabetes and hyperlipidemia. The Home Delivered Meals program coordinates with primary care providers to ensure that services are medically necessary and consistent with nutritional needs. To promote adherence to prescribed medical standards, the home delivered meals program also ensures that these vulnerable clients receive a medical nutrition visit from their primary care or specialty provider.

The Emergency Financial Assistance program is available for eligible PLWH/A to provide short term payments directly to agencies for emergency expenses related to essential utilities, food, and medication when other resources are not available. This cost effective program coordinates closely with local pharmacy and utility providers, as well as other charity sources to ensure access to service, without financially overwhelming the system.

- **Providers Capacity and Capability by Service Category**

HIV resources available in Dutchess County are limited (See report on funding availability in Appendix). One capacity issue shared by all service providers relates to the increasing need for cultural competent staff. Currently, the County is experiencing a shortage of Spanish-speaking service providers at all levels of care. Beyond language, the subtleties of cultural competency in relation to HIV can impact trust, disclosure and maintenance in care.

Additionally, the absence of a teaching hospital or a Designated AIDS Center in the TGA makes it necessary for some residents to seek specialty care out of the TGA, in Kingston, Albany, and Westchester. Traveling a distance may impact a consumer's compliance with monitoring visits. Many PLWH/A first access the local system in a serious health crisis, with intensive and costly medical and psycho-social needs. These issues have unique repercussions on the TGA's Part A continuum of care.

Among the providers who were surveyed, most had a moderate level of staffing with a low to moderate staff turn over. Most turn over of staff was among "Counselors" and "Case Managers." Eighty three percent (83%) of the providers surveyed had evening and weekend hours of operation. A third of them have 24 hours on-call services and about 17% have 24 hours pharmacy services.

The following is a review of the providers' capacity by service category:

- Medical Care

Ryan White Part A funds 2 primary care providers: Hudson River Health Care (Beacon and Poughkeepsie sites), and Institute for Family Health (Hyde Park site). Both providers offer comprehensive primary care, laboratory services, medical case management, adherence counseling, nutritional counseling and mental health services. Additionally, two private physicians also offer primary care services to people infected with HIV virus.

- Medical Case Management providers

Part A funds medical case management services through two area providers who are well connected to key points of entry. AIDS Related Community Services (ARCS) provides Early Intervention Services (EIS), as well as case management and has offices in Poughkeepsie and Beacon. Catharine Street Community Center (CSCC) located in Poughkeepsie, is a minority-based agency is also contracted for case management and MAI services. CSCC additionally provides after-school programs and other non-HIV community support programs so that it is not solely identified as an AIDS Service Organization.

Part D case management is funded within one of our primary care and helps makes sure that through referral we have targeted interventions and supportive services for WICY clients. Additionally, case management services with a community based not-for-profit agency that has parenting and after school programs has decreases issues with stigma, and ensure that WICY clients have a safe place to go.

➤ Testing & Counseling

Counseling & Testing services are available through various service providers including Planned Parenthood, Vassar Brothers Medical Center, ARCS, Hudson River Health Care, and the Dutchess County Department of Health. The Health Department also offers Partner Notification Program.

➤ Early Intervention Services

Early Intervention Services are available through ARCS and Hudson River Health Care. ARCS EIS program is funded by Part A and utilizes a van to provide outreach, counseling, testing and referral services to identify people with HIV disease who are not accessing primary care and those at increased risk. These services do not replace existing counseling and testing. Instead, they are conducted at times and places where there is a high probability that HIV infected individuals will be reached through street outreach.

➤ Substance Abuse and Mental Health providers

Clients requiring mental health or substance abuse treatment are referred to community based or residential services. Where substance abuse impedes access to appropriate and consistent care, PLWH/A are linked to the Part A Service Coordination program to address “traditional” treatment readiness and counseling.

The NYS Department of Mental Hygiene, NYS Office of Alcohol and Substance Abuse Services (OASAS) and local government provide funds for licensed mental health and substance abuse treatment in Dutchess County. This funding and Medicaid are the primary source of individual and group mental health treatment, counseling, residential and community based substance abuse treatment and detoxification services, none are HIV specific.

➤ Oral Care

Besides the few dentists who accept Medicaid, PLWH/A can access oral care through Hudson River Health’s Part III funded program in Southern Dutchess.

F. RESOURCE INVENTORY BY SERVICE CATEGORY,

The *HIV specific services* available in Dutchess County are listed on the Dutchess County Department of Health website at:

<http://www.co.dutchess.ny.us/CountyGov/Departments/Health/HDrwhite.htm>.

G. BARRIERS TO CARE

Consumers and providers identified several reasons why infected individuals may not be accessing care in the county:

- *Confidentiality* with regard to HIV status is cause for concern for many infected individuals in a small county where “everyone knows everyone else” and there is still significant stigma associated with an AIDS diagnosis. As a result, many consumers are reported to seek care outside of the county.
- Similarly, individuals who have had prior “*bad experiences*” with the service system are reported to have dropped out of care or to be accessing care outside of the county.
- A significant proportion of those out of care are believed to be homeless, mentally ill, and/or struggling with issues related to *chronic alcohol/substance abuse*. For these individuals, their HIV status is perceived to be of lesser significance than the multitude of other problems they face on a daily basis in order to meet their basic needs.
- The *migrant worker populations* in the eastern and northern sections of the county are also reported to be of concern, as they tend to be disconnected from the traditional service system due to language barriers as well as immigration status.
- The infected *GLBT population* in the county is not highly visible and may need specialized outreach in order to better understand their needs and concerns related to service utilization.
- Although youth prevention activities exist, there are no specific programs for young people infected with HIV. There is a need for *support services for youth* who are HIV+.
- Individuals who have been infected for long periods of time report that they have learned how to manage their own illness and often feel better when they are not on medication. While some continue to have their health status monitored on a regular basis, others stay out of care until a decline in their health status precipitates a return to care.
- Service providers note that, as infected individuals live longer with the assistance of new drug regimens, they are beginning to see more seriously ill consumers with increased *medical complications*; i.e. heart disease, renal failure, diabetes. These medical complications often necessitate even more complex medication regimens, which are increasingly difficult for consumers to manage.
- Complicated medical regimens makes *adherence challenging* for many consumers, resulting in some adjusting their medications without informing their primary medical providers. Side effects and difficulties with scheduling are primary reasons reported for straying from medical regimens.

- There is no single location in the county where infected individuals can access ALL of the medical care they need in order to manage their illness. The constant need for both service coordination and transportation presents additional barriers to accessing care. In particular, lack of adequate coordination is reported to limit the continuity of care between service providers. Many consumers view centralized access to services through a *one-stop-shopping center* as offering potential for improving service access and coordination.
- As the county population has expanded rapidly over the past decade, the demand for, and consequently, the cost of housing in the county has risen dramatically. Apart from both HIV and AIDS specific care services, the *lack of safe, affordable, accessible housing* is the most frequently identified need in the county cited by both service providers and consumers. The fact that there is not enough affordable housing for PLWH/A in Dutchess County is cited as a core issue that impacts every other aspect of consumers' lives, particularly their ability to stay connected to primary care services.
- Although there appears to be a sufficient supply of transportation services available to consumers in the county, consumers reported having experienced significant problems related to the reliability and timeliness of the transportation provided by the taxi companies contracted to provide Medicaid reimbursable transportation services.
- Medicaid transportation guidelines are becoming stricter which in turn is placing increased demand on Part A funded transportation, which is reported to have the same problems related to timeliness and reliability as noted above.
- Staff of organizations that serve PLWH/A, but are not primary providers of AIDS services, need increased education and training about HIV disease, the service continuum that exists in the county, and the specific benefits that may be available for PLWH/A. For example, it appears that not all DSS workers know about and/or communicate the fact that there is housing money available to financially eligible PLWH/A.
- While Part B funds a transitional jail program in the TGA, the funding does not support post release follow up.

SECTION 2: WHERE DO WE NEED TO GO?: WHAT SYSTEM OF CARE DO WE WANT?

MISSION

It is the mission of the Dutchess County HIV Services Planning Council to create an effective compassionate and comprehensive system of health care and other support services for people living with HIV/AIDS in Dutchess County.

VISION

We will ensure a comprehensive, well-integrated system of care that is characterized by universal, barrier-free service access; that is flexible and adaptable; that is responsive to changes in the epidemic that result in changing needs; and that is comprised of service providers with specific training and expertise in HIV/AIDS so that they may best serve our communities.

SHARED VALUES

The continuum of care for individuals infected and affected by HIV and AIDS in Dutchess County will be characterized by services that:

- Treat all people with compassion and respect;
- Ensure equity of access to services for all residents of the county;
- Support the right to self-determination for all those infected with HIV/AIDS;
- Deliver services in a culturally competent manner; and
- Promote accountability as the cornerstone of our service delivery system.

The overarching goal of the TGA is reflected in its mission to create an effective compassionate and comprehensive system of health care and other support services for people living with HIV/AIDS in Dutchess County. This goal will be achieved by responding to the existing and emerging needs of those infected and affected by HIV/AIDS in the TGA.

The goals and objectives in Section 3 of this document are ways that the Council, the Grantee, and the service providers can continue responding to the TGA's mission, both directly and indirectly, over the next three years.

SECTION 3: HOW WILL WE GET THERE?

HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF AND ACCESSIBILITY TO CORE SERVICES?

The Planning and Allocation Committee of the Dutchess County HIV Planning Council developed recommendations for continued enhancement of the continuum of care in Dutchess County based on their review of the epidemiological data, information collected through the key informant interviews, consumer and provider surveys, community forum, identification of services gaps, barriers to care as well as factors and trends that could influence the service delivery system in Dutchess County.

The New York State AIDS Institute was in the process of conducting the Statewide Coordinated Statement of Need (SCSN) at the time of the writing of this document. A draft copy of the SCSN was shared with the Planning/Allocation Committee. The Committee referenced the document during the planning process.

When the Treatment Modernization Act was reauthorized in 2006, the funding formula changed and Dutchess County no longer met the qualifications as an EMA. Dutchess County became a Transitional Grant Area (TGA), and it is in danger of losing the funding entirely as it fails to meet the new funding criteria for three consecutive years. The current long term goals were adopted with the understanding that the current policies which guide the provision of Part A services, as well as present funding allocations may change dramatically pending the outcome of the anticipated reauthorization of the Ryan White Treatment Modernization Act in October 2009.

LONG TERM GOAL: Develop and Maintain High Quality Continuum of Primary Care and Support Services for PLWH in the TGA

Establish and support a comprehensive, coordinated system of HIV/AIDS care, including prevention and treatment services that facilitate full access to and successful utilization of services for all consumers across the continuum of care.

LONG TERM GOAL: Sustain Ongoing Planning For HIV/AIDS Services

Develop a mechanism to provide a platform for exploring funding opportunities, community input and consumer feedback, regardless of the HIV/AIDS Treatment Modernization Act changes. Conduct planning activities that respond to changing trends in the HIV epidemic and support the timely and responsive development and implementation of comprehensive, coordinated services along the continuum of care.

Goal: DEVELOP AND MAINTAIN HIGH QUALITY CONTINUUM OF PRIMARY CARE AND SUPPORT SERVICES FOR PLWH IN THE TGA

Rationale

The Planning Council must promote the best possible level of medical services for those diagnosed with HIV or AIDS to ensure optimal health and to decrease the chances of further transmission of the HIV virus. PLWH/A co-morbidities are not typically receiving coordinated comprehensive primary care services, which results in poor health outcomes and continued high-risk behaviors. Specialty care from providers with specific HIV/AIDS training and/or experience in treating people with HIV/AIDS is difficult to obtain in Dutchess County. Most PLWH/A in the TGA live in unstable, marginalized circumstances making it very difficult to engage and retain them in care. Fostering linkages with, and training for, care and treatment programs will make available *comprehensive* HIV medical care services.

Objectives	Activities
<ul style="list-style-type: none"> • By February 2010, ensure implementation of existing standards of care relative to essential staff training. 	<ul style="list-style-type: none"> • Grantee will monitor service providers’ staff training and provide technical assistance as needed. • Support the linguistic and cultural competence of direct service staff
<ul style="list-style-type: none"> • By February 2010, conduct outreach with non-HIV specific service providers for the purposes of improving coordination of services and increasing understanding of HIV specific issues. 	<ul style="list-style-type: none"> • Planning Council will identify and assess non funded provider systems for HIV capacity • Training opportunities will be communicated to non HIV specific service providers. • Conduct outreach to non-funded primary care providers likely to be seeing PLWH/A (e.g., infectious disease practices) in order to: <ol style="list-style-type: none"> 1. Inform them about RW services and eligibility. 2. Recruit to serve on the Planning Bodies. • Continue to serve on non-HIV related boards and consortiums to “keep HIV at the table” • Identify ways to better coordinate with points of entry- especially hospitals and correctional transitional planners

CONTINUING.....

Goal: Develop and Maintain High Quality Continuum of Primary Care and Support Services for PLWH in The TGA.

Objectives	Activities
<ul style="list-style-type: none"> • By December 2009, investigate feasibility of a “one stop shopping” service delivery model by co-locating primary care providers and specialists at accessible locations. 	<ul style="list-style-type: none"> • Planning Council and Grantee will hold meetings with medical providers to encourage primary care providers to expand services available on site.
<ul style="list-style-type: none"> • By December 2009, primary care providers, hospital discharge planners and support services will have established formal linkage agreements to expedite cross referrals. 	<ul style="list-style-type: none"> • Grantee will continue to require formal linkage agreement as part of contractual requirement of all Part A funded providers • Encourage “real life” linkages beyond MOUs and formal agreements
<ul style="list-style-type: none"> • Develop an annual implementation plan that reflects the goals and objectives in the CSP. 	<ul style="list-style-type: none"> • Grantee will review progress reports from contracted service providers to ensure progress toward implementing identified services on a semi annual basis. Grantee will report findings to Evaluation Committee of the Planning Council. • Grantee will monitor emerging issues and make recommendations as necessary.

Goal: SUSTAIN ONGOING PLANNING FOR HIV/AIDS SERVICES

Rationale

With the Ryan White Treatment Modernization Act re-authorization in the horizon, the eligibility of the TGA will impact funding availability. The Planning Council needs to ensure long term ability to plan, coordinate and fund HIV services in Dutchess County. It should also be noted that the participation of PLWH/A is essential to the planning process and Planning Council must establish system for on going recruitment and training of members.

Objectives	Activities
<ul style="list-style-type: none"> • By October 2009, develop a contingency plan to sustain funding for essential services and Planning Council functions if necessitated by the outcome of the re-authorization. 	<ul style="list-style-type: none"> • Monitor the re-authorization • Develop a contingency plan that will identify alternative ways to support the Planning Council functions, such as identifying a “sponsor” the Planning Council activities, plan activities which do not require monetary resources (eg. networking activities and problem solving, roundtables), and identifying ways to maintain and increase consumer input , CABs, town hall, use of pre-existing groups • Develop a contingency plan that will identify alternative ways to support the current continuum of care related to direct services, including but not limited to: <ul style="list-style-type: none"> ➤ Outreach to engage existing service systems (mental health, substance abuse) ➤ Promote HIV capacity development in these systems to ensure quality of care ➤ Look for other funding sources (SAMSHA etc., grant finder, OASAS) ➤ Promote seminars about how to write grants and to lend capacity ➤ Maximize 3rd party reimbursement ➤ Consider co-locations and other collaborations to reduce costs ➤ Support maintenance of data systems ➤ Promote Self Management techniques and models <i>before</i> funding disappears to assist and empower clients

CONTINUING.....

Goal: Sustain Ongoing Planning for HIV/AIDS Services

Objectives	Activities
<ul style="list-style-type: none"> By December 2009, build linkages with the AIDS Institute Prevention Planning Group (PPG) and other prevention partners for the purposes of coordinating Planning Council activities with prevention planning 	<ul style="list-style-type: none"> Planning Council will continue coordination with Part B and will reach out to Prevention, Counseling and Testing programs and state wide Prevention Planning Groups
<ul style="list-style-type: none"> By December 2009, enhance Planning Council membership base to ensure ongoing high level of participation at full council and committees. 	<ul style="list-style-type: none"> Membership Committee of the Planning Council will engage in concerted recruitment Identify and implement additional strategies to maintain representative and reflective membership Consider other ways to engage participation such as networking/community outreach committees to allow a more “hands on” experience vs. planning activities Provide annual training to all planning council members; provide orientation and assign a “mentor” to every new member; develop written procedures and protocol with quick reference sheets.
<ul style="list-style-type: none"> By September 2009 inform stakeholders (government, funders, service providers and community at large) of emerging issues related to the RW program and obtain support for its sustainability. 	<ul style="list-style-type: none"> Coordinate efforts with Part B Policy Advisory Committee. Inform stakeholders and advocate for funding sustainability.

B. CONTINUUM OF CARE GOALS AND OBJECTIVES

The following is the Service Specific Goals and Objectives which related to the TGA’s overarching long term goal of Developing and Maintaining High Quality Continuum of Primary Care and Support Services for PLWH.

SERVICE CATEGORY	ACTIVITIES	CLIENTS TO BE SERVED	PROJECTED SERVICE UNITS
<p>Outpatient Ambulatory Care</p> <p>Service Goal: Provide HIV Outpatient/Ambulatory medical care that meets or exceeds PHS standards, according to NYS AIDS Institute guidelines.</p>	<ul style="list-style-type: none"> ▪ Provide 100% of patients with appropriate specialty care referrals. ▪ Meet with clinical and community case managers for interdisciplinary case conferencing. ▪ Provide individualized medication adherence intake and assessment. ▪ Provide adherence specific support session. 	220	880
<p>Medical Case Management/ Treatment Adherence</p> <p>Service Goal: Provide Medical Case Management (Including Treatment Adherence services).</p>	<ul style="list-style-type: none"> ▪ Participate in case conferencing with Primary Care programs. ▪ Provide information and referral to HIV Primary Care, specialty care, and supportive services ▪ Provide medication adherence treatment education and information. 	80	600
<p>Substance Abuse</p> <p>Service Goal: Access to care for PLWH/A who have chemical dependency by providing substance abuse treatment, readiness counseling, and other related support.</p>	<ul style="list-style-type: none"> ▪ Provide PLWH/A with substance abuse treatment, counseling, and support services. ▪ Link PLWH/A with substance abuse treatment, counseling, and support services. ▪ Linkage to and increased access to primary medical care and HIV/AIDS service providers as necessary. 	40	960

CONTINUING.....

Continuum of Care Goals & Objectives

SERVICE CATEGORY	ACTIVITIES	CLIENTS TO BE SERVED	PROJECTED SERVICE UNITS
<p>Early Intervention Services</p> <p>Service Goal: Identify PLWH/A not in care & provide linkages to HIV primary medical care</p>	<ul style="list-style-type: none"> ▪ Provide HIV counseling and testing to targeted populations. ▪ Provide referral and follow up services to identified PLWH/A ▪ Provide counseling regarding essential clinical & diagnostic services, including CD4 & VL, & resistance testing to PLWH/A. 	200	600
<p>ADAP</p> <p>Service Goal: Provide Access to HIV/AIDS drugs through NYS ADAP</p>	<ul style="list-style-type: none"> ▪ Provide essential HIV/AIDS medication 	25	100
<p>Insurance Premium</p> <p>Service Goal: Ensure access to the ADAP Plus Insurance Continuation Program (APIC) for PLWH/A in the TGA.</p>	<ul style="list-style-type: none"> ▪ Determine eligibility for NYSDOH APIC and NYS Medicaid AHIP ▪ Facilitate application process, including documentation requirements ▪ Issue Health Insurance Premiums 	25	100
<p>Outreach Services</p> <p>Service Goal: Locate and engage PLWH/A who are not in care.</p>	<ul style="list-style-type: none"> ▪ Locate / engage PLWH/A who are not in care. ▪ Link identified PLWH/A to primary medical care. ▪ Provide risk & harm reduction education, facilitating access to HIV care and treatment. 	200	600

CONTINUING.....

Continuum of Care Goals & Objectives

SERVICE CATEGORY	ACTIVITIES	CLIENTS TO BE SERVED	PROJECTED SERVICE UNITS
<p>Transportation</p> <p>Service Goal: To provide medically appropriate transportation for PLWH/A who reside in the Dutchess TGA to access core services.</p>	<ul style="list-style-type: none"> ▪ Provide transportation to medical and core services appointments. 	<p>35</p>	<p>300</p>
<p>Emergency Financial Services</p> <p>Service Goal: Administer & provide emergency financial assistance, including a food pantry.</p>	<ul style="list-style-type: none"> ▪ Provide emergency assistance for telephone, utilities, medications and other specified emergencies (as provided by standard of care). ▪ Provide PWLH/A access to food pantry. 	<p>20</p>	<p>20</p>
<p>Home Delivered Meals</p> <p>Service Goal: Provide home-delivered meals to promote optimal health for PLWH who are deemed medically homebound.</p>	<ul style="list-style-type: none"> ▪ Provide home delivery of meals for PLWH/A. ▪ Ensure maintenance in HIV primary care. Ensure nutritional assessment for clients (i.e. through primary care provider, other referral sources). 	<p>50</p>	<p>18,200</p>

SECTION 4: HOW WILL WE MONITOR OUR PROGRESS?:
HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR
SHORT AND LONG TERM GOALS?

A. MONITORING & EVALUATING THE COMPREHENSIVE PLAN

Implementation of the plan will require monitoring of the political and social realities, including funding levels and Ryan White Treatment Modernization Act re-authorization. The Planning & Allocation Committee will be responsible for monitoring and evaluating progress on the specific strategies and goals in the work plan.

Monitoring of the plan will require reviewing the goals and objectives regularly to ensure recognition of possible barriers to the implementation of specified activities. Monitoring questions include: Did we accomplish the activity? How well did we do? If we were unable to accomplish the activity, are there barriers to making progress? How can we address the barriers? The Planning & Allocation Committee will report progress and issues to the full Planning Council during the Council's regular meetings.

The Planning & Allocation Committee will also be responsible for identifying emerging issues, analyzing the issue and its impact on the plan, and making appropriate recommendations to the Executive Committee and the full Planning Council on issues which may need to be added to the work plan itself.

Required activities of the Planning & Allocation Committee include:

Develop an annual work plan that reflects the goals and objectives in the CSP.

- Review progress toward implementing identified objectives on a quarterly basis and make revisions and adjust recommendations as necessary.
- Monitor emerging issues and make recommendations as necessary.

The Executive Committee will evaluate the Comprehensive Service Plan on a yearly basis. The evaluation of the Comprehensive Services Plan will include the following questions: Are programs removing barriers to primary care? Are programs providing services within established standards of care? Are programs achieving the stated goals and objectives of the Comprehensive Services Plan? The Committee will consider demographic and outcome information from service providers, the epidemiological profile of the TGA, service utilization updates, and information provided by Planning & Allocation as well as Evaluation Committees.

Activities:

- Evaluation Committee continuously reviews Standards of Care.
- Increase awareness of both service providers and consumers about the existing procedures for reporting issues of concern related to service delivery.

B. QUALITY MANAGEMENT

Quality Management (QM) has been prioritized in the TGA as an essential component of the administrative function. The Grantee continues to work toward supporting the necessary organizational development to ensure effective implementation of quality related activities with the goal of improved services and systems to enhance clinical HIV/AIDS care in the TGA.

- **Improving Client Level data**

The New York State AIDS Reporting System (AIRS) provides a seamless transition to the new client level data reporting requirements. As an added benefit, NYS offers extensive Technical Assistance and training for AIRS users. The Administrative Agency has determined that utilizing AIRS is the most cost effective and quality based way to implement client level data collection across its system.

AIRS captures unduplicated data about HIV service clients across a prescribed continuum of care. Information such as demographics, income, insurance, HIV risk, disease progression, and co-morbidities are collected and tracked to monitor local changes in the epidemic. Care coordination, optimal service mix, referrals and point of entry to system can be analyzed for optimal quality of care. Providers are able to run custom agency level reports showing new client intakes, service units captured and staff based client and activity lists, among many others. System-wide custom reports provide information about how many Part A eligible clients are served, which services are being highly utilized and what service mix produces the optimal potential for improved health outcomes.

The system is currently being adapted so that the New York State (NYS) quality management software, HIVQUAL, will be integrated. While AIRS is essential to the Administrative Agency by collecting and referencing data indicators, AIRS can also serve as a useful tool for providers. Providers are able to run custom agency level reports showing new client intakes, service units captured and staff based client and activity lists, among many others. AIRS has streamlined the reporting process for Part A providers and allowed the Grantee's Administrative team to receive more accurate and consistent data from providers. Data collected from these reports are able to reflect trends in enrollment by age, race, gender, HIV risk, income and insurance status. This new format also provides a "snapshot" of program utilization, and outcome success at half and full year marks, as well as any time period requested by the grantee.

Clinical data collected from Outpatient Ambulatory care, contracted for HIV primary care providers are based on HIVQUAL indicators. Broadly they are Clinical Visits, ARVT Management, TB testing, Pelvic Exam, Mental Health, Substance use, Tobacco use, Hepatitis C and Syphilis screening and dental exams. A sub- set of mental health screening included the following indicators: Cognitive, Depression, Anxiety, Psychiatric, Psychosocial, Sleeping, Appetite, Domestic violence, PTSD. FY 2008 client level data has been submitted to the Grantee and is in the process of being analyzed.

- **Measuring Clinical Outcomes**

Quality service indicators developed with input from the Evaluation Committee of the Planning Council are helpful in assessing that programs are providing services in accordance with Grantee expectations, contract language, and Standards of Care. The following table reflects categorical indicators:

SERVICE CATEGORY	Target and INDICATOR
HIV Outpatient Ambulatory Care	90% of patients will be assessed for medication adherence 75% of patients will demonstrate adherence to medical protocols 85% of patients will have CD4 & viral loads monitored quarterly 90% of patients will be assessed and referred to appropriate specialty care 90% of patients will be assessed for mental health & substance abuse treatment needs and referred to appropriate treatment. 90% of patients will be assessed and referred to support services The following HIV Primary care clinical indicators are also tracked consistent with NYS AIRS, HIVQUAL and RDR reporting: Antiretroviral therapy , PCP Prophylaxis, MAC Prophylaxis, PPD Screening, GYN Care (Pelvic exam with PAP Smear, syphilis serology, GC culture, and Chlamydia screening), AND Specialty Referrals – Dental, Nutrition and Ophthalmology
Medical Case Management	90% MCM clients will have attended 2 HIV primary care visits at least 3 months apart. 90% of MCM clients will have lab work completed to assess their viral load and CD4 counts <i>at least</i> once every six months.
Substance Abuse	75% of PLWH will demonstrate sobriety for 3 months 90% PLWH will have attended 2 HIV primary care visits at least 3 months apart. 90% of PLWH will have lab work completed to assess their viral load and CD4 counts <i>at least</i> once every six months.
Early Intervention Services	50% of identified PLWH with intake will attend 2 HIV primary care visits 3 months apart 85% of identified PLWH with intake will have either a CD4 or Viral Load test 75% of PLWH without intake will demonstrate: PLWH with “Unmet Need” (HIV+ aware, not in care) will receive a documented referral and follow up to HIV primary care. PLWH with “Unmet Need” will report risk and harm reduction methods used
Home Delivered Meals	100% of clients receiving home delivered meals will receive a documented nutritional assessment from a registered dietician 100% of clients receiving home delivered meals will have a quarterly HIV primary care visit
Transportation	85% of reviewed charts will indicate a client no show rate of less than 50%
Emergency Services	100% of clients provided with assistance will report medication was accessed 100% of clients will report the assistance has ameliorated crisis living conditions and participation in HIV primary care
Treatment Adherence	100% of clients will be assessed for HIV antiretroviral treatment history at the initial visit. 100% of clients will have adherence to medications assessed and described quantitatively every 4 months.

APPENDIX A

AIDS Incidence, AIDS Prevalence and HIV (not AIDS) Prevalence BY DEMOGRAPHIC GROUP AND EXPOSURE CATEGORY in DUTCHESS COUNTY.

Demographic Group/ Exposure Category	AIDS INCIDENCE: Source: NYSDOH Bureau of HIV/AIDS Epidemiology 01/01/06 TO 12/31/07		AIDS PREVALENCE Source: NYSDOH Bureau of HIV/AIDS Epidemiology AS OF 12/31/07		HIV (NOT AIDS) PREVALENCE Source: NYSDOH Bureau of HIV/AIDS Epidemiology AS OF 12/31/07 ¹	
	<i>AIDS Incidence is defined as the number of new AIDS cases diagnosed during the period specified.</i>		<i>AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.</i>		<i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.</i>	
<i>Race/Ethnicity</i>	Number	% Of Total	Number	% Of Total	Number	% Of Total
White, Not Hispanic	18	26.87%	196	22.84%	277	24.24%
Black, not Hispanic	34	50.75%	383	44.64%	514	45.05%
Hispanic	13	19.4%	257	29.95%	311	27.27%
Asian/Pacific, Islander	-	-	-	-	4	0.4%
American Indian/Alaska Native	-	-	-	-	-	-
Multi-Race	2	2.99%	22	2.56%	35	3.03%
Not Specified	-	-	-	-	-	-
Total	67	100%	858	100%	1141	100%
<i>Gender</i>	#	% Of Total	#	% Of Total	#	% Of Total
Male	54	80.6%	697	81.24%	811	71.11%
Female	13	19.4%	161	18.76%	330	28.89%
Total	67	100%	858	100%	1141	100%
<i>Age at Diagnosis (Years)</i>	#	% Of Total	#	% Of Total	#	% Of Total
<13 years	-	-	-	-	7	0.61%
13 – 19 years	2	2.99%	6	0.7%	25	2.22%
20 – 29 years	3	4.48%	17	1.98%	56	4.85%
30 - 49 years	42	62.69%	457	53.26%	675	59.19%
50+	20	29.85%	378	44.06%	378	33.13%
Total	67	100%	858	100%	1141	100%

As per suggestion of the HIV/AIDS Bureau/HRSA and CDC, THE NYSDOH HIV Prevalence Estimate 2007 was adjusted to reflect changes in the TGA from 2006 to 2007. Please see narrative for an explanation of the methodology used.

Demographic Group/ Exposure Category	AIDS INCIDENCE: 01/01/06 TO 12/31/07		AIDS PREVALENCE AS OF 12/31/07		HIV (NOT AIDS) PREVALENCE AS OF 12/31/07 ¹	
	<i>AIDS Incidence is defined as the number of new AIDS cases diagnosed during the period specified.</i>		<i>AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.</i>		<i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.</i>	
Adult/Adolescent AIDS Exposure Category	#	% Of Total	#	% Of Total	#	% Of Total
Men who have sex with men	18	26.87%	127	14.8%	168	14.75%
Injection drug users	19	28.36%	397	46.27%	461	40.4%
Men who have sex with men and inject drugs	5	7.46%	41	4.78%	42	3.64%
Heterosexuals	7	10.45%	115	13.4%	240	21.01%
Other/hemophilia/blood transfusion	-	-	2	0.23%	2	0.2%
Risk not reported or identified	18	26.87%	176	20.51%	228	20%
Pediatric	0	0	0	0	0	
Total	67	100%	858	100%	1141	100%
Pediatric AIDS Exposure Categories	#	% Of Total	#	% Of Total	#	% Of Total
Mother with/at risk for HIV infection	1	50%	4	80%	12	92.31%
Other/hemophilia/blood transfusion	-	-	-	-	-	-
Risk not reported or identified	1	50%	1	20%	1	7.69%
Total	2	100%	5	100%	13	100%

Please Complete: Does your State have HIV reporting? (Check one.) Yes No

¹ As per suggestion of the HIV/AIDS Bureau/HRSA and CDC, we adjusted our NYSDOH HIV Prevalence Estimate 2007 to reflect changes in the TGA from 2006 to 2007. Please see narrative for an explanation of the methodology used.

**APPENDIX B :
PART A FUNDING IN THE CONTEXT OF OTHER PUBLIC FUNDING - DUTCHESS COUNTY**

Services	2008 Amount and Percent of Public Funding Source									
	Ryan White Part A		Other Federal Funds*		State Funds**		Local Funds		TOTAL FUNDS	
	Funds	%	Funds	%	Funds	%	Funds	%	Funds	%
Home/Community Based Support Services	\$466,000	45.8%	\$431,545	25.0%	\$0	0.0%	\$0	0.0%	\$897,545	19.67%
Ambulatory/Outpatient Medical Care	\$350,000	34.4%	\$148,158	8.6%	\$281,557	22.5%	\$0	0.0%	\$779,715	17.08%
State AIDS Drug Assistance Program	\$5,000	0.5%	\$793,469	45.9%	\$950,803	75.8%	\$0	0.0%	\$1,749,272	38.32%
Other Outpatient/Community Based Primary Medical Care Services	\$0	0.0%	\$4,271	0.2%	\$18,420	1.5%	\$565,193	100%	\$587,884	12.88%
Oral Health Care	\$0	0.0%	\$1,805	0.1%	\$3,353	0.3%	\$0	0.0%	\$5,158	0.12%
Substance Abuse/Mental Health Services	\$84,588	8.3%	\$225,618	13.1%	\$0	0.0%	\$0	0.0%	\$310,206	6.80%
Minority AIDS Initiative	\$112,436	11.0%	\$122,801	7.1%	\$0	0.0%	\$0	0.0%	\$235,237	5.16%
TOTAL FUNDS	\$1,018,024	100.0%	\$1,727,667	100.0%	\$1,254,133	100.0%	\$565,193	100%	\$4,565,017	100.0%

* The "Other Federal Funds" category includes Ryan White Part B and Part C Funds.

** These lines include State contracts, State funds appropriated for the uninsured care programs and other funds (insurance recoveries, rebates, etc.) obtained by the State to support the uninsured programs.

*** Includes matching funds for STD HIV Clinic.

Not included in the table are the following: Part B and State funds supporting insurance continuation \$103,432 & State Funds Supporting training \$170,000

APPENDIX C

2009 ACTION PLAN

***Goal # 1:* DEVELOP AND MAINTAIN HIGH QUALITY CONTINUUM OF PRIMARY CARE AND SUPPORT SERVICES FOR PLWH IN THE TGA**

OBJECTIVES	ACTIVITIES	RESPONSIBLE	REVIEW DATE
By February 2010, ensure implementation of standards of care relative to essential staff training.	<ul style="list-style-type: none"> • Grantee will monitor service providers' staff training and provide technical assistance as needed. 	Grantee	December 2009
	<ul style="list-style-type: none"> • Support the linguistic and cultural competence of direct service staff 	Grantee	December 2009
By February 2010, conduct outreach with non-HIV specific service providers for the purposes of improving coordination of services and increasing understanding of HIV specific issues.	<ul style="list-style-type: none"> • Planning Council will identify and assess non funded provider systems for HIV capacity 	Planning/Allocation Committee	October 2009
	<ul style="list-style-type: none"> • Training opportunities will be communicated to non HIV specific service providers. 	Grantee	December 2009
	<ul style="list-style-type: none"> • Conduct Outreach to non-funded primary care providers likely to be seeing PLWH/A (e.g., infectious disease practices) in order to: <ol style="list-style-type: none"> 1. Inform them about RW services and eligibility. 2. Recruit to serve on the Planning Bodies. 	Executive Committee and Grantee	October 2009
	<ul style="list-style-type: none"> • Continue to serve on non-HIV related boards and consortiums to "keep HIV at the table" 	Executive Committee and Grantee	December 2009
	<ul style="list-style-type: none"> • Identify ways to better coordinate with points of entry- especially hospitals and correctional transitional planners. 	Planning/Allocation Committee and Grantee	December 2009

CONTINUING.....

Goal 1- 2209 Action plan

OBJECTIVES	ACTIVITIES	RESPONSIBLE	REVIEW DATE
<p>By December 2009, investigate feasibility of a “one stop shopping” service delivery model by co-locating primary care providers and specialists at accessible locations.</p>	<ul style="list-style-type: none"> • Planning Council and Grantee will hold meetings with medical providers to encourage primary care providers to expand services available on site. 	<p>Executive Committee and Grantee</p>	<p>December 2009</p>
<p>By December 2009, primary care providers, hospital discharge planners and support services will have established formal linkage agreements to expedite cross referrals.</p>	<ul style="list-style-type: none"> • Grantee will continue to require formal linkage agreement as part of contractual requirement of all Part A funded providers • Encourage “real life” linkages beyond MOUs and formal agreements 	<p>Grantee</p> <p>Grantee</p>	<p>October 2009</p> <p>December 2009</p>
<p>Develop an annual implementation plan that reflects the goals and objectives in the CSP.</p>	<ul style="list-style-type: none"> • Grantee will review progress reports from contracted service providers to ensure progress toward implementing services on a semi annual basis. Grantee will report findings to Evaluation Committee & Planning Council. • Grantee will monitor emerging issues and make recommendations as needed. 	<p>Grantee and Evaluation Committee</p> <p>Grantee and Evaluation Committee</p>	<p>December 2009</p> <p>December 2009</p>

Goal # 2: **SUSTAIN ONGOING PLANNING FOR HIV/AIDS SERVICES**

OBJECTIVES	ACTIVITIES	RESPONSIBLE	REVIEW DATE
<p>By September 2009 inform stakeholders (government, funders, service providers and community at large) of emerging issues related to the RW Part A continuum of Care and obtain support for its sustainability</p>	<ul style="list-style-type: none"> • Inform public officials and funders to obtain support for continuous funding of the TGA • Intensify relationship with other county agencies and Community Based Organizations • Develop and distribute white paper on impact of re-authorization and lack of funding to TGA 	<p>Planning Council members and Grantee</p> <p>Grantee and Planning Council</p> <p>Grantee</p>	<p>Spring 2009</p> <p>On Going</p> <p>March 2009 and on going to update as data becomes more available</p>
<p>Coordinate efforts with Part B Policy Advisory and Education Committee</p>	<ul style="list-style-type: none"> • Planning Council members and Grantee representatives will participate in Part B Policy Advisory meetings to gain knowledge and perspectives regarding health policy, budgets and on. 	<p>Grantee and Planning Council members</p>	<p>March 2009 and on going</p>
<p>By October 2009, develop a contingency plan to sustain funding for essential services and Planning Council functions if necessitated by the outcome of the re-authorization.</p>	<ul style="list-style-type: none"> • Monitor the re-authorization and stay current on policies • Develop a contingency plan 	<p>Grantee and Executive Committee</p> <p>Executive Committee and Grantee</p>	<p>August 2009</p> <p>October 2009</p>

CONTINUING.....

Goal 2: 2009 Action Plan

OBJECTIVES	ACTIVITIES	RESPONSIBLE	REVIEW DATE
<p>By December 2009, build linkages with the AIDS Institute Prevention Planning Group (PPG) and other prevention partners for the purposes of coordinating Planning Council activities with prevention planning</p>	<ul style="list-style-type: none"> • Continue coordination with Part B • Reach out to Prevention, Counseling and Testing programs and state wide Prevention Planning Groups 	<p>Executive Committee and Grantee</p> <p>Executive Committee Planning/Allocation committee and Grantee</p>	<p>October 2009</p> <p>December 2009</p>
<p>By December 2009, enhance Planning Council membership base to ensure ongoing high level of participation at full council and committees.</p>	<ul style="list-style-type: none"> • Engage in concerted recruitment • Identify strategies for reflective and representative membership • Engage participation to allow a more “hands on” experience vs. planning activities • Provide annual training to all planning council members 	<p>Membership Committee</p> <p>Membership Committee</p> <p>Membership Committee</p> <p>P.C. Support staff and Membership Committee</p>	<p>October 2009</p> <p>December 2009</p> <p>October 2009</p> <p>October 2009</p>

Goal #3

TO ENSURE ONGOING MONITORING AND ASSESSMENT OF THE IMPLEMENTATION OF THE COMPREHENSIVE SERVICES PLAN

OBJECTIVES	ACTIVITIES	RESPONSIBLE	REVIEW DATE
Monitoring progress toward implementing identified objectives on a semi-annual basis and make revisions and adjust recommendations as necessary	<ul style="list-style-type: none"> • Develop an annual work plan that reflects the goals and objectives in the CSP. • Review progress toward implementing identified objectives and make revisions and adjust recommendations as necessary. • Monitor emerging issues and make recommendations as necessary. 	<p>Each Committee</p> <p>Committees will review and report to Executive Committee & Full Council</p> <p>Planning & Allocation Committee</p>	<p>June 2009</p> <p>October 2009 and December 2009</p> <p>Monthly in 2009</p>
Ensure compliance with standards of care, quality management policies and plans	<ul style="list-style-type: none"> • Site visit and client charts review by Grantee QM Coordinator to ensure compliance • Review of Client level data to assess clinical outcomes are met • Identify emerging issues and make recommendations as necessary to the Planning Council. 	<p>Grantee</p> <p>Grantee will review and report to Evaluation Committee</p> <p>Grantee and Evaluation Committee</p>	<p>March-June 2009 On Going</p> <p>March – June 2009 On Going</p> <p>On Going</p>

Appendix D: MODEL CONTINUUM OF CARE FOR PEOPLE LIVING WITH HIV/AIDS

