

**State of Indiana
Statewide Comprehensive Plan
including the
Statewide Coordinated Statement of Need**

FY 2012 – 2013
FY 2013 – 2014
FY 2014 – 2015

**Prepared for the
Health Resources and Services Administration
by the
Indiana State Department of Health**

April 2013

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LETTER OF CONCURRENCE



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1 April 2013

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Mr. Carney-

After close collaboration and careful review, the Executive Committee of the Comprehensive HIV Services Planning and Advisory Council is pleased to offer our concurrence with the revision of the Division of HIV/STD's Statewide Comprehensive Plan for Fiscal Year 2013-2014.

Please let us know if we may be of any further assistance. The council looks forward to working together with you in the coming year.

Sincerely,

A handwritten signature in black ink, appearing to read "Eric K. Farmer".

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INTRODUCTION

Purpose

The Statewide Comprehensive Plan is a thorough description of the HIV service delivery system as implemented in Indiana. The plan documents the state's Ryan White HIV/AIDS Treatment Extension Act of 2009 (hereinafter referred to as the Ryan White Program) Part B funding allocation rationale, its efforts to provide services to those not currently receiving care, its collaborations with other service providers, and its goals and objectives for the maintenance and improvement of the system of care. The plan fully incorporates Indiana's Statewide Coordinated Statement of Need.

Process

In response to the legislative mandates of the Ryan White Program, the Division of HIV/STD (hereinafter referred to as the Division) at the Indiana State Department of Health (ISDH) regularly revises its HIV service delivery plan based on the changing demands of the epidemic. The current plan was prepared by the Division based on current utilization and epidemiological trends and is informed by the results of numerous needs assessment surveys. The Planning Committee of the Comprehensive HIV Services Planning and Advisory Council (CHSPAC) – comprised of Ryan White Parts A, B, C, and F grantees, service providers, persons living with HIV, and other community members – reviewed the document in draft form and conducted a series of meetings to update the appropriate sections. Selected action steps taken by the Planning Committee are noted below.

1. The committee established a timeline and agreed on work assignments.
2. It conducted two work group meetings to update the HIV service delivery system description and the identified barriers and gaps. ISDH was available during these meetings but did not directly participate in order to avoid influencing the committee's opinions.
3. The committee conducted two work group conference calls to update the optimal system design. ISDH was available during these calls and provided insight regarding possible improvements to the system of care.
4. The committee reviewed and updated the goals and objectives, incorporating feedback solicited from the members' respective organizations and unaffiliated consumers.
5. The committee conducted a final meeting to review all changes and final edits. The final draft was later prepared by ISDH and submitted to the Executive Committee for a letter of agreement.

ISDH also conducted a special meeting with the Part A, B, C, and F grantees to obtain additional feedback regarding the draft plan and its proposed goals. Input was solicited by ISDH from the Office of Medicaid Policy and Planning as well. The final draft subsequently received approval from the Executive Committee for submission to the Health Resources and Services Administration (HRSA).

Comment on Revisions

This Statewide Comprehensive Plan was originally drafted in 2011 and early 2012 for the three-year period of April 2012 through March 2015. Relevant sections of the document will be updated annually to create April 2013 and April 2014 revisions which will reflect current trends and developments. Updated sections in 2013 and 2014 will be clearly marked with an asterisk (*) throughout the document.

EXECUTIVE SUMMARY

Indiana is primarily a rural state reporting 514 new and 9893 living cases of HIV disease in 2010. More than 55% of the living cases have had an AIDS diagnosis. The largest proportion of cases continues to be White males over the age of 40, though Blacks are still more disproportionately affected by the disease than any other demographic group. In a year with decreasing total case reports, Blacks experienced a 7% increase in new reports, and new cases for Hispanics increased by 10%.

Indiana's various instruments to assess the needs of people with HIV have yielded results which affirm the importance of the six core service areas originally defined by HRSA. In addition to Outpatient and Ambulatory Health Services, AIDS Drug Assistance Program Treatments, Oral Health Care, Medical Case Management, Mental Health Services, and Substance Abuse Outpatient Care, the Division has added Emergency Financial Assistance, Housing, and Medical Transportation to describe its priority service needs.

Of those living with HIV, the Division has estimated that 33% are not currently in care. The current continuum of care is designed to address this population by minimizing barriers and optimizing access to HIV-related medical and social services. The resources of the state's Ryan White Program grantees and other providers have been coordinated in an attempt to impact each of the priority service needs in an effective and efficient manner.

Indiana is the proud home of four Ryan White grants representing Parts A, B, C, and F. In general, Part A provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV epidemic. Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, an ADAP supplemental award, and a base supplemental award. Part C provides grants directly to service providers, such as ambulatory medical clinics, to support outpatient HIV early intervention services and ambulatory care. Part C also funds planning grants, which support organizations in more effectively delivering HIV care and services, and capacity development grants to enhance a grantee's capacity to develop, strengthen, or expand access to high quality HIV primary healthcare services for people living with HIV or at risk of infection in underserved or rural communities and communities of color. Part F provides support for the AIDS Education and Training Centers Program which is a network of 11 regional centers (and more than 130 local associated sites) that conduct targeted, multidisciplinary education and training programs for healthcare providers treating people living with HIV. As the clinical training component of the Ryan White Program, these centers seek to increase the number of healthcare providers who are effectively educated and motivated to counsel, diagnose, treat, and medically manage people with HIV disease, and to help prevent high-risk behaviors that lead to HIV transmission. The program targets providers who serve minority populations, the homeless, rural communities, incarcerated persons, and other vulnerable groups affected by the HIV epidemic.

However, despite the coordinated efforts of the Ryan White Program grantees and other providers, challenges remain for the state. To address them, Indiana has compiled a number of suggestions for service delivery improvement. Many of these are incorporated into its goals and objectives for 2012-2015. Evaluation of the progress towards these goals – and of the continuum of care itself – will be accomplished through the monitoring efforts of the Ryan White Program grantees and the Division's advisory council.

Section 1, Part 1 – STATEWIDE COORDINATED STATEMENT OF NEED

Overview

As a component of each edition of the Comprehensive Plan, the Division develops an updated version of its Statewide Coordinated Statement of Need (SCSN). The SCSN is a general statement of the needs of persons living with HIV in the State of Indiana. It seeks to describe the epidemiological trends, service history, needs assessments, priority service areas, gaps in and barriers to care for the affected population, unmet need estimates, unaware of status estimates, and prevention collaborations occurring in the State.

Description of State

Indiana is a mostly rural state with several urban and metropolitan centers; it has an estimated population of 6,483,802 people, based on Census Bureau projections for 2010. The majority of the population is White. The largest minority group is Black, followed by persons who identify as Hispanic. The remainder of the population is comprised of Asian-Americans, American Indians and Alaska Natives, and Pacific Islanders.

Epidemiological Profile Summary*

Indiana's surveillance data are derived from the HIV and AIDS reports submitted by providers and laboratories to Indiana's Office of Clinical Data and Research (OCDR). Prevalence data do not include those cases known to have moved from the state or to have died. The information that follows is a brief overview of the state's significant epidemiology. (A complete epidemiological profile for HIV disease in the State of Indiana is available upon request.)

Table A. New Case Reports by Calendar Year 2002-2011

New Cases by Year	HIV		AIDS		Total Disease	
	#	Total Δ	#	Total Δ	#	Total Δ
2002	531	+ 26%	372	+ 29%	903	+ 27%
2003	399	- 25%	303	- 19%	702	- 22%
2004	347	- 13%	252	- 17%	599	- 15%
2005	339	- 2%	395	+ 57%	734	+ 23%
2006	382	+ 13%	340	- 14%	722	- 2%
2007	374	- 2%	328	- 4%	702	- 3%
2008	367	- 2%	146	- 55%	513	- 27%
2009	399	+ 9%	145	- 1%	544	+ 6%
2010	386	- 3%	128	- 12%	514	- 6%
2011	385	- 0%	133	+ 4%	518	+ 1%

Table A shows the number of new reports received each year, beginning in 2002. The percent of change (Δ) in each category total compared to the preceding year is also presented in the table. As evidenced in Table C, after 2007, previous patterns and trends were confounded by a change in OCDR's calculation method. In 2008, OCDR ceased to include "in-year" AIDS conversions in the AIDS case total; instead, the figures presented represent the number of diagnoses as first reported per category. This change in methodology resulted in a massive reduction in the number of new AIDS cases in 2008. Because of this, in many ways, the 2009 data represented a new baseline for new case report trends.

In 2010, the combined number of new positive tests (including both in-state and out-of-state reports submitted to Indiana) decreased by 6% compared to the previous year. Since that time, new cases of HIV have remained steady (386 in 2010; 385 in 2011), and cases of AIDS have increased modestly (from 128 to 133). Combined cases have risen by 1%. In 2010, the percentage of new HIV cases had reached 75% of all new cases for the first time, indicating that efforts to discover HIV infection earlier in the disease process are yielding sustained, measurable results. The percentage for 2011 was 74%.

Table B shows total numbers and percentages by race and gender characteristics for new cases reported within the last ten years. It also calculates the percent of change in each category total from one year to the next. Despite the often erratic nature of the trend of new HIV and AIDS cases over the past decade, the demographic qualities of the new cases themselves have tended to remain relatively consistent. The percentage of new male reports from 2002 through 2009 hovered near 80% each year, and the reports by race have fluctuated between 45-55% for Whites, 35-42% for Blacks, and 6-10% for Hispanics. In 2010, however, males represented 83% of all reported cases; this was a ten-year high. Similarly, Whites reached a low of 42%, while Blacks reached a high of 45%. Only Hispanics remained within the expected range at 9%. The data also revealed an unexpected reduction (29%) in the number of new female cases compared to 2009. In 2011, the demographic percentages for new case reports returned to more normal ranges. Males dropped to 82%, Whites rebounded to 46%, and Blacks fell to 43%. Again, Hispanics remained at 9%. Additional drastic reductions in the number of new female cases were not observed.

Table B. New Case Report Demographics by Calendar Year 2002-2011

New Cases by Year	White	Black	Hispanic	All Other Races	Total		Total Δ
					#	%	
2002							
Male	425	253	46	12	736	82	+ 40%
Female	67	87	9	4	167	18	- 10%
Total	492	340	55	16	903	100	+ 27%
Race %	54	38	6	2	100		
Total Δ	+ 27%	+ 25%	+ 31%	+ 78%			
2003							
Male	302	202	45	3	552	79	- 25%
Female	57	83	7	3	150	21	- 10%
Total	359	285	52	6	702	100	- 22%
Race %	51	41	7	1	100		
Total Δ	- 27%	- 16%	- 5%	- 63%			
2004							
Male	246	165	48	3	462	77	- 16%
Female	44	85	6	2	137	23	- 9%
Total	290	250	54	5	599	100	- 15%
Race %	48	42	9	1	100		
Total Δ	- 19%	- 12%	+ 4%	+ 0%			
2005							
Male	351	184	43	12	590	80	+ 28%
Female	53	76	12	3	144	20	+ 5%
Total	404	260	55	15	734	100	+ 23%
Race %	55	35	8	2	100		
Total Δ	+ 39%	+ 4%	+ 2%	+ 200%			
2006							
Male	329	187	43	11	570	79	- 3%
Female	51	81	13	7	152	21	+ 6%
Total	380	268	56	18	722	100	- 2%
Race %	53	37	8	2	100		
Total Δ	- 6%	+ 3%	+ 2%	+ 20%			
2007							
Male	273	197	37	19	526	75	- 8%
Female	68	82	14	12	176	25	+ 16%
Total	341	279	51	31	702	100	- 3%
Race %	49	40	7	4	100		
Total Δ	+ 10%	+ 4%	+ 9%	+ 72%			
2008							
Male	194	157	39	13	403	79	- 23%
Female	35	58	11	6	110	21	- 38%
Total	229	215	50	19	513	100	- 27%
Race %	45	42	10	3	100		
Total Δ	- 33%	- 23%	- 2%	- 39%			
2009							
Male	231	142	37	12	422	78	+ 5%
Female	39	75	4	4	122	22	+ 11%
Total	270	217	41	16	544	100	+ 6%
Race %	50	40	8	3	100		
Total Δ	+ 18%	+ 1%	- 18%	- 16%			
2010							
Male	187	183	41	16	427	83	+ 1%
Female	29	50	4	4	87	17	- 29%
Total	216	233	45	20	514	100	- 6%
Race %	42	45	9	4	100		
Total Δ	- 20%	+ 7%	+ 10%	+ 25%			
2011							
Male	206	175	36	10	427	82	+ 0%
Female	31	48	9	3	91	18	+ 5%
Total	237	223	45	13	518	100	+ 1%
Race %	46	43	9	2	100		
Total Δ	+ 10%	- 4%	+ 0%	- 35%			

Table C shows the basic demographic qualities of all persons living with HIV in Indiana. The percent of change in each categorical percentage from the end of the previous report period is also displayed. The AIDS prevalence data presented are based on the total number of AIDS diagnoses reported to OCDR, less those known to have moved from the state or to have died, as of 31 December 2011. Likewise, HIV prevalence data are derived from reports submitted to OCDR. Also accurate as of 31 December 2011, these figures exclude those known to have progressed to an AIDS diagnosis, moved from the state, or died. For purposes of HIV services planning, decisions are made primarily on the basis of total living cases of HIV disease (HIV and AIDS reports). This combination provides the most accurate total number of known HIV-infected persons who may require care and services.

Table C. Prevalence Demographics through Calendar Year 2011

Prevalence As of 12/31/11	% in pop (2011)	HIV			AIDS			Combined		
		#	%	% Δ	#	%	% Δ	#	%	% Δ
Gender										
Male	49	3606	78	+ 0	4623	82	- 1	8229	80	+ 0
Female	51	999	22	+ 0	995	18	+ 1	1994	20	+ 0
Total	100	4605	100		5618	100		10223	100	
Race										
White	82	2411	52	- 2	3053	55	+ 0	5464	53	- 2
Black	9	1736	38	+ 1	1928	34	+ 0	3664	36	+ 1
Hispanic	6	309	7	+ 1	457	8	+ 0	766	8	+ 1
Other	3	149	3	+ 0	180	3	+ 0	329	3	+ 0
Total	100	4605	100		5618	100		10223	100	
Age										
0-19	28	71	2	+ 0	23	0	- 1	94	1	- 1
20-29	13	737	16	+ 2	290	5	+ 0	1027	10	+ 1
30-39	13	1060	23	- 1	935	17	- 1	1995	20	+ 0
40-49	14	1528	33	- 2	2199	39	- 2	3727	36	- 2
Over 49	32	1209	26	+ 1	2171	39	+ 4	3380	33	+ 2
Total	100	4605	100		5618	100		10223	100	
Transmission										
MSM	--	2295	50	+ 1	2777	49	- 1	5072	49	- 1
IDU	--	133	3	+ 0	251	5	+ 0	384	4	+ 0
Heterosexual	--	797	17	- 1	1026	18	+ 0	1823	18	+ 1
Perinatal	--	66	1	+ 0	40	1	+ 0	106	1	+ 0
Other/No Risk	--	1314	29	+ 0	1524	27	+ 1	2838	28	+ 0
Total	--	4605	100		5618	100		10223	100	

Between 2005 and 2006, the total number of persons living with HIV disease in Indiana had increased by 20.2%. Additional small increases were seen from 2007 through 2010 (2.6%, 4.6%, 5.9%, and 1.0%, respectively). As of 31 December 2011, OCDR reported 4605 living HIV and 5618 living AIDS cases, compared to 4412 and 5481 at the end of 2010. This is a combined increase of 3.3%. The numbers also continue to show that approximately 55% of all living cases in Indiana have progressed to a diagnosis of AIDS.

The information in Table C indicates that the vast majority of living cases of HIV disease (80%) in Indiana are men. The increases in the percentages of women and the decreases in the percentages of men which had been seen early in the decade have not been seen since 2005. In fact, this trend essentially reached a plateau after 2003. In 2011, Whites continued to be the most infected racial group. Compared to their presence in the population at large, Blacks were still the most disproportionately affected. The overall distribution of disease among racial categories has shown a slow and steady shift from White to non-White since 2004. In that year, the prevalence population was 40% non-White; at the end of 2011, it was 47%.

The largest risk group continued to be composed of men who have sex with men. The exact size of this and the injection drug use risk groups remain in question, however, due to the high number reported in the "Other/No Known Risk" category. The disease concentration in the 30-39 and 40-49 age brackets continued to weaken while the over-49 bracket experienced sustained growth. For male youth, the greatest risk of exposure was homosexual contact; for women of all ages, it was heterosexual contact. Infection due to the use of injection drugs – to the extent it had been accurately measured given the concern noted above – remained stable among all groups.

Overall, this epidemiological data reinforce some familiar trends. First, regardless of gender, Blacks continue to be the most disproportionately represented in the data. Blacks account for 38% of the living cases of HIV and 34% of the living cases of AIDS, yet they comprise only 9% of the general population. Second, the 2011 data show that, for

the seventh year in a row, two-thirds or more of the prevalence population is over the age of 40 and, for the first time, a full third of the population is 50 or older.

Brief History of Service Response to HIV in Indiana

The first specific reference to AIDS in the Indiana State Code appeared in 1986 when the state required physicians and hospitals to report confirmed cases of AIDS to ISDH. The state's first service component was the HIV Care Coordination Program which was the end result of recommendations made by the HIV/AIDS Health and Human Services Planning Project for Indiana conducted during 1989 and 1990. It was determined in the planning process that "care coordination services are the foundation upon which all other HIV/AIDS health and human service programs are built." The plan identified the need for regional care coordination on a statewide basis, site communication, and the standardization of data collection and intake procedures. By the early 1990's two sites were well established as service providers, the AIDS Task Force in Fort Wayne and the Damien Center in Indianapolis. As the plan for provision of statewide services evolved, pilot projects in Evansville and Gary were established and overseen by the Damien Center. The projects were funded through a small grant from Indiana's Family and Social Services Administration (FSSA).

By 1991, the Division was receiving federal Ryan White dollars. The award was used to implement traditional ADAP and Early Intervention Plan (EIP) programs through a subcontractor. From the beginning, these services were available statewide.

In 1992, Indiana received its first Title III (now Part C) award. This was the first HIV-specific funding that was allocated for a particular metropolitan area (in this case, Marion County). The project provided access to medical services and some case management activities for those living within its geographical area. Additional Title III programs were funded over the years, both for planning projects and for service delivery.

In December 1992, FSSA transferred the administration of the HIV Care Coordination Program to the Division, which then became responsible for issues concerning funding, policy setting, and program administration. By 1993, the number of care sites had increased to twelve. Since that time, clinic-based medical case management programs have been developed at Wishard and Indiana University (formerly Methodist) hospitals in Indianapolis, and several sites have expanded to include Spanish-language, housing, and substance abuse specialists.

Funds for housing and emergency assistance were first received in 1993 and administered by a sister agency of the ADAP subcontractor. (These two agencies eventually merged.) Like ADAP and EIP, these services were immediately available around the state through the network of HIV Care Coordination sites.

By the end of the decade, administration of the housing program was transitioned to the Indiana Housing and Community Development Authority, and the Division also ended its relationship with the ADAP subcontractor. As all medical services were brought in-house at ISDH, the program shifted from its focus on ADAP and developed a new insurance-based service. Leveraging premium payments made to the state's high-risk insurance pool, the Division doubled the number of its enrollees in less than a year and was able to offer comprehensive medical coverage rather than only the traditional ADAP and EIP services.

Currently, Indiana boasts a robust Part C program in Indianapolis, a strong partnership with the neighboring Part C clinic in Northwest Kentucky, a free statewide insurance-based HIV Medical Services Program, statewide HIV Care Coordination and housing programs, an HIV substance abuse support program, a Part A project in the Indianapolis transitional grant area, and a local site of the regional Midwest AIDS Training and Education Center (MATEC).

Assessment of Service Needs*

The Division regularly conducts activities designed to ascertain the service needs of Indiana's HIV-positive population. The information gathered from these activities is used in conjunction with that supplied by OCDR to develop service delivery plans that address the identified needs and barriers to quality care. The following paragraphs briefly describe the most significant activities to date.

1. State Needs Assessment Report 2002

For some time, the primary source of information used to create the Statewide Coordinated Statement of Need has been the state's official HIV/AIDS Needs Assessment Report, which was prepared in February 2002 by the Partnership for Community Health, Inc., a consulting agency based in New York. The complete needs assessment contained three separate reports. The first was an epidemiological report which provided a profile of potential service recipients. The second report described the findings of the actual needs assessment and presented the quantitative and qualitative information obtained through surveys and focus groups with 404 HIV-positive persons from various subpopulations including African Americans, Hispanics, heterosexual men and women, and injection drug users. This assessment report addressed absolute service needs, perceived needs

or demands, fulfilled needs, absolute unmet needs, unmet perceived needs, and barriers to care as identified by HIV-positive persons. The third report incorporated information gathered from service providers in order to estimate the capacity of the system and any related gaps.

Four different data collection methods were used by the Partnership for Community Health for this project.

- a. A review of secondary information (including epidemiological and service utilization data provided by ISDH) was performed to estimate the HIV and AIDS incidence and prevalence rates, the sampling frame, the number of service units provided by the care system, and the general health status of HIV-positive persons in Indiana.
- b. A survey was conducted among a representative sample of HIV-positive persons, many of whom were identified as out-of-care or belonging to difficult to reach populations. The survey provided updated demographic estimates, as well as information on co-morbidities, service awareness levels, and adherence rates. It also gathered data related to the perceived knowledge, demand, utilization, and barriers related to particular services.
- c. Sixteen focus groups were conducted among target populations, along with key informant interviews. These sessions provided an in-depth view of the needs and barriers to services and helped to validate findings from the survey.
- d. A provider information form was circulated to collect information on the services provided, funding for services, number of clients served, unduplicated client counts, and providers' perceptions of service barriers.

2. Consumer Satisfaction Survey 2003

The Division conducted a satisfaction survey of its HIV Care Coordination and HIV Medical Services Program clients in the spring of 2003. The responses were submitted to sociologists Carrie E. Foote-Ardah, Ph.D., and Eric R. Wright, Ph.D., at Indiana University – Purdue University Indianapolis for analysis. The resulting report was reviewed by the Division and circulated to the advisory council.

The survey included a battery of questions developed to measure client satisfaction with each program. Part A of the questionnaire pertained to case management services, Part B to medical services. Satisfaction was measured using a five point Likert scale in response to positive statements about the programs such that agreement corresponded with satisfaction. Additional questions gathered the client's gender, race, current program enrollment status, length of enrollment, and place of service. A total of 726 questionnaires were returned and analyzed.

3. Women and Families Needs Assessment 2003

The "Indiana HIV/AIDS Women, Children and Families Needs Assessment Study" was conducted in 2003 with HIV-positive women and HIV Care Coordination staff from around the state. Dr. Carrie E. Foote-Ardah, working in conjunction with the Family AIDS Network, initiated a statewide exploratory assessment of the needs of women, children, and families impacted by HIV. The study documented the HIV-related needs of women and children in the State of Indiana with specific attention to the nature and quality of available supportive and care resources (e.g., housing, case management, medical care, legal services, child and family services, transportation, mental health, substance abuse, support groups), the experiences and satisfaction with services used, the barriers to supportive services and care resources, and the changes needed to improve existing services and the lives of women and children impacted by HIV.

The study consisted of three phases. Phase one consisted of administering a small survey to 125 staff members from the HIV Care Coordination sites across Indiana. Staff included program managers, HIV Care Coordinators, prevention specialists and substance abuse counselors. Data were collected from 90 of these staff members regarding the services offered to women and children at their respective agencies (if any), the perceived service needs of women, any perceived barriers to accessing available services, and possible solutions to existing gaps in services.

Phase two consisted of three focus groups conducted with a smaller sample (32) of the HIV Care Coordination staff in three different parts of the state: north, central, and south (representing 12 care sites). Although groups were not representative of the entire staff population, they were very diverse with regard to key demographics. Through the focus groups, more in-depth data regarding women and children service needs and barriers were collected, emphasizing HIV Care Coordination experiences.

Phase three consisted of seven focus groups (involving 60 total participants) and in-depth interviews with two additional HIV-infected women. Of the participants in this phase, 51% were Black, 43% were White, and 6% were Hispanic or "Other" races. Nearly all had at least one child (88%), and 76% were currently taking HIV medications. Separate focus groups were completed in different parts of Indiana (two in central and one each in

east central, northeast, northwest, southeast, and southwest Indiana). Data gathered paralleled that collected from care site staff but emphasized female consumer experiences.

4. State Needs Assessment Update 2004

In the spring and summer of 2004, the Division endeavored to update its 2002 Needs Assessment Report. The Division distributed 466 client surveys to its 15 HIV Care Coordination sites. The surveys asked clients if certain medical and social services were currently needed, available, and being received on a regular basis. Basic demographics were also collected for each respondent.

The Division received 444 completed surveys in response. Males composed 74% of the respondents, females composed 25%, and 1% identified as transgendered. The racial composition of the respondents was Black (35%), White (55%) Hispanic (7%), and Other (3%). Marion County was the best represented county among respondents (37%), followed by Lake (9%), Allen (9%), St. Joseph (9%), and Vanderburgh (5%). All other counties had a response rate of less than 5%.

The design of the questionnaire allowed for the analysis of the degree to which a particular service was needed but not currently available. This discrepancy between need and availability (i.e., the “unmet need”) was considered to be of primary importance.

In terms of overall unmet needs, respondents from smaller counties tended to report more needs that were not currently being met. These counties included Lawrence, Owen, Hamilton, Spencer, and Jay. Respondents from larger counties (such as Marion, Lake, and Allen) tended to report fewer unmet needs.

5. Emergency Financial Assistance Project 2004

In October 2004, the Division launched a short-term emergency financial assistance project throughout Indiana. The Division allocated \$600,000 in unobligated Title II funds to the project and used its network of standard HIV Care Coordination sites and a third party payer to implement it. Requests for assistance were coded as either “Agency-Direct” or “Client-Direct.” The former were requests for reimbursement of bulk-quantity purchases of items to be distributed by the agency to needy clients. The latter were requests for reimbursement of payments made by the agency on behalf of a particular client. The care sites submitted a total of 1176 unduplicated requests between October 2004 and March 2005.

The raw number of requests was distributed among the regions in this way: Northern (36%), Central (21%), and Southern (43%). The actual expenditure distribution, however, was slightly different – Northern (33%), Central (11%), and Southern (57%). For the “Client-Direct” requests, 22% were submitted for female clients and 24% for non-White clients. These percentages are slightly less than those of the HIV Care Coordination population which is 24% and 41% for females and non-Whites, respectively.

Analyzing expenditures by geographic region, the largest percentages were spent on men in the Southern region (65%) and on women in the North (58%). The expenditures for Blacks and “Other” races were greatest in the North (58% and 91%) and for Whites and Hispanics in the South (66% and 60%).

6. State Needs Assessment Update 2005

In an effort to confirm the continued relevance of data from earlier assessments, the Division conducted a larger-scale survey of its HIV Care Coordination clients in June 2005. The survey was mailed to 1715 individuals and consisted of 22 questions presented in English and Spanish. Of the 550 responses, 544 were in English. The main portion of the survey asked a series of questions about the period of time during which clients experienced a particular hardship (e.g., the number of days in the last month the client was hungry or unable to get food).

While each of the state’s HIV Care Coordination regions was represented, the majority of responses were received from the Indianapolis, Gary, and Fort Wayne areas. Most respondents were male (80%) and White (71%). Nineteen percent of the respondents were Black, and 6% were Hispanic. Most respondents (84%) had been receiving HIV Care Coordination services for more than 12 months, and over half (59%) reported an annual income of less than \$12,000.

7. Consumer Focus Groups 2007

In 2007, the Division enlisted the assistance of the Consumer Advisory Board (CAB) to conduct small-scale focus groups throughout the various service regions of the state. For ten months, the members were given a different monthly topic to discuss with other HIV-positive constituents in their respective areas. Among the topics, the Division included its eight priority services which included the six original core services identified by HRSA. Each focus group utilized a simple survey form to document the participants’ opinions; some surveys

were also administered individually by the HIV Care Coordination staff. The Division received a total of 586 survey responses.

8. Never In Care Focus Group 2008

The Division conducted a focus group in early 2008 with five HIV-positive persons from the central Indiana area who had been identified as “not being in care within 90 days of diagnosis.” Most of the participants (80%-90%) were under age 40, and many (60%-75%) appeared to be newly diagnosed and still struggling with the situation. Major barriers to care identified by the group were lack of money, confidentiality, stigmatization by healthcare workers or other health facility workers, embarrassment about HIV status, and lack of knowledge about where to get care. Most were unsure of whether HIV-positive people should see a doctor on a regular basis and were concerned about relationships with family and significant others. Factors that could improve the likelihood that HIV-positive people will seek or receive care were identified by the group and included: financial incentives, increased confidentiality at health facilities, and stronger messages stressing that healthcare will prolong life and improve its quality.

9. Part A Transitional Grant Area (TGA) Needs Assessment 2008

After receiving Part A funding in 2007, the Marion County Public Health Department (MCPHD) began to coordinate a community-based needs assessment for the central Indiana HIV population in collaboration with the Health and Hospital Corporation of Marion County. Initial project planning activities began in late 2007, with most of the data collected in early 2008. Through focus groups and key informant interviews with HIV-positive residents and providers, the project sought to identify the real and perceived health-related issues of HIV-positive persons across age, gender, racial, and ethnic categories; to uncover the real and perceived barriers that keep individuals from entering, remaining, and being adherent to care; and to identify opportunities to address those barriers. Targeted populations included women, expectant mothers, substance users, persons recently incarcerated, Hispanic immigrants, HIV-positive people residing in suburban areas surrounding Indianapolis, gay men, and minority men with same-sex risk factors.

Focus groups and key informant interviews were conducted with local HIV-positive residents and providers with an understanding of the significant needs, potential solutions, and experiences of those with HIV. Responses from the focus groups and key informant interviews were analyzed, and serious barriers to healthcare and other services were identified.

Based on the information gathered from these activities, specific recommendations were made by the Part A grantee in three areas. First, existing healthcare system barriers need to be removed by improving the interaction and communication between providers and patients, increasing awareness of services, and increasing the number of providers. Second, programs and initiatives need to be developed to ensure that individuals with HIV have access to basic services addressing social, educational, and employment needs. Finally, basic and specialized medical care services for the target population need to be expanded.

10. Part A TGA Provider Capacity Assessment 2009

In the summer of 2009, 21 area HIV service providers responded to a survey that was developed and approved by the Ryan White Part A Planning Council Needs Assessment Committee. Providers chosen to participate in the survey were those that subcontracted with the Ryan White Parts A or C Programs, as well as those that were major providers of services to HIV-positive persons in the Indianapolis area.

The purpose of the assessment of provider capacity and capability was to identify the extent to which HIV-related services in the area are accessible, available, and appropriate for people living with HIV in the Indianapolis TGA. It has since been used to assist the Ryan White Council in making informed decisions about improving the system of care for the people living with HIV in this grant area.

A wide range of services was available from the surveyed providers and all major Ryan White service categories were represented, with the exception of home health care. Based on the number of referrals that providers reported giving, the most needed core services were case management, HIV-related medical care, and mental health care. The most needed support services were financial assistance, psychosocial support, and housing assistance. Nearly all of the agencies actively verified that their clients were engaged in HIV-related primary medical care.

According to estimates of the number of clients on their current caseloads and maximum caseloads, the system of care appeared to be able to absorb more clients, even while some individual agencies were at or above 100% capacity. The same conclusions were reached when agencies were asked explicitly whether they would be able to continue to serve clients with their current levels of resources and staff if their caseload were to increase by 5%, 10%, or 20%. However, wait times for new clients to get into services were more than 2 weeks for all

medical case management providers, indicating providers may be more stretched than they are reporting. There was evening and weekend availability for most service types, with the exception of medical case management. Not all agencies had evening or weekend hours, so clients might be restricted in their choice of service provider if they needed to regularly receive services outside of traditional hours.

Surveyed providers were well prepared to serve a diverse group of clients. Over a third reported specifically targeting services towards a particular vulnerable population group; all of the providers employed at least one strategy for serving clients that were non-native English speakers, and all but one agency reported fostering cultural competency through at least one method. Despite these levels of preparedness, however, agencies still reported difficulties serving clients who are hearing impaired or speak a language other than Spanish or English.

Agencies reported various barriers to providing care including insufficient staff to manage the client load (43%), difficulty filling vacant staff positions (14%), difficulty linking clients to community resources (29%), difficulty linking clients to financial resources by which they could pay for services (40%), and insufficient resources to service clients that did not speak English (33%). The majority of providers felt that there was not enough communication between their agency and other agencies that serve their clients, but providers felt that they did have adequate time for communication with their clients. About half of providers felt they had difficulty managing the different expectations across the Ryan White Parts.

The vast majority of providers (77%) indicated that their clients had difficulties keeping their appointments. About half (48%) felt that their clients had difficulties getting transportation to their organization, 19% felt that their clients had difficulties accessing care due to physical disabilities, and 62% felt that substance abuse and mental health issues were barriers for clients remaining engaged in care. Agencies felt that clients were reluctant to seek services due to financial barriers such as co-pays, spend down, or services being uncovered (71%), stigma or fear of disclosing their status (60%), undocumented immigration status (47%), and cultural norms (25%).

11. HIV Services Needs Assessment 2009

In mid-2009, the Division collaborated with the Comprehensive HIV Services Planning and Advisory Council and researchers at Indiana University-Purdue University Indianapolis to complete a comprehensive statewide HIV services needs assessment. It included two components: a survey of HIV Care Coordination clients and a survey of providers serving individuals living with HIV (including care coordinators, infectious disease doctors, nurse practitioners, pharmacists, prevention counselors, and substance abuse support specialists). A total of 746 men and women living with HIV and 111 service providers participated in the research. Two reports summarized the client and provider findings. These reports provided critical information about the gaps in HIV related services and the needs of HIV-positive people across the state. Services discussed included primary care, health insurance, dental, optical, case management, housing, mental health, substance abuse, and transportation. In addition to addressing gaps in each of these services, both reports highlighted several challenges to providing optimal care that cross service categories. These included problems with limited HIV education (among consumers, providers, and the general public), AIDS stigma, poverty, a lack of general funding resources, and limited community support for HIV-related efforts.

The provider report also contained a lengthy section addressing barriers to the coordination of care among HIV services, mental health services, and alcohol and substance abuse services. Nearly all of the providers surveyed (96%) engaged in referral services, but some had no systematic way of tracking referrals for alcohol and substance abuse (10%) or mental health services (11%). Others were unaware of whether tracking mechanisms existed (14% and 10%, respectively). About 30% of the providers rarely or never experienced difficulties making referrals, about half experienced occasional difficulties, and nearly 25% experienced difficulties most of the time or all of the time.

12. HIV Care Coordination Satisfaction Survey 2010

In April 2010, the Division mailed 4063 satisfaction surveys to active, maintenance, and closed clients in the HIV Care Coordination Program at 13 of its locations. Surveys were mailed to consumers who wished to receive HIV specific mail as noted in the program's database. A total of 698 surveys (17%) were returned to the Division and analyzed to measure client satisfaction and determine the level of customer service provided by case management staff funded by ISDH.

Though all regions were represented, the majority of responses were received from the Indianapolis (33%) and Gary (11%) areas. Most respondents were male (75%) and White (65%). Nineteen percent of the respondents were Black, and 7% were Hispanic. Most respondents (86%) had been receiving HIV Care Coordination services for more than 12 months.

The survey revealed that 84% of respondents have a favorable opinion of the HIV Care Coordination Program. Most unfavorable responses were related to questions of the timeliness of assistance and the availability of HIV Care Coordination staff.

13. HIV Services Mini-Survey 2010

In April 2010, the Division also conducted a small-scale “mini-survey” asking HIV Care Coordination clients to simply rank the nine identified priority service areas according to their importance in their daily lives. The survey was mailed to 4063 active and closed clients. Despite its elementary design, the survey garnered only 219 valid responses (5%). An additional 431 responses (11%) were received but could not be tabulated due to errors in the completion of the survey (e.g., ranking all of the nine services as “1”). Of the valid responses, 88% were submitted by males, 84% by Whites, and 12% by Blacks.

14. Part A TGA Needs Assessment 2012

In 2012, MCPHD contracted with Luther Consulting, LLC, to conduct a second large-scale assessment of needs in the Indianapolis TGA. Data for the assessment was collected using three different methods. First, an online survey collection tool was employed. Second, paper surveys (identical to the online survey) were distributed through various social and professional networks. Finally, participation in one of four focus groups organized by Luther Consulting, at individual HIV Care Coordination sites gave participants the opportunity to respond.

Over the course of this study Luther Consulting collected data from 40 HIV-positive persons, 17 medical providers, and 15 key stakeholders. The majority of HIV-positive respondents were white (64%), male (82%), over the age of 40 (87%), living in Marion County (82%), and had attended college courses (74%). Ratings of either “excellent” or “good” in physical (64%) and mental (77%) health were reported by a majority of consumer participants. However, only one respondent reported experiencing no signs of mental health distress.

Almost all of the medical provider respondents provided care in Marion County (89%), with 60% receiving Part A funding. All key stakeholders provided services to residents of Marion County, while three (20%) reported that they provide care to residents of all counties in the TGA.

Among core medical services, the three groups of respondents were fairly uniform in their feelings pertaining to insurance premium and cost sharing, primary medical care, and medication assistance; all of these categories were rated high in need. Home health and hospice care ranked among the lowest of needs. However, there was little agreement among the three respondent groups concerning need for core social services. Consumers and medical providers both ranked medical case management as most important, while key stakeholders rated this service category as fourth out of 16 service categories. Medical providers and key stakeholders did agree upon the importance of need for housing and support services.

The respondent groups disagreed about access to mental health and substance abuse services. In terms of substance abuse treatment, key stakeholders ranked this as the fourth-highest need; providers noted this in the middle, and consumers ranked this service second to last. Both medical providers and key stakeholders ranked mental health as their second-highest ranked medical service, while consumers ranked it towards the bottom.

15. HIV Services Needs Assessment 2013

In early 2013, the Division again collaborated with the Comprehensive HIV Services Planning and Advisory Council and researchers at Indiana University-Purdue University Indianapolis to complete a comprehensive statewide HIV services needs assessment. Like the 2009 assessment, it included two components: a survey of HIV Care Coordination clients and a survey of providers serving individuals living with HIV (including care coordinators, infectious disease doctors, nurse practitioners, pharmacists, prevention counselors, and substance abuse support specialists). A total of 640 men and women living with HIV and 126 service providers participated in the research. As in 2009, two reports summarized the client and provider findings related to service needs and gaps. The survey was designed to elicit information regarding primary care, health insurance, dental, optical, case management, housing, mental health, substance abuse, and transportation. Both reports highlighted several challenges to providing optimal care in each service category. These included HIV stigma, poverty, a general lack of funding resources, and uncertainty related to the Affordable Care Act.

The provider report also contained a lengthy section addressing barriers to the coordination of care among HIV services, mental health services, and alcohol and substance abuse services. While the responses to the 2009 survey focused on issues related to making and tracking referrals, the respondents to the 2013 survey focused heavily of behavioral issues among clients. These included medication adherence, failure to present for appointments, failure to return necessary paperwork, frequent undisclosed address and phone number changes, dishonesty, and impulse control.

Priority Service Needs*

Based on the information obtained through the activities described above, the Division has recognized the following priority service areas: Outpatient and Ambulatory Health Services, AIDS Drug Assistance Program Treatments, Oral Health Care, Medical Case Management, Mental Health Services, and Substance Abuse Outpatient Care. These are among the “core medical services” established by the HRSA prior to the 2006 Ryan White reauthorization. The Division also notes the importance of Emergency Financial Assistance, Housing, and Medical Transportation which are considered by HRSA to be “support services.” The paragraphs which follow describe Indiana’s specific rationale for each category’s inclusion as a priority service need.

1. Outpatient and Ambulatory Health Services

In the 2002 Needs Assessment Report, more than half (53%) of the HIV-positive respondents indicated that primary medical care was the service most necessary to ensuring good health. Regardless of gender or race, respondents consistently ranked medical care as their top need. Even in the absence of severe symptoms, access to treatment, particularly primary medical care, was widely recognized by respondents as absolutely necessary to maintain and improve the health of HIV-positive individuals.

In the Division’s satisfaction survey, clients were asked about their experiences in the HIV Medical Services Program. More than two-thirds of these respondents indicated program satisfaction across all items. Among the areas with the highest ratings were: the program’s success with helping clients to access medications (84%) and medical care (81%). Though these high levels of satisfaction highlight the importance of the HIV Medical Services Program, some clients (27%) disagreed with the statement that the program covers all of their medical needs. Therefore, in addition to access, securing comprehensive medical coverage is also considered a need in Indiana.

The Needs Assessment Update conducted in 2005 confirmed that access to basic medical care remains one of the most critical needs of HIV-positive persons. Respondents ranked this area second only to pharmaceuticals. The results of the 2004 Emergency Financial Assistance Project pointed to the same conclusion; nearly one-third of the available \$600,000 was used to reimburse physicians, hospitals, and laboratories for HIV-related services that had been rendered. The 2007 focus group reports indicated that HIV-positive individuals still consider regular access to quality healthcare to be essential.

Based on the comments and responses from the interviewees and focus group participants in the 2008 TGA needs assessment, the grantee recommended that basic and specialized HIV medical care services to the target population be expanded in order to meet demand.

The Division’s 2009 Needs Assessment surveys reinforced the importance of access to primary medical care for HIV-positive persons. However, in the gap analysis, 17% of consumer respondents still reported some barriers to medical care. Of this group, 8% had not received medical care in the previous 12 months, and 14% had received care from an emergency room due to a reported inability to schedule a physician appointment. Additionally, 24% identified access to specialty medical care as their most important concern, and 26% reported vision care among their most important service needs unrelated to HIV. Of those who sought vision care, 35% reported access barriers (including lack of insurance coverage and high co-payments.) Fifteen percent of the providers surveyed identified access to primary medical care as the most problematic issue when attempting to provide services.

In the “mini-survey” conducted by the Division in 2010, outpatient health services were ranked as the second most important service to respondents (regardless of whether or not the need for this service was currently being met). The most important service was identified as HIV-related medications. Outpatient health services were rated high in importance in the 2012 TGA survey as well.

In contrast to the Division’s 2009 Needs Assessment report, only 4% of the 2013 respondents reported significant barriers to receiving medical care. However, 13% reported some problems in obtaining HIV medical care in the preceding year, and 14% indicated use of the emergency room due to an inability to arrange for a primary care appointment.

2. AIDS Drug Assistance Program Treatments

In the 2002 Needs Assessment report, 12% of the HIV-positive respondents ranked drug cost reimbursements among their most important needs. Though this figure was lower than expected, the development and utilization of new antiretroviral (ARV) agents has been central to the treatment of HIV disease and has increased the life expectancy of infected persons. The documented positive health outcomes arising from the use of these innovative medications have confirmed the continued need for HIV medication assistance. This need for pharmaceuticals is substantiated by other findings within the Needs Assessment Report. According to the

report, 54% of the HIV-positive population in Indiana exhibit symptoms that would indicate the need for antiviral treatment (based on the criteria established in the Department of Health and Human Services treatment guidelines).

The Needs Assessment Update of 2005 confirmed the importance of access to pharmaceuticals. The majority (more than 40%) of the survey respondents ranked this area as their primary area of need. As expected, the 2007 consumer focus group reports also confirmed that access to medications remains a paramount concern for HIV-positive individuals. Gap analyses show that, as with primary medical care, the high cost of medications continues to be a barrier to care and that enrollment caps, funding restrictions, and narrow eligibility guidelines often prevent immediate access to life-saving pharmaceuticals.

The Division's 2009 Needs Assessment report supports previous assertions that pharmaceutical access remains a critical issue. According to the report, 29% of consumer respondents reported limited access to medications due to lack of insurance. Sixty-seven percent of the sample reported difficulty obtaining drugs due to insufficient funds for high co-payments even when insurance benefits were available. The assessment's gap analysis illustrated that the cost of medications, insurance assistance program enrollment caps, funding restrictions, Medicaid spend-downs, and narrow eligibility guidelines frequently inhibit timely access to life-saving drugs. Forty-two percent of providers surveyed identified access to medications and health insurance as the most problematic issue when attempting to provide services.

In the Division's 2010 mini-survey of consumers, HIV-related medications were ranked as the single most important service to respondents. This area was also highly rated in the 2012 TGA survey.

The Division's 2013 Needs Assessment report shows some marked improvements compared to its 2009 report. According to the report, only 13% of consumer respondents reported limited access to medications due to lack of insurance (down from 29% in 2009). Likewise, only 24% of the sample reported difficulty obtaining drugs due to insufficient funds for high co-payments even when insurance benefits were available (down from 67%).

3. Oral Health Care

Nearly a quarter (24%) of the respondents in the Needs Assessment of 2002 indicated that dental care was the service most necessary to ensuring good health. The report also revealed that dental care is the greatest unmet service need in Indiana. Of all respondents, 65% indicated some level of need for dental services, but only 52% acknowledged that they had received the necessary care. In general, dental care was ranked as the third most important service for HIV-positive persons.

Not surprisingly, the 2004 and 2005 Update surveys confirmed this ranking as well, with 10% of the respondents to the 2005 survey indicating considerable trouble in obtaining dental care services. The Emergency Financial Assistance Project results are further evidence that Oral Health (or the ability to pay for it) remains a serious concern; nearly 24% of the available funds were used to reimburse dental providers for services rendered.

Consumers in 2007 indicated that there remains a longstanding belief that oral health care is simply inaccessible and unaffordable. Participants still believed that some providers will not treat an HIV-positive patient. The dental benefits provided by Part A, B, and C programs in Indiana are designed to address these perceptions, but the sizeable gaps caused by enrollment caps, funding shortages, geographic limitations, and eligibility guidelines continue to persist.

Also in 2007, the Division of Oral Health added HIV to its Indiana Oral Health Plan, a document which the Association of State and Territorial Dental Directors has defined as a public health strategic plan to systematically address the burden of oral diseases and to enhance the oral health of the state's residents. The plan is based on appropriate oral health needs assessment and surveillance findings at the state and local levels and uses evidence-based interventions that have been shown effective through research. Such a plan is considered key to establishing a vision for improving the oral health and well-being of the residents of the state and local communities, developing policies, and targeting actions. The plan for 2007 included the narrative below.

"Financial restrictions, lack of insurance, lack of available preventive services, and lack of access to restorative services were the reasons cited for visiting a dentist only every 2-5 years. The HIV Cost and Services Utilization Study (HCSUS) concluded that 58 percent of HIV-positive individuals did not seek oral health care in the previous six months. The HCSUS also found that 20 percent of the individuals reported having unmet dental needs and that unmet dental needs outnumbered other unmet health needs by a ratio of 2 to 1."

For the 2012 Oral Health Plan, this paragraph was replaced with the language below which was crafted by CHSPAC and the Division of Oral Health.

“The Oral Health Program will support efforts that allow all persons with HIV/AIDS to receive appropriate and timely oral health care. Oral health is an important and often overlooked area of health care for people living with HIV/AIDS. It is recommended that all HIV patients have dental examinations to identify infections which may have an impact on their overall health. Adequate oral health care is also important to support HIV treatment and maintain the quality of life of people with HIV/AIDS. The Oral Health Program will work with the Division of HIV/STD and its collaborators to help address the oral health care needs of people with HIV/AIDS.”

The Division’s 2009 Needs Assessment report confirmed the HIV-positive population’s continued need for comprehensive dental care. When asked which service (other than primary medical care and drug coverage) was most important to them, 32% of the client sample indicated dental care. This percentage increased to 43% when responses are included for people that identified more than one service. The gap analysis illustrated that 47% of those surveyed reported difficulty obtaining dental care at some point. Barriers included the limited duration of the Division’s EIP dental benefits, strict income guidelines for discounted services, an inability to afford sliding scale payments (if eligible), high Medicaid spend-down amounts, and a complete lack of dental benefits through Medicare. The survey responses also suggested that many clients do not have dental insurance and are not aware of free or low-cost dental care. Interestingly, only 10% of providers surveyed noted oral health as the primary problem experienced when providing services to clients.

In the 2010 mini-survey, oral health services were ranked as the sixth most important service to respondents. Only the categories of mental health, medical transportation, and substance abuse services were ranked lower. Likewise, consumers rated access to oral health services fifth among important core medical services in the 2012 TGA survey.

The Division’s 2013 Needs Assessment results did not differ greatly from 2009 on the topic of oral health. When asked which service (other than primary medical care and drug coverage) was most important to them, 26% of the client sample indicated dental care. Only access to “specialty” medical care was considered more important.

4. Medical Case Management, including Treatment Adherence Services

In the Needs Assessment Report of 2002, one-fifth (20%) of respondents indicated that case management was the single service most necessary to ensuring good health. The need for case management services was ranked just slightly lower than dental services.

Based on the Division’s satisfaction survey results, clients appear very satisfied with their case managers. Across a number of indicators, clients report strikingly high levels of satisfaction with most dimensions of the program. In terms of overall HIV Care Coordination experience, twelve respondents (less than 7%) reported having had a bad experience. Those expressing dissatisfaction were most likely to express concern with accessibility issues (e.g., case manager availability and response time to client concerns).

Case management was again ranked as one of the top five necessary services in the 2005 Needs Assessment Update survey. Most respondents (84%) indicated satisfaction with the competency of their case managers. The 2007 focus group reports yielded similar feedback regarding the need for and positive satisfaction with Indiana’s HIV Care Coordination Program. Respondents believed that case management plays a central role in increasing access to medical and social support services and in decreasing the fragmentation of care.

The 2009 Needs Assessment report confirmed the continued need for case management services. Of the clients surveyed, 50% reported always feeling comfortable sharing problems with their care coordinators. Thirty-five percent reported feeling comfortable some or most of the time, and only 15% reported never feeling comfortable. Of those surveyed, the majority of the clients (82%) reported that they never had difficulty getting case management services in the past year. Twelve percent reported experiencing difficulty on up to three occasions, and 6% reported problems accessing case management services on four or more occasions in the past year. Ten percent of the providers surveyed identified issues with accessing case management as the primary problem experienced when providing care or services to patients.

The 2009 report also indicated that the longer a client remains enrolled in care coordination (“more than one year” compared to “less than one year”), the more the client improves on several indicators, including access to food, housing, utility assistance, mental health care, HIV medication, and HIV medical care needs. These findings suggest that despite certain limitations, the provision of care coordination services has a positive effect on client outcomes.

In the 2010 mini-survey, case management services were ranked as the third most important service to respondents. Only the categories of HIV-related medications and outpatient care were ranked higher. Consumers responding to the 2012 TGA survey ranked case management as the most important support service.

The 2013 Needs Assessment report reconfirmed the need for case management services. Of those surveyed, 48% reported always feeling comfortable sharing problems with their care coordinators. Thirty-four percent reported feeling comfortable some or most of the time, and only 18% reported never feeling comfortable. Of those surveyed, the majority of the clients (82%) reported that they had no difficulties getting case management services in the past year; this is the same percentage as in 2009. Seven percent reported experiencing difficulty on up to three occasions, and only 3% reported problems accessing case management services on four or more occasions in the past year.

5. Mental Health Services

Mental health treatment did not rank as a priority concern in the 2002 Needs Assessment, neither had it been exhaustively addressed by the Division to date. In the 2005 survey, after respondents chose their top “critical” need, they were asked to indicate which of five additional services was most important to them. Mental Health Treatment received the third largest number of responses (more than 15%). In 2007, the Consumer Focus Group participants provided a wealth of qualitative information regarding the importance of good mental health care. Many believed that their mental health diagnoses had a greater impact on their overall health and well-being than did their HIV-positive status. Mental health was associated by the respondents with daily living skills and self-care in general. Some proposed that HIV-positive persons may view the mental health care community as more judgmental than the medical communities and, therefore, may be less likely to seek this type of care.

In the 2009 Needs Assessment report, only slightly more than 10% of the clients sampled identified mental health treatment as their most important non-HIV medical service. However, nearly 40% of the sample reported that they had missed work, school, or appointments due to mental stress in the past 30 days. Of these respondents, 20% reported difficulty obtaining mental health services one or more times in the past year. Forty-four percent of the providers surveyed noted that mental health issues contribute to their patients’ inability to consistently access care.

Mental health services were ranked as the seventh most important service to respondents in the mini-survey conducted by the Division in 2010. This low ranking confirmed the assumption that consumers are less likely than providers to identify problematic mental health issues. This same phenomenon was seen in the responses to the 2012 TGA survey.

In the 2013 Needs Assessment report, only 9% of the clients sampled identified mental health treatment as their most important non-HIV medical service. However, 26% reported that they had missed work, school, or appointments due to mental stress in the past 30 days. Of these respondents, 8% reported difficulty obtaining mental health services once or more in the past year (an improvement compared to 20% in 2009). However, 54% of the providers surveyed noted that mental health issues hinder their patients’ ability to access care.

6. Substance Abuse Outpatient Care

Like mental health services, substance abuse treatment did not rank as a major concern on the 2002 Needs Assessment. By 2005, little had changed. Of the five secondary services from which to choose on the 2005 survey, respondents chose Substance Abuse Treatment least often (less than 7%). Given the anecdotal evidence available through case management program audits, this percentage is surprisingly low, though it is expected that the issue would be drastically under-reported – even in anonymous settings – due in part to its illicit nature. The qualitative data gathered during the 2007 consumer focus group process indicated that disclosure of a substance use issue remains difficult. Few respondents to the surveys – though demographically and geographically diverse – were willing to report personal chemical dependency concerns; although, overall, the concept of low-cost or free drug treatment was supported by respondents provided that such services were not promoted as “mental health care,” interestingly pointing to possibly greater stigma attached to mental illness than to drug abuse.

The 2009 Needs Assessment report showed similar results. Only 2% of consumer respondents identified drug and alcohol services as their most important non-HIV medical service need. However, 59% of the providers surveyed noted that drug and alcohol use contribute to their patients’ inability to consistently access care.

Not surprisingly, substance abuse services ranked ninth out of the nine possible service categories in the Division’s 2010 mini-survey. Consumers also ranked this category lower than providers responding to the 2012 TGA needs assessment.

As in 2009, the 2013 Needs Assessment report showed that only 2% of consumer respondents identified drug and alcohol services as their most important non-HIV medical service need. However, 50% of the providers cited drug and alcohol use as a leading factor in their patients' failure to consistently engage in care.

7. Emergency Financial Assistance

Thirty-three percent of consumer respondents to the 2009 Needs Assessment listed emergency financial services (including food assistance) as the most important support service to them. Despite a decrease since 2005, 25% of the respondents continued to report being hungry one or more days in the past month. The 2009 Needs Assessment report further confirmed consumers' need for these forms of assistance; 32% reported that they were notified of possible disconnection from their utilities at least once in the past year. Among those who were on medications, 57% reported being unable to obtain medications due to lack of money. Fifty-seven percent of the providers surveyed noted that difficulties paying and lack of insurance contribute to their patients' inability to consistently access care. Eighty-nine percent of all consumer respondents claimed to have an annual income of less than \$25,000 per year; of these, 44% were earning less than 100% of the poverty level. Given these numbers, it is clear that many clients continue to need emergency financial assistance in order to meet even their most basic needs.

In the 2010 mini-survey, emergency financial services were ranked as the fifth most important service to respondents. Four service categories were ranked higher, and four were ranked lower. However, consumers responding to the 2012 TGA survey ranked this category second most important among all support services.

The 2013 Needs Assessment report again underscored the need for emergency assistance. Twenty-six percent of the respondents reported that they were notified of possible disconnection from their utilities at least once in the past year, and 32% ranked emergency assistance as the most important non-medical need (not including case management). As in 2009, 89% of all consumer respondents claimed to have an annual income of less than \$25,000; of these, 44% were earning less than \$10,000 per year.

8. Housing

Consumers often require housing (and utility) assistance in order to maintain an adequate standard of living. Housing assistance in Indiana is generally confined to short- or long-term rental assistance. Those without access to assistance of this kind are often in jeopardy of hunger and homelessness. In 2003, AIDS Housing of Washington drafted the Indiana HIV/AIDS Housing Plan for the Indiana Housing and Community Development Authority, the City of Indianapolis, and the Damien Center. The plan identified affordability as the primary barrier to accessing housing for HIV-positive people in Indiana. In every region of the state, it is extremely difficult to find safe and sanitary housing that is affordable for low-income individuals.

The preliminary analysis of the Women and Families Needs Assessment data reveals that the presence of children in the household intensifies the need for housing assistance and brings with it the additional need for child care. Nearly all care site staff (89%) reported child care as a significant need for their clients, yet 43% of staff indicated that this service was not available. In general, child care was ranked as the fourth most important auxiliary service need (after case management, mental health care, and housing) for women.

The results from the Needs Assessment Updates of 2004 and 2005 indicated that shelter-related issues continue to impact HIV-positive individuals significantly. In the secondary "additional concerns" tier of the 2005 survey, 30% of the respondents chose housing as the area most important to them. Likewise, the Emergency Financial Assistance Project spent nearly 13% of its funds to reimburse shelter-related providers.

In the 2009 Needs Assessment report, a quarter of the consumer sample identified housing assistance as the second most needed support service. Nine percent of the sample had experienced homelessness or unstable housing at some time within the previous year. Seven percent had missed work, school, or a doctor's appointment at least once in the last 30 days due to unstable housing, and 15% of the sample had been notified of possible eviction from their home. Forty-five percent of the providers surveyed noted that homelessness and other forms of unstable housing contribute to their patients' inability to consistently access care.

In the mini-survey conducted in 2010, housing services were ranked as the fourth most important service to respondents. Medical care, medications, and case management were the only categories ranked higher. Surprisingly, consumers did not rank housing in the top five most important support services in the 2012 TGA needs assessment.

In the 2013 Needs Assessment report, 22% of the consumer sample identified housing assistance as the second most needed support service. Four percent had experienced homelessness or unstable housing within the previous year, and 5% had missed work, school, or a doctor's appointment at least once in the last 30 days due

to unstable housing. Eleven percent had been notified of possible eviction from their home. Thirty-two percent of the providers surveyed indicated that housing issues prevent their patients from accessing care regularly.

9. Medical Transportation

In the Needs Assessment Report of 2002, nearly one quarter (24%) of the respondents indicated that transportation was the service most necessary to ensuring good health. While access to this type of service is regarded as essential to quality of life, consumers consistently report that they are unable to obtain the service on a regular basis. The inability to find affordable, reliable methods of transportation is often cited as a reason for failure to access services that are otherwise available.

A substantial portion of the Emergency Financial Assistance Project funds (nearly 5% or approximately \$30,000) were used to address transportation-related needs in 2005. The Needs Assessment Update of the same year indicated that a significant proportion of the respondents missed work or were unable to obtain their medications (22% each) due to the unavailability of adequate transportation.

The 2009 Needs Assessment report confirmed that transportation remains a barrier to accessing services. Of those who needed supportive services, 7% listed transportation as their most important need. Twenty-five percent of consumer respondents reported that they missed work, school, or a doctor's appointment at least once in the past 30 days due to a lack of transportation, and 10% reported missing these types of obligations four or more times in the last 30 days. Thirty-six percent of the providers surveyed noted that difficulties with transportation contribute to their patients' inability to consistently access care.

Medical transportation services were ranked as the eighth most important service to respondents in the Division's mini-survey conducted in 2010. Only substance abuse services were ranked lower. This category was ranked similarly low in the 2012 TGA survey.

In the 2013 Needs Assessment report, the Division noted that only 6% of the consumer respondents listed transportation as their most important need; however, 21% reported that they had missed work, school, or a doctor's appointment at least once in the past 30 days due to a lack of transportation. Nine percent reported missing these types of obligations four or more times in the last 30 days. Thirty-seven percent of the providers surveyed ranked "lack of transportation" as a leading barrier to care.

Unmet Need Estimate*

Prompted in part by the results of its needs assessment activities, in 2003, the Division first calculated the number of persons who are aware of their HIV-positive status but are not actively engaged in care. The original estimate was 4726, and it has been updated annually since 2003 as shown in Table D. The 2011 estimate is 3282.

Table D. Unmet Need Estimates by Year 2003-2012

Year	Result	Prevalence Total	% with Unmet Need	% Δ in Raw Number
2003	4726	7495	63%	
2004	4246	8370	51%	-10%
2005	3657	8049	45%	-14%
2006	2911	7179	41%	-20%
2007	3362	8776	38%	+15%
2008	3544	8955	40%	+5%
2009	3621	9331	39%	+2%
2010	3459	9704	36%	-4%
2011	3282	9927	33%	-5%
2012	3286	10325	32%	+0%

As in previous years, to develop the 2012 estimate, the Division began by reviewing surveillance data from the OCDR to determine the total size of the population of persons living in Indiana with HIV. As of 31 March 2012, OCDR had 4705 surveillance records for individuals living with HIV and 5620 records for those living with AIDS. These included all confidential case reports originating from Indiana plus all cases reported only through laboratory testing (to account for otherwise unreported in-migration) less all cases known to have expired or relocated out-of-state (to account for out-migration). From these, any record which also had corresponding CD4 or viral load laboratory reports from any in- or out-of-state facility dated between 1 April 2011 and 31 March 2012 was subtracted. There were 2758 such reports for the HIV group and 4150 for the AIDS group.

Medicaid information from the same time period was then solicited from the Office of Medicaid Policy and Planning. Included in this information were claims data for HIV drug therapy, CD4 counts, and viral load testing. Within the data

set, 16 and 30 records matched with names in the remaining HIV and AIDS groups respectively. These names then were eliminated from the prevalence data set.

Finally, utilization data from the Division's HIV Medical Services Program was reviewed. For the timeframe of 1 April 2011 through 31 March 2012, ADAP and HIAP data were analyzed for evidence of HIV drug therapy, CD4 counts, or viral load testing. Among all applicable records, 57 and 28 additional matches were found in the HIV and AIDS groups respectively. These were then eliminated from the balance of prevalence records. The remaining records comprise the state's unmet need population. For 2012, this population is estimated to consist of 1874 individuals with HIV and 1412 individuals with AIDS.

Table E shows the first and final stages of Indiana's official estimate of unmet need for 2012. It describes the demographics of the original prevalence population as well as those of the final "unmet need" population. Gender, race, age range at diagnosis, and primary risk type are included. Reliable information was not available to include details regarding income or healthcare coverage for these populations.

The Division developed the 2012 estimate using actual client-level data from the sources described above in an effort to present the most reliable, accurate, and useful estimate possible. This estimate is assumed to be the state's population of HIV-positive people with knowledge of their status but without access to or need for medical care. The Division acknowledges that it has certain limitations. By design, it does not define those who are receiving only non-HIV medical services or drugs as "in care." Further, it does not take into account those possessing private or subsidized insurance coverage (e.g., the HIV Medical Services Program) if CD4 counts, viral load counts, or specific drugs have not been obtained within the narrow reporting period. However, despite its limitations, the estimate appears to be sufficient for basic analysis of the population.

The current estimate shows that the number of individuals believed to be without primary medical care in Indiana has increased from 3282 (in 2011) to 3286 (in 2012). While the raw number of persons remained essentially unchanged, this represents the fourth consecutive decrease in the percentage of the total prevalence population (from 33% to 32%) since 2008. The table for Stage 5 above fully describes the demographic qualities of the individuals believed to have unmet needs.

As in previous years, analysis shows that the demographics of the unmet need group largely resemble those of the entire prevalence group. When the HIV and AIDS subtotals are combined, both groups contain between 80-82% males. Approximately 47% and 54% of the prevalence and unmet needs groups, respectively, are non-Whites. Approximately 56% and 58% are 30-49 years of age, and approximately 50% and 46% indicated same-sex risk factors. The unmet need group also seems to be located around the state in similar patterns to the larger prevalence group. Approximately 34% of the unmet need group reside in Northern Indiana, 56% in Central Indiana, and 10% in Southern Indiana. This appears to indicate that particular subpopulations are not impacted disproportionately by access-to-care issues; therefore the results of this exercise did not significantly impact the design of the service delivery model or the resources allocated to provide services.

Comparing this data to the previous year's estimate, very few remarkable changes can be seen in the various demographic qualities. In terms of race, the gap between the Blacks and Whites in 2011 was six percentage points in the combined total; in 2012, this gap had narrowed to five points. There was a continued shift among the age groups; the percentage of those in the > 49 age group rose from 30% to 31% in the combined total. For all cases which identified a possible mode of transmission, heterosexual contact increased slightly from 15% to 16%. Injection drug use risk showed a small decrease, dropping from 6% to 5%. Similarly, the number of individuals unwilling to disclose a risk behavior remained essentially constant, falling only one point to 32%.

Taking into consideration the five estimates since 2007, the most significant trends that are not associated with the evolving epidemiology of the prevalence population itself appear to be subtle shifts in race and risk. In 2007, virtually no significant gap existed between the prevalence and unmet need percentages for Blacks, and the data showed that the percentage of those without an identified risk was actually two points less among the unmet need group. By 2011, the gap for Blacks had become undeniable (6 percentage points), and the percentage of those without an identified risk was now five points greater in the unmet need group. In 2012, some improvements were seen; both the racial and risk gaps fell by one percentage point each.

Based on the constant and substantial size of the estimated "unmet need" population, the Division recognizes that one of the primary challenges to care continues to be the difficulty of consistently engaging and maintaining HIV-positive persons in services and treatment. To address this issue, the Division continues to conduct activities to identify HIV-positive individuals who are not actively seeking care. Many of these activities are not associated with Part B funding.

Table E. Unmet Need Framework for FY 10-12 by Stage

Stage 1							INDIANA PREVALENCE								
Time period	As of 31 March 2012														
Source	Indiana Office of Clinical Data and Research														
Parameters	All confidential HIV case reports originating from Indiana, plus All cases reported only through laboratory testing to account for in-migration, less All cases known to have expired or relocated out-of-state to account for out-migration														
	HIV Diagnosis			AIDS Diagnosis			Combined Total								
	#	%	#	%	#	%									
Male	3685	78%	4621	82%	8306	80%									
Female	1020	22%	999	18%	2019	20%									
	4705	100%	5620	100%	10325	100%									
Black	1785	38%	1924	34%	3709	36%									
White	2452	52%	3058	55%	5510	53%									
Hispanic	315	7%	457	8%	772	8%									
Other	153	3%	181	3%	334	3%									
	4705	100%	5620	100%	10325	100%									
< 20	80	2%	23	0%	103	1%									
20-29	787	16%	290	5%	1077	10%									
30-39	1081	23%	939	17%	2020	20%									
40-49	1540	33%	2195	39%	3735	36%									
> 49	1217	26%	2173	39%	3390	33%									
	4705	100%	5620	100%	10325	100%									
Heterosexual	823	17%	1025	18%	1848	18%									
Homosexual	2334	50%	2777	49%	5111	49%									
IDU	135	3%	252	5%	387	4%									
Perinatal	69	1%	40	1%	109	1%									
Other/No Risk	1344	29%	1526	27%	2870	28%									
	4705	100%	5620	100%	10325	100%									
Subtotal A	4705	46%	5620	54%	10325	100%									
Stage 5							INDIANA "UNMET NEED" POPULATION								
Time period	As of 31 March 2012														
Source	Indiana Office of Clinical Data and Research														
Parameters	Original prevalence population, less All individuals with indications of "met need" according to the established definition														
	HIV Diagnosis			AIDS Diagnosis			Combined Total								
	#	%	#	%	#	%									
Male	1479	79%	1205	85%	2684	82%									
Female	395	21%	207	15%	602	18%									
	1874	100%	1412	100%	3286	100%									
Black	835	45%	515	36%	1350	41%									
White	816	44%	692	49%	1508	46%									
Hispanic	160	8%	166	12%	326	10%									
Other	63	3%	39	3%	102	3%									
	1874	100%	1412	100%	3286	100%									
< 20	20	1%	11	1%	31	1%									
20-29	262	14%	59	4%	321	10%									
30-39	429	23%	206	15%	635	19%									
40-49	672	36%	598	42%	1270	39%									
> 49	491	26%	538	38%	1029	31%									
	1874	100%	1412	100%	3286	100%									
Heterosexual	300	16%	224	16%	524	16%									
Homosexual	799	43%	706	50%	1505	46%									
IDU	83	4%	93	7%	176	5%									
Perinatal	23	1%	4	0%	27	1%									
Other/No Risk	669	36%	385	27%	1054	32%									
	1874	100%	1412	100%	3286	100%									
Subtotal D	1874	57%	1412	43%	3286	100%									

Currently, the state-funded HIV Care Coordination Program oversees 16 agencies that work closely with service providers across the state to coordinate medical care, health insurance for the uninsured, and social services. Many out-of-care consumers are brought back into care through referrals into this network. In Marion County specifically, the Part A-funded Minority AIDS Initiative projects also have been highly effective in its efforts to capture consumers who have been “lost to care,” bringing them back into the system to receive necessary social and medical services.

Procedure within the Division dictates that, for persons who test HIV-positive but do not return for their test results, a Disease Intervention Specialist will be dispatched by the OCDR to deliver the test results in person and to provide information about available services. New specialists receive training regarding the availability of HIV Care Coordination services throughout the state and are instructed to provide this information to HIV-positive persons that they encounter. The relationship between the Division’s service programs, the HIV Care Coordination agencies, the various counseling and testing sites, and the Disease Intervention system is continually monitored to ensure that the programs are operating with the common goal of engaging and maintaining persons with HIV in care. In 2010, a new protocol was enacted, requiring all Disease Intervention Specialists and HIV testing counselors to actively arrange for the HIV Care Coordination referral for newly diagnosed persons and to follow-up on every referral to ensure its success. A new referral card also was developed specifically for this purpose.

To strengthen its ability to retain consumers in care, the Division established a requirement in January 2004 for all HIV Medical Services Program recipients to engage and remain in the state’s HIV Care Coordination Program. All new applications must originate from – and all recertification interviews must be performed by – the sanctioned care sites where quality control measures can be enforced. This requirement was validated by the Division’s 2009 needs assessment results which indicated that the longer a client remains enrolled in care coordination, the more the client improves on several indicators, including access to food, housing, mental health services, medication, and medical care.

Unaware of Status Estimate

The unmet need estimate intentionally excludes those with HIV who do not yet know their status. To better understand and quantify this equally important population, the Division created its first Early Identification of Individuals with HIV/AIDS (EIIHA) population estimate in 2010. Major elements of the nascent strategy related to this estimate are described later in this document.

The number of living HIV-positive individuals who were unaware of their status as of 31 December 2009 can be calculated as “ $(p/1-p) \times N$ ” where **p** equals the national proportion of undiagnosed HIV cases (21%), and **N** equals the number of individuals living with HIV as of 31 December 2009 (9646). The calculation for Indiana is: $(.21/.79) \times 9646 = 2564$.

As of 31 December 2010, the Division has conducted 238,878 HIV tests using a variety of local, state, and federal funds. Indiana has no mechanism to account for all HIV tests that have been conducted in the state. Therefore, the HIV testing and awareness data used for this estimate are based on the information that has been collected in the HIV Prevention Program’s *EvaluationWeb* database since 2001. It does not take into consideration any subsequent referrals to the DIS network for delayed notification of results.

While the specific needs of the 2564 individuals believed to comprise the unaware population are unknown, the Division’s strategy includes efforts to reach out to persons at high risk for infection, provide testing and test results and, whenever necessary, facilitate the referral and linkage to care. It also describes the most relevant barriers to identifying this population.

The Centers for Disease Control and Prevention (CDC) recommends that diagnostic HIV testing and opt-out HIV screening become a part of routine clinical care in all healthcare settings. The recommendations are intended for providers in all healthcare settings, including hospital emergency departments, sexually transmitted disease (STD) clinics or other venues offering clinical STD services, tuberculosis clinics, substance abuse treatment clinics, public health clinics, correctional healthcare facilities, and primary care settings. The Division’s EIIHA strategy supports the CDC recommendations by providing testing services primarily in substance abuse treatment settings throughout the state. It, however, does not address HIV testing in general practice where true “routine” testing must necessarily occur; this is a function of lack of authority and is not the result of prohibitive state or local legislation.

Service Gaps and Barriers

In addition to the issues surrounding the task of identifying, engaging, and maintaining people in care, the Division recognizes a number of other serious gaps and barriers. These exist despite a healthy continuum of care and a wealth of quality service providers. For planning purposes, they have been roughly correlated to each of the state’s priority service needs and impact both those considered to be in and out of care according to the HRSA definition of

“unmet need.” The following paragraphs briefly describe the most evident issues for each priority service need. These gaps and barriers include both the obstacles experienced by the consumer and those facing the providers.

1. Outpatient and Ambulatory Health Services

- a. “Access-on-demand” is not a reality in Indiana. The ability to afford primary medical care continues to affect the rate at which HIV-positive persons access such care. Many consumers lack insurance coverage or are unable to pay for services. Despite the Division’s funding commitment, the HIV Medical Services Program will be unable to serve all eligible applicants. An enrollment threshold for the number of enrollees exists, and the maximum capacity could be reduced if costs continue to increase. Other programs – such as the state’s Part A and C programs – exist with similar funding restrictions, are geographically limited, and are unable to serve every applicant. Strict eligibility criteria also affect how easily a person can access this type of care.
- b. The number of infectious disease specialists is low (less than 100 in the state). General practitioners may be reluctant to treat HIV-positive patients in large numbers due to the complexity of the disease. Low volume providers (such as in rural areas) often have less experience and less training, and this may impact the health outcomes experienced by their patients over time.
- c. The degree to which clients are able to comprehend and successfully use the Division’s HIV Medical Services Program is a concern, particularly for consumers of diverse racial or ethnic backgrounds.
- d. The consumer’s physical and mental health, as well as stigma and mistrust of the medical establishment, can prevent timely access to appropriate medical care or may interfere with adherence to prescribed treatments.
- e. Organizational barriers such as “navigating the system,” “dealing with red tape,” and “coordinating services” are often cited by consumers.
- f. The Indiana Comprehensive Health Insurance Association (ICHIA) requires applicants to file an Indiana Medicaid application; this is a significant barrier to those who are residing in the U.S illegally. A similar federal program, the Pre-Existing Condition Insurance Plan (PCIP), explicitly serves only legal U.S. residents.
- g. Consumers report a lack of effective communication with medical providers which may negatively impact the continuum of care.
- h. As consumers become healthier due to available treatments, retention of benefits (such as Medicaid and SSDI) becomes more difficult.
- i. Incarcerated consumers often experience difficulty or delays in accessing healthcare and other assistance upon release.
- j. The Indiana Medicaid system (including traditional Medicaid, risk-based managed care, CareSelect, and MDWise) remains difficult for consumers to understand and navigate. Patients are often auto-enrolled into managed care plans that require them to change providers; the process to correct this issue is lengthy, and patients are often unable to attend medical appointments until the matter is resolved. In many areas, local offices and case managers have been replaced by “call centers,” the employees of which are often unfamiliar with the complexities of the HIV service delivery system in Indiana.

2. AIDS Drug Assistance Program Treatments

- a. As with primary medical care, the high cost of medications continues to prevent many individuals from accessing necessary pharmaceuticals. Despite the Division’s funding commitment, the HIV Medical Services Program will be unable to serve all eligible applicants. An enrollment threshold for the number of enrollees exists, and the maximum capacity could be reduced if costs continue to increase.
- b. ICHIA’s eligibility guidelines require applicants to document one full year of Indiana state residency.
- c. Hospital-based assistance programs for low-income patients are not available statewide.
- d. Medicaid offers pharmaceutical coverage comparable to that of the HIV Medical Services Program; however, the enrollment process is lengthy and the eligibility standards (which often require applicants be determined disabled by the State Medical Review Team) exclude a large number of potential enrollees. Many Medicaid managed care programs have drug formulary restrictions that do not exist for traditional Medicaid.
- e. The “spend-down” policy (similar to a monthly deductible) ensures that enrollees remain impoverished. The policy does not allow the recipients to earn an adequate income without jeopardizing their coverage.
- f. Many manufacturer-sponsored indigent drug assistance programs are short-term, and the application process is cumbersome for providers and consumers (especially those without case management assistance).
- g. Adverse side effects and potential drug interactions may prevent consumers from accessing available HIV pharmaceuticals and adhering to treatment.
- h. Medicare Part D can be an expensive and significantly challenging option for consumers. Those under the age of 65 and enrolled in a Medicare Part D drug plan are not eligible for the HIV Medical Services Program. Many are also ineligible for “extra help” and are responsible to pay for the premium, deductible, and co-

payments associated with the coverage. Depending on the plan chosen, the consumer may experience a period of no coverage (the “donut hole”). Consumers whose pharmacies do not accept certain Part D plans must change either their pharmacy or their Part D plan, potentially delaying their ability to obtain medications.

3. Oral Health Care

- a. Without assistance, the out-of-pocket costs for dental care can be prohibitive to many HIV-positive consumers.
- b. Dental care benefits begin within the first three months of enrollment in the HIV Medical Services Program but are limited to \$2000 annually. Indiana Medicaid provides an annual dental benefit of only \$1000. Part A dental services are limited to certain clinic-based providers, are only available in the TGA, and have capped benefits. Even private dental plans often limit coverage of many important dental services (such as extractions and dentures).
- c. Many private dental providers do not accept Medicaid or have waiting lists for Medicaid patients.
- d. Many private dentists are not prepared to manage the special oral health needs of those with HIV disease. Some dental providers in rural areas are unwilling to treat patients with HIV.
- e. Consumers report that dental hygiene is not often considered a priority due to other more urgent needs (such as shelter and food).
- f. Consumers remain unaware of available low-cost dental service options.

4. Medical Case Management, including Treatment Adherence Services

- a. The Division’s HIV Care Coordination Program is available to all HIV-positive residents at no cost through 15 care sites located around the state. The program continues to expand each year despite decreasing funding. State block grant funding for the HIV Care Coordination Program has decreased 20% between 2001 and 2011. While no eligible person has been denied HIV Care Coordination services to date, continued funding reductions will ultimately impede the Division’s ability to provide this essential service without restrictions.
- b. Staffing statewide is not adequate to meet demand. More than half of the HIV Care Coordination sites within the ISDH network are managing caseloads that exceed the maximum acceptable case manager-to-client ratio of 1:40.
- c. As clients live longer, their needs have evolved to include issues that previously would not have been within the scope of HIV case management. These issues include employment, family planning, and budget counseling. Clients with multiple health and social issues are particularly difficult to manage.
- d. HIV Care Coordinators are not uniformly knowledgeable about issues and services that are unique to women, children, and families.
- e. HIV Care Coordination sites are not uniformly equipped to manage non-English speaking consumers.
- f. HIV Care Coordination providers are not uniformly equipped to provide the highest level of medical case management and adherence support, and some may not be well connected with the physician community.
- g. HIV Care Coordination grantees are not adequately funded to allow for sufficient outreach efforts to take place in underserved populations.
- h. HIV Care Coordination grantees are not adequately funded to allow for the development of targeted support programs (e.g., peer support, group support, educational workshops) for specialized populations (such as detainees, sex workers, women, children, and minority groups).
- i. Consumers report a perception of inconsistent quality between the various case management providers.
- j. HIV Care Coordination services are not routinely available during evening hours or on weekends to address emergency situations.

5. Mental Health Services

- a. Access to affordable mental health treatment is fairly limited in Indiana for those with low incomes or without insurance. The out-of-pocket costs for mental health care can be prohibitive to many HIV-positive consumers.
- b. During the residency waiting period, the HIV Medical Services Program covers only the cost of a small number of anti-depressant and anti-anxiety drugs. Once this period has expired and full insurance benefits are available, the enrollee is covered for only 30 outpatient visits for mental health and substance use issues combined. Inpatient visits are limited to a combined 180 days for major medical, mental health, and substance abuse treatment. ICHIA utilizes an industry-standard drug formulary that includes most psychotropic medications. Part A mental health services are limited to outpatient treatment, specific providers, and are only available in the TGA.
- c. Many private mental health providers do not accept Medicaid or have waiting lists for Medicaid patients.
- d. Many traditional mental health providers are not equipped to address the disclosure, sexual, and chronic illness issues that may accompany an HIV-positive diagnosis.

- e. Many consumers are reluctant to seek mental health treatment due to the stigma of such a diagnosis; consumers also perceive a stigma related to their HIV status when seeking care from mental health providers.

6. Substance Abuse Outpatient Care

- a. Access to affordable addictions treatment is fairly limited in Indiana for those with low incomes or without insurance. The out-of-pocket costs for addictions treatment can be prohibitive to many HIV-positive consumers.
- b. The Part B HIV Medical Services Program provides very limited access to withdrawal management medications and addictions treatment services until insurance begins. ICHIA allows for coverage of only 30 outpatient visits for mental health and substance use issues combined. Inpatient visits are limited to a combined 180 days for major medical, mental health, and substance abuse treatment. ICHIA utilizes an industry-standard drug formulary that does not include specific withdrawal management medications such as Methadone. Part A substance abuse services are limited to outpatient, specific providers, and are only available in the TGA.
- c. Assistance with preparatory counseling is available only in certain areas of the state. The Division funds eleven agencies across the state to provide intensive supportive care services designed to prepare the consumer for entry into treatment. Often, as affordable treatment options fail to appear, the support specialist will act as the pro tem treatment professional, working to encourage harm-reduction strategies, HIV medication adherence, and engagement with other care systems.
- d. Many substance abuse treatment providers do not emphasize harm reduction and, therefore, may limit the number of consumers willing to seek treatment following a relapse.
- e. Many inpatient substance abuse treatment facilities have waiting lists for Medicaid and other patients and are, therefore, unable to accept new patients at the most advantageous time.
- f. Many consumers are reluctant to seek substance abuse treatment due to the stigma of having such a condition; consumers also perceive a stigma related to their HIV status when seeking care from substance abuse providers.

7. Emergency Financial Assistance

- a. Due to the adverse effects of HIV disease, consumers often experience difficulties sustaining employment over time. Those considering returning to work often fear that their access to benefits will be adversely affected. These benefits alone, however, often do not provide sufficient income to support the consumer's daily living expenses.
- b. Many local food pantries are overwhelmed with requests for assistance, are often under-stocked, and limit the number of times a person may access the pantry within a designated time period.
- c. The rising cost of utility services is imposing additional financial burden on consumers with limited income. Access to flat-line monthly billing (referred to as "Budget Billing") is not always available to consumers who have had difficulty paying their utility bills on time in the past. For those enrolled in the Housing Opportunities for Persons with AIDS (HOPWA) Program, assistance for utility bills is limited to 21 weeks per grant year.
- d. Local trustee offices and other agencies providing financial assistance to low-income individuals often cap the level of assistance offered at a very minimal amount.

8. Housing

- a. The majority of housing services for HIV-positive individuals in Indiana are provided by the Indiana Housing and Community Development Authority through the HOPWA program. (In Indianapolis, HOPWA is coordinated by the City of Indianapolis.) Sub-grants are awarded to the local agencies (usually HIV Care Coordination providers) to assist clients determined to be most in need. Strict eligibility criteria apply and, in most cases, the client remains responsible for a portion of the housing cost. HOPWA program guidelines impose a limit on the duration and type of assistance. Currently, nearly every region is maintaining a waiting list for this form of assistance and cannot satisfy the demand for assistance. Waiting lists also exist for most public housing programs, including Section 8.
- b. Many available options impose restrictions which prevent certain populations (e.g., the formerly incarcerated) from being eligible for service. Affordable housing is limited and is often unacceptable for the disabled population; options (including shelters) are especially limited for women with children.
- c. Housing-specific case management is not uniformly available in all areas of the state.

9. Medical Transportation

- a. Personal transportation is often unaffordable for HIV-positive persons who are unemployed or living on a limited income.
- b. Affordable public transportation in rural (and some suburban) areas is scarce. Where available, public transportation can be difficult to use for consumers with children or disabilities.

- c. None of the Ryan White programs in Indiana currently operate a large-scale transportation program. Transportation paid by Medicaid is contingent on enrollment and limited to only approved “medically necessary” travel.

Underserved and Special Populations

Regardless of the barriers, the Division strives to serve all affected subpopulations in proportion to their representation in the prevalence statistics regardless of sexual orientation, gender, race, ethnic origin, disability, religious beliefs, lifestyle, or manner in which HIV was contracted. Since 2005, the Division has been successful in meeting its goals for women, infants, children, and youth (WICY). However, the Division historically has been unable to meet its goal of 35% for Black enrollees in the HIV Medical Services Program. Some of the commonly recognized reasons for this failure are noted below.

- Blacks were over-represented (46%) in the HIV-positive Indiana Medicaid population in 2011. Medicaid enrollment disqualifies a person from receiving Part B services.
- Blacks were over-represented (62%) in the HIV-positive prison population in 2011. Current incarceration also disqualifies a person from receiving Part B services.
- Blacks may seek services less frequently than other groups due to cultural mistrust of medical establishments.

The Division has been more successful in proportionately serving Hispanics, partly due to the reality that the undocumented subpopulation is often ineligible for many other state and federal programs. However, the language barrier and a simple lack of knowledge about the service delivery system continue to be challenges. Fear of deportation can keep some from seeking services, even if they are aware of and are otherwise eligible for them. In the most desperate cases, individuals may falsify information in order to obtain employment, housing, or benefits, putting themselves at risk for deportation and other legal ramifications.

In addition to those who may be disproportionately affected by HIV, other special populations of interest include adolescents, injection drug users, the homeless, transgender persons, and Burmese refugees.

1. Adolescents

To date, OICDR has documented a total of 339 HIV and AIDS cases diagnosed in the age range of 13-19 in Indiana. Currently, 76 HIV-positive persons in this age range are living in the state. From a provider's perspective, one of the main challenges in working with adolescents is the transition from pediatric to adult medical care. According to Danielle Osterholzer, an Assistant Professor of Clinical Medicine and Pediatrics at Indiana University Health with dual appointments allowing her to practice in both the pediatric and adult infectious disease divisions within her hospital, developing a strong transition plan is essential. A plan that is not well-considered is likely to result in the patient leaving care or requesting to remain with the pediatric provider. Dr. Osterholzer explains that most adolescent patients seen in her practice were infected perinatally and have been treated by the same medical provider since birth. The patients have grown accustomed to a level of care that is not generally afforded in an adult clinic. The doctor-patient relationship is also different in adult practices. A pediatric provider approaches the patient as a child or young adult and uses concrete thinking techniques to communicate health information; an adult provider may communicate in a more abstract way that does not allow many adolescent patients to process the consequences of actions (such as failing to adhere to prescribed medication regimens). Because of the real and perceived differences between pediatric and adult providers, many patients experience problematic transitions. Dr. Osterholzer believes that a good transition plan incorporates a check-list developed by the provider that includes activities to be discussed at each visit as the patient enters adolescence. The transition plan will often begin several years before the patient is actually transitioned.

Other issues that face adolescents relate to disclosure and parental support. Many of the young patients seen by Dr. Osterholzer are unaware of their HIV status, compromising patient-centered care. Guilt and fear of stigma often prevent parents from explaining the issue to the infected child. Frequently, the parent is also infected and managing their own diagnosis poorly. The American Academy of Pediatrics strongly recommends that HIV-positive school-age children be fully informed of the nature and consequences of their illness and encouraged to actively participate in their own medical care, citing that children exhibit better coping skills and fewer psychosocial problems when appropriately informed about their illness. Studies suggest that children who know their HIV status have higher self-esteem than children who are unaware, and parents who have disclosed their own status to their children experience less depression than those who do not (American Academy of Pediatrics, 1999).

2. Injection Drug Users

Among the OICDR incidence and prevalence data, the exact size of the injection drug use risk groups remain in question due to the high number reported in the “Other/No Known Risk” category. When reviewing the Unmet

Need Estimate results, however, approximately 6% of those who did identify a possible mode of transmission indicated an injection drug use risk. Targeted case finding activities are performed by substance abuse program testers to reach marginalized subpopulations and underserved groups like injection drug users. In the third quarter of FY 2011, the majority of test subjects indicated active substance use, and 50% identified injection drug use as their primary risk factor. Subjects were severely impoverished (with 82% earning less than \$10,000 annually), and most (77%) presented with concomitant risks for Hepatitis C. Twenty-six percent of the subjects were non-White, and 37% were female.

Awareness of HIV status for injection drug users and their sex and needle-sharing partners is obstructed by a number of competing needs. These are generally related to financial resources and include food, shelter, and access to the drugs of choice. The illicit and stigmatizing nature of injection drug use also impact this population's propensity for HIV testing and can compromise the efforts of public health professionals to accurately identify and locate persons at high risk.

Treatment resources for injection drug users are very limited. According to the CDC, "the need for substance abuse treatment vastly exceeds our capacity to provide it." Access to clean needles and other sterile injection equipment also remains a barrier to increased disease prevention. Research has proven that syringe exchange programs decrease disease transmission. Avert.org reports that "a study of HIV among IDUs in New York between 1990 and 2001 found that HIV prevalence fell from 54 percent to 13 percent following the introduction of needle exchange programs." Additionally, the World Health Organization (WHO) published a report in 2004 that reviewed the effectiveness of needle exchange programs in many countries and examined if they promoted or prolonged illicit drug use. The results produced "convincing evidence that needle exchange programs significantly reduce HIV infection and no evidence that they encourage drug use."

3. Homeless Individuals

At the end of 2006, when the total U.S. population was estimated to be approximately 300 million people, the CDC reported 1.1 million Americans (0.37%) were infected with HIV. However, in the homeless population, HIV disease was much more prevalent. In its "Fact Sheet" dated 10 August 2006, the National Alliance to End Homelessness estimated that 3.4% of the nation's 3.5 million homeless adults and adolescents were HIV-positive, making HIV nearly 10 times as prevalent in this vulnerable group as compared to the general population. The Alliance noted that, in general, HIV-positive individuals are at a higher risk of homelessness than the general population and that as many as half of all people with HIV are at risk of homelessness due to unaffordable housing costs and the high cost of medical care.

Indiana has not been spared from the epidemic of homelessness. In 2011, the National Alliance to End Homelessness reported that 6196 Hoosiers lacked a permanent residence. While this figure represents only approximately 0.1% of the state's current general population of 6.5 million, the impact of homelessness on Indiana's HIV-positive community is feared to be substantially worse. Using the national estimate noted above (3.4%), the Division believes that more than 300 of its 9893 HIV-positive residents are currently homeless. Other sources suggest a more severe scenario. In a 2003 survey of HIV-positive individuals conducted by AIDS Housing of Washington (in which Indiana was represented), an alarming 11% of respondents were homeless at the time of the survey. If the Division were to base its estimate on this information, it would conclude that nearly 1100 HIV-positive Hoosiers are currently homeless. Exacerbating the problem, many may not be aware of their status.

For those who are aware of their status, obtaining adequate care and treatment while homeless becomes significantly more challenging. Most homeless individuals are uninsured and unable to pay for essential health services and medications. When medications are available, homelessness makes consistent compliance with medical advice nearly impossible. As the National Alliance to End Homelessness noted in 2006, adherence is very difficult for people without access to stable housing, clean water, bathrooms, refrigeration, and food. For anyone living with HIV, these barriers are compounded by the complexity of the antiretroviral treatment regimens.

In Indiana, the HIV Care Coordination Program is uniquely positioned to intervene with positive residents at risk for or experiencing homelessness. Of the 15 current HIV Care Coordination providers, 13 are also HOPWA grant recipients and one program is actually managed by a local Housing Authority. HIV Care Coordinators also are experts in other local housing resources. Currently, only 1.3% of the program's active clients are living without a permanent residence.

4. Transgender Persons

Statewide data regarding the needs of the transgender population is lacking. However, in 2011, MCPHD conducted an interesting analysis of its service utilizers to ascertain if any trends could be identified for

transgender enrollees. Demographic and service utilization data obtained from the Part A grantee's data management system were used to describe the transgender population that accessed medical and supportive services at Part A-funded agencies in 2010. The results revealed that Black male-to-female (MTF) transgender persons who accessed services were more likely (50%) than Whites (25%) and Hispanics (25%) to present with AIDS at initial HIV diagnosis, suggesting missed opportunities for HIV testing and treatment. Of those presenting with AIDS at first diagnosis, 80% were Black, and 20% were White. Data also revealed that MTF transgender persons are at risk for infrequent care and for abandoning care altogether. Of the MTF persons that accessed HIV services, 31% had an inactive service enrollment status at the end of the year. These findings underscore the need for outreach strategies to re-engage and retain this population in care. The Part A grantee concluded that a quality improvement team consisting of members of the affected population, public health outreach professionals, and Part A grantee staff should be formed to identify retention barriers and assist in the development of outreach and peer-led strategies that could be used to overcome them.

5. Burmese Refugees

For more than 35 years, Indiana has participated in a humanitarian movement to assist refugees and facilitate resettlement. Refugees living in Indiana come from Burma, Columbia, Cuba, Eritrea, Iran, Iraq, Afghanistan, Liberia, Russia, Rwanda, Ethiopia, Somalia, Sudan, Uzbekistan, Democratic Republic of Congo, and other countries. Refugees are individuals or families who have come to the U.S. because they were forced to flee their homeland, many times with little or no belongings, leaving behind family and friends, and are unable to return (Department of Health website <http://www.in.gov/isdh/24670.htm>). Many refugees have a history of health problems as a result of a lack of medical care in their country of origin or due to problems encountered during their flight from persecution. However, most health problems are addressed by healthcare services in first-asylum camps and in refugee processing centers before refugees are admitted to the United States.

Since 2008, Indiana has provided HIV services to an emerging population of Burmese refugees. Unlike many other refugees, those from Burma (also known as Myanmar) often have multiple healthcare concerns due to extremely poor medical care. For some, they have received inadequate care since birth. Many of these health concerns have lingered unaddressed until resettlement.

According to one of the largest HIV medical clinics in Indiana, 3% of their active caseload is now Burmese. Fortunately, and unlike many other immigrant populations, the clinic has been able to easily engage patients in care because they qualify for Medicaid temporarily and can be transitioned to the HIV Medical Services Program to receive comprehensive health insurance coverage. The clinic reports that the Burmese patients have been prescribed HIV medications, tend to take them consistently, and keep their medical appointments faithfully.

However, several barriers to care still exist for this population, including language, transportation, and unique cultural norms. Very few Burmese translators are available in the United States and, although the hospital housing the clinic mentioned above does employ a dedicated translator, not every patient speaks the same dialect. Many refugees do not own automobiles and rely on carpool networks to travel to and from work, making it difficult to schedule medical appointments during the work week. According to one of the HIV Care Coordination sites in Indiana serving eight refugee clients, providing culturally sensitive referrals can be a challenge. For example, Burmese individuals will not eat meat that has not been prepared in front of them. Therefore, referrals to a local food pantry may not be appropriate; to meet this particular challenge, the agency has been able to raise funds to purchase food that is ethnically reflective of the norms for this community. Other challenges are simply the unavoidable consequences of submersion in an unfamiliar culture that speaks a different language. Simply stated, the Burmese refugees must learn how to ride the bus, apply for benefits, open a checking account, navigate the U.S. healthcare system, purchase a car and auto insurance, and learn a new language with very little assistance and few readily available resources.

Healthcare Workforce Shortfalls

While the Ryan White grantees have focused much attention on specific barriers and special populations, some basic medical resources have fallen into jeopardy. In its September 2011 report on Primary Care Health Professional Shortage Areas, HRSA designated 15 geographic areas of Indiana – including five entire counties – as medically underserved areas. In the same report, HRSA also identified 28 low-income population groups as medically underserved. This is especially significant for persons living with HIV as they require more extensive healthcare than those without the disease. Furthermore, HIV-positive Hoosiers are disproportionately affected by poverty; in March 2012, the Division determined that 60% of its 4193 HIV Care Coordination clients reported incomes less than 100% FPL in 2011.

The lack of medical care options for persons living with HIV in Indiana was documented in the Division's 2009 Needs Assessment in which providers in nine regions, representing 73 counties, reported a lack of infectious disease specialists in their areas. Similar results were found in the responses from consumers; 17% of respondents reported

having difficulty getting HIV medical care appointments and 14% reported seeking care at an emergency room because they were unable to obtain an appointment with their HIV medical provider.

It is important to note, however, that this healthcare shortage is not unique to Indiana. In January 2011, the Association of American Colleges reported that the shortage of medical professionals in the United States is expected to quadruple by 2020, reaching a total shortage of 91,500 doctors. According to the report, one third of today's physicians will soon be retiring and not all will be replaced by new providers. With this startling data in mind, the Division anticipates that Indiana's healthcare shortfalls will only continue to increase.

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Section 1, Part 2 – CURRENT SYSTEM OF CARE

Overview

As a component of each edition of the Comprehensive Plan, the Division develops an updated version of its Statewide Coordinated Statement of Need (SCSN). The SCSN is a general statement of the needs of persons living with HIV in the State of Indiana, and it is contained in Section 1, Part 1 of this document. Refer to this section for epidemiological information, the Unmet Need Estimate, and the Unaware of Status Estimate.

Brief Description of the Part B Program*

With regard to Part B funds, the provision of comprehensive medical services is considered to be the Division's first priority. This funding, therefore, is largely dedicated to the operation of the Division's primary HIV healthcare project: the HIV Medical Services Program. This program consists of ADAP, EIP, HIAP (which works in conjunction with the state's high-risk insurance pool), and the Medicare Part D Assistance Plan (MDAP). Together, these plans ensure that eligible applicants have access to quality healthcare coverage at little or no cost. The program serves HIV-positive Indiana residents who are uninsured, ineligible for Indiana Medicaid, living at or below 300% of the Federal Poverty Level, and participating in HIV Care Coordination. As of 1 April 2013, the program is operating near its capacity of 2340 enrollees but does not anticipate the creation of a waiting list in the near future.

Continuum of Care*

The Division maintains that a robust service continuum begins with a commitment to providing free, comprehensive case management services for people testing positive for HIV. The HIV Care Coordination Program, supported largely through state appropriations, is considered to be the "backbone" of the service delivery system and serves as the gateway to every other major HIV-related service in the state. The Division is similarly committed to providing low- or no-cost medical services and pharmaceuticals to the maximum number of eligible individuals who can be supported with existing funding. This goal is achieved through the efficient operation of the HIV Medical Services Program. These programs, along with others that address the state's priority service needs, are described in the sections below.

1. Outpatient and Ambulatory Health Services

The Division provides access to medical care primarily through its HIV Medical Services Program. This program has two main medical care components: EIP and HIAP. EIP provides immediate access to a limited array of HIV-related healthcare procedures. The EIP benefits expire once certain residency requirements are met, at which time the HIAP benefits become effective. The Division has allocated \$146,664 to maintain EIP in FY 2013.

More comprehensive than EIP, HIAP ensures access to full-coverage medical care. The program leverages its funding by purchasing insurance for enrollees through the Indiana Comprehensive Health Insurance Association (ICHIA), the state's high-risk insurance pool. HIAP pays for the premium and other expenses associated with the ICHIA policies. These plans are available to Indiana residents who are HIV-positive, enrolled in HIV Care Coordination, earn less than 300% of the federal poverty level, are otherwise uninsured, and are under the age of 65. The Division has allocated \$9,846,770 to maintain HIAP in FY 2013.

Additional access to primary medical care is provided through the Part A program in Indianapolis which provides clinical services to eligible residents of the Indianapolis TGA. The majority of the primary medical services are provided by Wishard Hospital and Indiana University Health. The clinical services are designed to supplement existing healthcare services in the Indianapolis area. These clinics provide access to quality early interventions, outpatient medical care, and necessary laboratory services as a stop-gap measure until the consumer can be transitioned into more comprehensive programs. The Part A program defines outpatient ambulatory medical care as the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Services provided by the Part A program typically include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (including all medical subspecialties). Primary medical care for the treatment of HIV infection is expected to be consistent with the Public Health Service guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

MCPHD supports two complimentary projects through its Part C Program. Primary healthcare services are offered through Wishard Hospital, Indiana University Health, and several other agencies. These sites provide services to residents of Marion and the surrounding counties at little or no cost. Another Part C project in Kentucky (Matthew 25 AIDS Services) provides client care in southwest Indiana.

Indiana Medicaid also serves a large number of HIV-positive individuals, providing a comprehensive array of health services to those who meet the strict eligibility requirements. In the year ending 31 March 2012, Indiana Medicaid served 2600 individuals with a primary diagnosis of HIV. A combined total of nearly \$19.1 million was spent to provide inpatient and outpatient services to these enrollees.

In late 2007, Indiana launched the new Healthy Indiana Plan (HIP), a state-operated health insurance plan for adults. It provides a comprehensive package of benefits through private insurance providers. Its enrollees pay a determined amount each month into an account to cover a portion of their allowable expenses. Enrollees who do not make monthly payments will be terminated and cannot reapply for 12 months. The plan's eligibility criteria limit its membership to persons with family incomes less than 200% of the federal poverty level who have been uninsured for 6 months or more and are not eligible for employer-sponsored health insurance. Participants must contribute up to 5% of their gross family income into a health savings account, and complete insurance protection starts once annual medical costs exceed \$1,100. Because of its capped enrollment, the impact of this plan on the HIV service delivery system has been minimal to date. As of 1 April 2012, there is a waiting list for HIP benefits.

2. AIDS Drug Assistance Program Treatments

The Division provides access to HIV drug treatments through its HIV Medical Services Program. The program has three pharmaceutical components: ADAP, HIAP, and MDAP. ADAP provides immediate access to a limited formulary of HIV-related drugs. The formulary is updated regularly and includes all of the drugs that have been FDA-approved for the treatment of HIV disease. Like EIP, ADAP benefits expire after certain residency requirements are met, at which time HIAP becomes effective. More comprehensive than ADAP, HIAP provides access to most FDA-approved pharmaceuticals through its full-coverage insurance benefits. ADAP is available to Indiana residents who are HIV-positive, enrolled in HIV Care Coordination, earn less than 300% of the federal poverty level, and are otherwise uninsured. HIAP is available to these same residents but only until the age of 65. The Division has allocated \$179,988 to maintain ADAP in FY 2013; the HIAP allocation appears above.

Once an enrollee reaches the age of 65, MDAP is provided to ensure an equivalent level of benefit. MDAP coordinates coverage with a variety of participating providers under the Medicare Part D prescription drug plan. It pays for the deductibles, co-insurance, and co-payments for charges allowed by the approved Part D plan. MDAP coverage is dependent on Part D enrollment and is not available to those under 65 years of age. MDAP does not pay for the Part D plan premiums; these are the responsibility of the enrollee. The Division has allocated \$182,160 to maintain MDAP in FY 2013.

In the TGA, the Part A and C programs work together to provide emergency access to HIV pharmaceuticals through the local AIDS Pharmaceutical Assistance Program. This limited program provides emergency coverage for drugs and is not considered a full-scale pharmacy or ADAP program. The program is currently working with Wishard Hospital Pharmacy and BioScrip (recently acquired by Walgreens) to provide free medications to eligible consumers who have no other current source of drug coverage. The Part C program in Northern Kentucky does not cover pharmaceutical costs.

Indiana Medicaid regularly serves approximately 2600 individuals with a primary diagnosis of HIV annually. In the year ending 31 March 2012, \$21.8 million was spent to provide identifiable pharmaceutical services to eligible Medicaid enrollees with an HIV diagnosis code. This is known to include more than \$12.1 million in identifiable ARV therapy costs in the period.

Nearly all of the HIV drug manufacturers sponsor emergency or "indigent" assistance programs for patients without the ability to pay for certain medications. These programs offer co-payment assistance or a limited supply of free medication and are designed to allow the patient time to arrange for other pharmaceutical coverage. HIV Care Coordinators are trained to assist clients with applying for these programs.

Some hospitals in Indiana offer special assistance programs for low-income patients. Wishard Hospital in Indianapolis, for example, operates the Wishard Advantage program which provides inpatient, outpatient, and pharmaceutical services on a sliding scale payment basis to residents of Marion County. HIV Care Coordinators and pharmacists at Wishard work with clients to obtain medications quickly in hopes of ensuring adherence. Wishard applies for and has been granted funds from the Indiana AIDS Fund for the past several years for a Direct Emergency Financial Assistance (DEFA) project; Wishard uses the DEFA funds to provide medication vouchers to cover the cost of co-payments at Wishard Pharmacies when patients are unable to pay. Wishard's HIV Care Coordinators and other staff also assist uninsured patients with Patient Assistance Program applications on a regular basis. The Wishard Pharmacy can provide an emergency 10-day supply of medication to a patient once every six months if a gap in insurance coverage occurs.

Other standard HIV Care Coordination sites in the state also receive DEFA funds or have developed their own internal projects using resources from fund-raisers. These projects can also provide emergency access to medications and help with co-payments. These stop-gap projects are crucial in helping clients maintain adherence to their medication regimens and their Plans of Care. Within the care plans, case managers include other potential community resources to help guarantee access and adherence to medications in the absence of longer-term solutions such as Medicaid or the HIV Medical Services Program.

Finally, as stated earlier, Indiana launched the aforementioned HIP initiative in 2007. This state-operated health insurance plan for adults provides a comprehensive package of benefits, including prescription medications, through private insurance providers, but its impact on the HIV service delivery system has been minimal.

3. Oral Health Care

The Division has maintained a limited number of dental services on its EIP formulary for several years but, by design, these benefits expired when the HIAP plan began. In FY 2012, dental services (including initial prophylaxis, periodic exams, and panoramic x-rays) was added to the HIAP benefits package to provide enrollees with a more permanent solution. The cost of these dental benefits is included in the HIAP allocation noted previously. Additionally, the Division of HIV/STD, has worked in conjunction with the Division of Oral Health to regularly disseminate a statewide directory of dental clinics for low-income individuals to its HIV Care Coordination network.

In Central Indiana, the Part A and C programs operated by MCPHD collaborate to provide access to numerous oral health services through contractual arrangements with three oral health care providers including the Indiana University School of Dentistry. Services include diagnostic, preventive, and therapeutic procedures provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers. There is currently a \$3000 annual service cap per person. Consumers are responsible for a small co-payment per service based on a sliding pay scale. The Part C project in southwest Indiana, Matthew 25 AIDS Services, does not currently provide oral health care services.

Other resources include an emergency dental clinic at Wishard Hospital and various assistance projects maintained by the local HIV Care Coordination sites throughout the state (funded largely by community support).

Indiana Medicaid covers the largest array of dental procedures. However, the program imposes a \$1000 annual cap on dental services per member. (Note that this cap has faced legal challenges recently and may be subject to change). Once this threshold is reached, the member must utilize other resources such as the low-income dental clinics. In the year ending 31 March 2012, more than \$400,000 was spent by Indiana Medicaid to provide dental services to more than 800 adults and children living with HIV.

4. Medical Case Management, including Treatment Adherence Services

The Division – using funding from the State, a block grant and, most recently, a Part B Supplemental award – currently operates a statewide network of 56 case managers stationed at 16 geographically diverse care sites. The HIV Care Coordination Program consistently provides comprehensive case management services to more than 4000 consumers seeking assistance per quarter.

The program consists of goal-oriented activities that serve to locate, facilitate access to, and monitor the full range of HIV-related services in cooperation with the client. It encourages the most cost-effective use of medical and community resources and promotes the overall well-being of the individual. It respects cultural diversity, emphasizes confidentiality, and strives to ensure the client's freedom of choice and self-determination. Its comprehensive and compassionate services are rendered in a safe, secure, and non-judgmental environment and are provided without cost to the client.

The primary goals of the HIV Care Coordination Program are to ensure the continuity of care, to promote self-sufficiency, and to enhance the quality of life for individuals living with HIV. This is achieved through the thoughtful coordination of services and the empowerment of the individual. The objectives of the HIV Care Coordination Program are:

- To promote a single point of access for a variety of health and human services;
- To develop an Individualized Care Plan (ICP) with the client;
- To link the individual's specific needs to the most effective services at the most appropriate time;
- To monitor all client referrals to ensure success;
- To identify gaps in services and to broker community resources to address service needs;
- To advocate on the behalf of clients for availability, timeliness, effectiveness, and appropriateness of services;
- To reduce the fragmentation and duplication of services;

- To contain costs through efficient utilization of services; and
- To monitor and review the client's needs and progress in relationship to the ICP, and to modify the plan as necessary.

As the gatekeeper for most Ryan White services, the largely state-funded HIV Care Coordination Program is integral to the HIV service continuum and strives to preserve continuity of care by adeptly assessing needs, strategically identifying resources, and diligently monitoring referrals. The Division currently expends approximately \$2.5 million annually to maintain its 16 care sites and related initiatives. No Part B base, ADAP, or ADAP Supplemental funds are used to provide this service.

In the TGA, the Part A program provides medical case management through contractual arrangements with three entities that also provide primary HIV medical care. Medical case management offered through Part A is distinct from the HIV Care Coordination Program. It is designed to intervene in the medical care of high-risk or non-compliant clients. It provides a limited range of services designed to retain clients in medical care. The coordination and follow-up of medical treatments is an essential component of medical case management. It strives to ensure timely and coordinated access to medically appropriate levels of healthcare through ongoing assessment of the client's understanding of and willingness to comply with established treatment plans. It includes the provision of treatment adherence counseling to ensure readiness for, and compliance with, complex HIV disease treatments. Key activities include assessment of adherence barriers; development of an individualized medical adherence plan; coordination of education and other interventions required to implement the medical adherence plan; client monitoring to assess the efficacy of the medical adherence plan; and periodic re-evaluation and adaptation of the medical adherence plan as necessary for the duration of the plan (usually 6-8 encounters). Additionally, the Part A program funds non-medical case management at four additional agencies in the Indianapolis area.

5. Mental Health Services

The Division's role in addressing mental health care is limited to the services available through HIAP and the associated insurance policy. HIAP enrollees are covered for only 30 outpatient visits per year for mental health and substance use issues combined. Inpatient visits are limited to a combined total of 180 days for major medical, mental health, and substance abuse treatment. Most psychotropic medications are covered. The cost of the HIAP mental health benefits is included in the allocation noted previously.

In the TGA, the Part A program funds four service providers to provide mental health services to eligible enrollees. Funded mental health services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the state to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers. The state's Part C programs do not currently offer mental health care benefits.

6. Substance Abuse Outpatient Care

Annually, Indiana's Department of Mental Health and Addiction (DMHA) receives an award according to Title 45, Part 96, Subpart L of the Code of Federal Regulations. DMHA subcontracts a small portion (\$1,125,000) of Indiana's award to the Division to implement Special Populations Support Program (SPSP) services. The Division, in turn, grants awards to specific entities in different communities throughout the state to perform the necessary testing and supportive care activities.

HIV-positive individuals are referred to the program's support specialists who engage the consumer with interventions designed to minimize substance use and maximize compliance with all applicable treatment plans. The specialists work closely with the local HIV Care Coordination agency to ensure that the consumer receives a full complement of quality care. SPSP also employs certified HIV testing counselors who have been specially trained to perform comprehensive risk assessments, pre-test counseling, testing, and post-test counseling with the substance using population. The testing counselors conduct their activities in a variety of diverse venues where the target population can be found, including the statewide addictions treatment facilities sanctioned by DMHA.

Overall, SPSP strives to minimize the negative impact of substance use on the health of persons at risk for or living with HIV disease. The Division currently funds a total of 13 agencies across the state to provide these free SPSP services. Each quarter, SPSP provides supportive care to more than 250 dually diagnosed persons and tests nearly 1500 high-risk individuals. No Part B funds are used to provide this service.

A complement to SPSP supportive care services, the Indiana Access To Recovery (INATR) program provides financial reimbursement for various treatment and support services to participating providers. INATR is funded

directly by the Substance Abuse and Mental Health Services Administration and is administered jointly by FSSA and Indiana's Office of Faith-Based and Community Initiatives. Currently, the program serves eleven counties, including Allen, Clark, Elkhart, Floyd, Lake, Johnson, Marion, Monroe, St. Joseph, Vanderburgh, and Vigo. Its target populations include those recently released from incarceration, drug-addicted women who are pregnant or have dependent children, methamphetamine addicts, military service personnel, and individuals who have recently signed an agreement with a diversion court. INATR provides its reimbursement based on a pre-determined fee schedule.

Reimbursable ATR clinical services include: clinical assessments, intensive outpatient, integrated treatment for co-occurring disorders, and detoxification. Recovery support services include: transportation, relapse prevention, addiction education, housing assistance, peer services, family and marital counseling, employment services, faith and community support, parenting services, supportive education, and alcohol and other drug screening. ATR allows for consumers to choose providers for services who have agreed to participate in the program and are well-versed in serving this challenging population.

The Division also addresses substance abuse treatment through HIAP and the associated insurance policy. HIAP enrollees are covered for only 30 outpatient visits per year for mental health and substance use issues combined. Inpatient visits are limited to a combined total of 180 days for major medical, mental health, and substance abuse treatment. The cost of the HIAP substance abuse treatment benefits is included in the allocation noted previously.

The Part A program has increased access to substance abuse treatment for eligible enrollees in the Indianapolis TGA. Its outpatient substance abuse program provides medical and counseling services to address addiction issues in an outpatient setting, rendered by a physician, by a professional under the supervision of a physician, or by other qualified personnel. Services are currently offered at two locations. The state's Part C programs do not currently offer substance abuse treatment benefits.

7. Emergency Financial Assistance

The Health Foundation of Greater Indianapolis provides emergency financial assistance statewide through the Gregory R. Powers Direct Emergency Financial Assistance (DEFA) program. With few exceptions, each HIV Care Coordination site receives funding according to the number of clients served within the previous 12-month period. The funding for the program comes primarily from the donations raised at the Indiana AIDS Walk which is held annually in Indianapolis. The funding is unique in that it may be used as needed for any emergency expense. Examples include such things as medication and other medical expenses, food, clothing, rent, utilities, and transportation expenses, including repairs. A request is submitted by the client to the HIV Care Coordinator and then goes to a committee for final approval in most cases. The amount funded to each HIV Care Coordination site varies from year to year depending on the success of the Indiana AIDS Walk. HIV Care Coordination sites are strongly encouraged to assist in the fund-raising efforts made by the Health Foundation of Greater Indianapolis. Since 1994, the foundation has become the largest private funder of HIV-related programs in Indiana.

The Part A program offers limited emergency assistance for utility costs and access to food (through the provision of food vouchers) for eligible enrollees who have exhausted all other resources. The Part B and C programs do not currently offer emergency financial assistance

8. Housing

There are no statewide housing programs operated with Ryan White funds in Indiana. HOPWA is the only major program for HIV-positive persons seeking housing and utility assistance. The Indiana Housing and Community Development Authority receives funding from the Office of Housing and Urban Development to administer the program. It then distributes allocations to the regional HIV Care Coordination sites to provide rental or emergency housing assistance to low-income HIV-positive persons living in their area. (Recipients must be actively engaged in case management services to qualify.) The duration of the assistance can range from one to twelve months, based on the determination of the project sponsors. The 2013 allocation for the state (excluding central Indiana) is expected to remain level at \$980,105.

The Department of Metropolitan Development (Division of Community Development and Financial Services) administers the HOPWA grant for the City of Indianapolis. This grant serves the Indianapolis Metropolitan Statistical Area of central Indiana, which includes Marion, Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Morgan, and Shelby Counties. The City of Indianapolis, as the fiscal agent, apportions these funds among several service providers in the region to provide the same type of housing assistance and support services that are available through the HOPWA program in the rest of the state. The City's HOPWA allocation for 2013 is \$831,882 which is a slight reduction compared to 2012.

9. Medical Transportation

Indiana is without an organized transportation solution for HIV-positive individuals. However, a few small programs are available in select areas. Various, limited modes of transportation are provided through Medicaid for eligible individuals. These services are provided only for medically necessary travel. In the TGA, medical transportation is provided through six independent transportation providers using Part A funds. The state's Part B and C programs do not currently offer medical transportation services.

While the continuum of HIV care in Indiana is strong – despite the identified barriers – funding reductions threaten to weaken key components, particularly those related to the HIV Care Coordination Program. Although essential to the service delivery system in Indiana, between 2001 and 2012, the program has experienced a cumulative reduction in funding of 20%. At the same time, the demand for case management services has increased by nearly 50%. In the first quarter of FY2001-2002, the program served 2705 unique HIV-positive clients; in the last quarter of FY2011-2012, the program served 4014 clients.

For FY 2013, the State of Indiana is expected to place an additional 3% reserve on all state funds. The result for the Division will be the further loss of \$61,624 in funding for this crucial service (bringing the cumulative decrease in funding since 2001 to 22%.) Even with the current Part B Supplemental funding, this will require the modification of contracts to eliminate more case managers, shrinking the total size of the program to only 54.5 case managers for the entire state. By eliminating more positions, the remaining case managers will experience even further increases in the size of their already challenging caseloads (averaging more than 70 active clients each). As caseload size increases, quality is in jeopardy of decreasing and clients of becoming more vulnerable to falling out of care.

Concurrently, while caseloads are growing and funding is shrinking, the landscape of HIV care in Indiana is shifting. A number of new and upcoming changes will require even more vigilance on the part of the case management staff to ensure that clients continue to have broad access to necessary medical care and support services.

Resource Inventory

In addition to funding, the continuum of care also is naturally dependent on the availability of quality service providers. The current resource inventory (Attachment A) describes the state's key provider(s) for each priority service need for each of the twelve defined service regions. The inventory, known as *Indiana's Practical Guide to HIV Resources*, also indicates how consumers can pay for the services and which are supported by Ryan White funding. These entities or programs were identified by CHSPAC members from the respective regions based on direct and – in most cases – extensive experience with the noted providers, making the inventory an invaluable directory of “HIV-friendly” resources. Use of the inventory by the HIV Care Coordination Program helps to ensure continuity of care and a positive experience for consumers.

Profile of Ryan White Providers*

As stated earlier, Indiana receives Part A, B, C, and F funds through the Ryan White legislation. Part A funds are awarded to the City of Indianapolis to serve the ten-county TGA surrounding Indianapolis. Part B funds are awarded to ISDH and administered by the Division. Part C funds are awarded to MCPHD and service an area roughly equivalent to the Indianapolis TGA. A second Part C provider, Matthew 25 AIDS Services, is based in Northern Kentucky but serves a section of Southern Indiana. Part F supports MATEC and its local performance site in Indiana. The vast majority of Ryan White funds are used to address the highest priority service needs: primary medical care and HIV-related medications.

1. Part A

MCPHD is the administrator for the Part A and Minority AIDS Initiative (MAI) funding within the Indianapolis TGA. These programs are administered by eleven staff: Director, two Business Coordinators, Project and Training Coordinator, MAI Community Liaison, MAI Health Education and Risk Reduction Program Coordinator, Planning Council Coordinator, Nurse Epidemiologist, Quality Management Nurse, Epidemiologist, and Data Manager. Collectively referred to as the Indianapolis Ryan White Services Program (RWSP), Part A, MAI, and Part C funding has been blended by MCPHD to increase access to and strengthen the HIV continuum of care. This design is consistent with HRSA's goals to reduce service barriers and decrease HIV-related health disparities among vulnerable populations and historically underserved communities. It is similarly consistent with the goals of the National HIV/AIDS Strategy.

The Director is responsible for overseeing all aspects of RWSP operations, including negotiating contracts, developing operational procedures and programmatic policies, supervising staff and subcontractor performance, and ensuring fiscal and program-specific monitoring (specifically support services). The Director acts as a liaison with internal departments and external entities such as federal, state, and local agencies and prepares and submits grants-related reports.

The Business Coordinators are responsible for internal reporting and fiscal monitoring with oversight from the Project Director. The positions monitor data and prepare reports on fiscal data from service providers and ensure that required reports are received in a timely manner and contain allowable costs. The Business Coordinators also compile utilization statistics, review monthly expenditure reports, process contractor requests for reimbursement, and conduct quality checks.

The Project and Training Coordinator provides trainings for all RWSP subcontractors and potential subcontractors. The position also is responsible for ensuring subcontractors compliance with programmatic and fiscal conditions of award. This position serves as the administrator and primary contact for a group of subcontracting agencies that provide direct HIV care services as allowed by the Ryan White Program's Part A, C, and MAI guidelines.

The MAI Community Liaison interacts with healthcare providers, conducts computer record searches, contacts clients by phone or in person, and documents the results of those inquiries. This position works with the Director and other staff to find eligible HIV-positive cases that are lost to care or not currently in care to provide clients a mechanism for entry or re-entry into HIV care. This position also identifies people who are at risk for HIV infection and are unaware of their HIV status. If the client tests positive, the Liaison assists the client in enrolling in treatment and supportive services. This position also actively assists in referring clients to medical and non-medical case management.

The MAI Health Education and Risk Reduction Program Coordinator is responsible for developing and implementing services that educate clients with HIV about how to reduce the risk of secondary transmission. This includes the provision of information about medical and psychosocial support services and counseling to help clients with HIV improve their health status. The position also is responsible for increasing health education services that target communities of color, specifically African Americans and Hispanics who are living with HIV.

The Planning Council Coordinator is responsible for providing guidance and capacity building assistance to members of the Part A planning body. This position facilitates development and attainment of the programmatic objectives, including fiscal oversight of planning council activities, coordination with the Part B advisory council, and providing administrative support to ensure the planning body completes its charge to assess the TGA's HIV service needs. This position also works with the planning body and program staff to establish priorities for allocation of funds, develops a comprehensive plan for the organization and delivery of HIV services that is compatible with existing state and local plans, and assesses the efficiency of MCPHD to rapidly allocate funds to areas of greatest need.

The Nurse Epidemiologist is responsible for the investigation of HIV and AIDS cases and application of control and prevention modalities. Responsibilities also include research, coordination, surveillance, evaluation, and provision of health education relative to prevention and control of infectious diseases. The Nurse Epidemiologist serves as a consultant to physicians, public health nurses, hospital infection control personnel, and the general public in matters related to HIV.

The Quality Management Nurse is responsible for implementing a clinical management plan to ensure that services are provided in accordance with Department of Health and Human Services (DHHS) guidelines and standards of care. This position institutes and monitors the indicators that the Part A quality management committee will use to evaluate outpatient and ambulatory services including the primary and secondary *HIV Core Clinical Performance Measures for Adults/Adolescent Clients*.

The Epidemiologist is responsible for providing the RWSP with epidemiological data in order to determine need and provides information to the Part A planning council for the determination of Priority Setting and Allocations. This position works with the Systems of Care Committee, Needs Assessment Committee, and Priority and Allocations Committee throughout the year to provide data – both epidemiologic and utilization – that allows the council to make decisions regarding the program and to comply with HRSA guidelines. This position also provides the Director and staff with data reports as requested, assists with the writing of all grants within the department through the provision of requested data, works to develop and maintain the resource guide for the TGA, assists with the completion and update of the Comprehensive Plan, and represents MCPHD in the community.

The Data Manager is responsible for the coordination of data through the MCPHD in-house data system and HRSA's CAREWare. This allows for the centralization of data, increases reliability of programmatic and financial data, and assists in the completion of measuring implementation plans. This position assists the Quality Management Program in the collection and evaluation of outpatient and ambulatory service data. The position

also works with the MAI program to collect and interpret data, develop and implement evaluation tools, and work with data to identify clients who have fallen out of care and are referred to the MAI outreach program.

RWSP implementation is achieved through collaboration between MCPHD and a variety of community partners throughout the TGA. Through this program, persons living with HIV have access to several core medical services as defined by HRSA, including primary outpatient medical care, pharmaceuticals, insurance assistance, mental health services, substance abuse services, oral health services, early intervention services, medical case management (including drug adherence counseling). Additionally, the program provides the following supportive services: non-medical case management, emergency financial services, legal services, linguistic services, medical transportation, outreach services, psychosocial support, and short-term emergency housing.

The Part A planning council has prioritized all of the allowable service categories as shown in Table F. (Note that some of these categories are not currently offered by the RWSP.) As result of this prioritization and collaborative planning between the RWSP and the Part B grantee, the RWSP has been able to provide a comprehensive continuum of care within the TGA, address the needs of newly infected and underserved populations, and ensure that clients who are out of care have greater access to points of entry. The results have been increased utilization of core and support services and improved retention in care.

Table F. Indianapolis TGA FY 2013 Service Priorities

1. Health Insurance Premium/Cost Sharing	14. Emergency Financial (Utilities)
2. Outpatient Ambulatory Medical Care Services	15. Emergency Financial (Food)
3. Local AIDS Pharmaceutical Assistance	16. Outreach Services
4. AIDS Drug Assistance Program	17. Legal Services
5. Non-Medical Case Management	18. Linguistic Services
6. Medical Case Management	19. Health Education/Risk Reduction Services
7. Oral Health Services	20. Nutrition Services
8. Medical Transportation Services	21. Food Bank/Home Delivered Meals
9. Early Intervention Services	22. Home Health Care Services
10. Psychosocial Support	23. Child Care Services
11. Mental Health Services	24. Hospice Care Services
12. Substance Abuse Services	25. Respite Care Services
13. Short Term Housing	

2. Part B

ISDH and the Division continue to have direct responsibility for administering programs funded through Part B of the Ryan White Program in Indiana. Operational activities are managed by the Division's HIV Services section. The Services Team consists of four Program Managers who report to the Services Coordinator. Each Program Manager oversees a specific HIV service component: Medical Services, Advisory Council Relations, Care Coordination, and Substance Abuse Services. (The two latter service components are not funded through Part B.) The team is augmented by necessary support staff. The Division consults with its advisory council for input on issues relative to Part B and state funds budgeted for HIV care programming. This advisory council consists of consumers and providers of HIV-related services, as well as members of the general public. The Division of Finance acts as the fiscal agent for all programs.

3. Part C

MCPHD houses the state's only Part C Program which serves the ten county Indianapolis Transitional Grant Area (TGA) which accounts for counties Marion Hancock, Hamilton, Hendricks, Johnson, Boone, Morgan, Shelby, Putnam and Brown. MCPHD provides outpatient early intervention services to residents living with HIV; these services include outpatient ambulatory/primary medical care, specialty care, at risk HIV counseling and testing, case management, oral health, vision services, pharmaceutical adherence education and consultation, and medical nutrition therapy. Although pharmaceutical adherence education and consultation and medical nutrition therapy are provided on a limited basis, they are vital to the growing population of patients being served. Early intervention services are provided in partnership with Wishard Infectious Disease Clinic, Wishard Emergency Room Department, and The Damien Center, Indiana University School of Dentistry, Indiana University School of Optometry and Community Walgreens Pharmacy. Specialty referrals are also made to providers outside the EIS provider network.

MCPHD employs two Part C Program staff: a Part C Project Director and a Part C Business Coordinator. The Director monitors and coordinates the activities of subcontractors to ensure that the goals and objectives of the Part C Program are carried out in accordance with federal guidelines and works in conjunction with the Part C Medical Director in regards to the Part C Continuous Quality Improvement (CQI) for the program. The Business Coordinator is responsible for the data entry and fiscal entries of the Part C program, including completion of

internal reporting and fiscal monitoring. This position monitors data, prepares reports, and ensures that required reports are received from service providers in a timely manner and contain allowable costs. The Business Coordinator also manages eligibility and enrollment, compiles utilization statistics, reviews monthly expenditure reports, processes contractor requests for reimbursement, and conducts quality checks.

In order to meet the needs of the community, the Part C Program provides early and easy access to primary medical care in neighborhoods most affected by HIV. Infected and at-risk populations can access services through neighborhood clinics and a hospital-based clinic. Once enrolled in MCPHD's Part C program, patients residing in the coverage area can access care at any affiliated provider regardless of the provider's geographic location.

The strength of Marion County's Part C program is derived from a coordinated system of care developed through collaborative relationships with a hospital based clinic, Marion County's largest AIDS Service Organization, University based oral health and optometry clinics and a community pharmacy.. This streamlined coordinated system of care provides access to quality primary care services and social services for the target population.

The Part C Program provides access to a variety of services, including outpatient ambulatory/primary medical care, infectious disease specialty services, and emergency pharmaceutical services. Referrals can be made for dentistry, gynecology, obstetrics, cardiology, psychiatry, podiatry, gastroenterology, neurology, dermatology, and ophthalmology. The program can also provide access to medical and non-medical HIV case management and nutrition education on a fee for service basis. Comprehensive oral health care is offered at a well-known University based oral health clinic: Indiana University School of Dentistry. Services are available to all clients with an annual cap of \$3,000 per year/per client unless pre-authorized by the RWSP to exceed the cap. Services include diagnostic, preventive, and therapeutic dental care that is in compliance with state dental practice laws, include evidence based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, are based on an oral health treatment plan, adhere to specified caps, and is provided by licensed and certified dental professionals.

Adherence education is a key component of routine medical visits and also of the general HIV counseling sessions provided to all newly diagnosed patients. The Part C Program pays the salaries of the clinicians at the Wishard Infectious Disease Clinic and Wishard Emergency Room Department and the staff funded under the Part C program at the Damien Center. Every patient prescribed ARV therapy (including those who change therapy) is counseled regarding aspects of medication adherence, including dosing, scheduling, food restrictions, storage, common side effects, and drug resistance due to non-adherence. Adherence counseling is also scheduled outside of clinic times for patients requiring intensive educational sessions. This includes specialized counseling regarding newer or complicated therapies for patients with identified barriers to adherence.

A second Part C project is funded in Henderson, Kentucky. The grantee operates a satellite clinic in Evansville to serve portions of southern Indiana. Matthew 25 AIDS Services provides HIV services at no cost or according to a sliding-scale fee schedule. The clinic has the ability to bill third-party insurance including ICHIA, Medicare, Medicaid, and other private insurance. Their services include: primary HIV medical care, adherence counseling, comprehensive risk counseling, HIV testing, transportation assistance, and a food pantry. Specialty referrals can be made for substance abuse, dental, and psychiatric care. Matthew 25 is also a Part D grant recipient.

4. Part F

Indiana is not a direct recipient of Part F funding. Indiana is served by MATEC which is located at the University of Illinois at Chicago. MATEC has a local performance site in Indiana housed at Wishard Health Services, a division of the Health and Hospital Corporation of Marion County. The site is known as MATEC Indiana.

MATEC Indiana collaborates with all Ryan White Program grantees. It is represented on both the Part B grantee's advisory council and the Part A grantee's planning body. MATEC Indiana uses information acquired from these meetings to guide training initiatives throughout the state. This includes targeting and training clinicians in regions of Indiana that report limited access to medical, dental, and pharmaceutical providers.

Capacity Development Needs

Due to the nature of the insurance-based service delivery system in Indiana, additional needs related to capacity development deficits resulting from disparities in the availability of services in underserved and rural communities have not been specifically documented. A description of the identified service and care needs, however, does appear in Section 1, Part 1.

Allocation Priorities

The majority of the Part B award is dedicated to the operation of the HIV Medical Services Program which is available to any eligible applicant living in any geographic region of the state. Part B allocations are not impacted by demographics. The specific allocations per program component appear earlier in this section under *Continuum of Care*.

Prevention Programming*

A complete continuum of care must account for HIV prevention interventions, testing, and linkage to care. To address these issues, the Division relies on its HIV Prevention and HIV Care Coordination Programs and the recently developed strategy to identify HIV-infected persons earlier in their disease process. Relevant features of the two programs are described below, followed by a detailed overview of the early identification strategy.

1. HIV Prevention Program

ISDH administers 24 grant-funded projects through its HIV Prevention Program. These projects provide an assortment of prevention interventions, including traditional Counseling, Testing and Referral (CTR) Services; Partner Services; Group Level Interventions; Outreach; Disease Intervention Services; and Comprehensive Risk Counseling Services. An additional 15 agencies providing CTR Services receive only in-kind support from ISDH. Overall, the program serves 60 of the 92 counties in Indiana.

The HIV Prevention Program collaborates regularly with other programs within the Division to improve service provision. The program's Comprehensive Risk Counseling Services program is a standard referral used frequently by the HIV Care Coordinators for clients who have been assessed as having an exceptional potential for continued high-risk sexual behavior. The HIV Prevention Program also includes Perinatal Hepatitis B components which provide comprehensive services to individuals at risk for or diagnosed with Acute Hepatitis B.

The HIV Prevention Program recently began to implement expanded HIV testing services in medical settings, with the goal of increasing the availability of HIV testing within the context of routine medical care for populations at increased risk for HIV who would not otherwise seek or receive testing services. Additionally, and in keeping with the goals of the National HIV/AIDS Strategy, the program is joining the CDC in its adoption of a "High-Impact Prevention" approach to reducing new HIV infections. The CDC believes that "by using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to increase the impact of HIV prevention efforts...for all Americans at risk for HIV infection, including gay and bisexual men, communities of color, women, injection drug users, transgender women and men, and youth." The approach relies on an increased focus on transmission prevention efforts with HIV-positive individuals and will require a subtle paradigm shift for both the HIV Prevention Program and its grantees which have traditionally focused more heavily on prevention interventions with high-risk HIV-negative individuals. However, despite these exciting new initiatives, there persists to be a lack of sufficient funds to support adequate statewide Comprehensive Risk Counseling Services or to develop new linkage to care programs for newly identified HIV-positive individuals.

In reviewing the epidemiological data, the importance of funding for effective prevention programs is evident. Blacks continue to be the most disproportionately affected group and, for the seventh year in a row, two-thirds of the prevalence population is over 40 years of age. The largest risk group continues to be composed of men who have sex with men. It is clear that the lack of funding for prevention programming translates into more positive cases and, therefore, more people needing services in Indiana.

2. HIV Care Coordination Program

In addition to the projects managed by the HIV Prevention Program, the Division's HIV Care Coordination Program launched an initiative in 2009 to incorporate into the social service setting a prevention technique that had been proven effective in clinical settings. The *Partnership for Health* intervention offers an evidence-based approach to integrating a healthcare provider-delivered behavioral intervention to HIV-positive patients each time they visit the provider. The intervention is short, usually taking only four minutes of time, and uses a technique called 'loss-framed' or 'consequence-framed' messages delivered to the HIV-positive patient by the provider.

In its clinical application, the *Partnership for Health* intervention uses the outpatient clinic and healthcare providers to provide brief behavioral prevention messages with each clinic visit. *Partnership for Health* uses message framing, repetition of the message, and reinforcement during patient visits to increase HIV-positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention. These techniques now have been modified for use in the HIV Care Coordination setting.

The *Partnership for Health* intervention was originally tested in a quasi-experimental design in which clinics were randomized according to the manner in which the prevention message was framed: two clinics used the “gain-frame message,” two clinics used the “loss-frame message” (also called the consequence-framed message), and two clinics used standard patient education. Patients in the clinics offering the “loss-framed” message demonstrated significantly fewer HIV risk behaviors than did patients in the clinics that used the ‘gain frame messages’ or standard patient education. Further analysis at the individual patient level indicated that patients who had two or more sex partners or at least one casual partner and who received consequences-framed messages were significantly less likely to engage in unprotected anal or vaginal sex.

In practice at the care sites, the case manager conducts a brief screening for risky behavior, and if the client reports engaging in risky behaviors (unsafe sex or injection practices), the case manager should provide an appropriate brief prevention message. This message may include:

- A general prevention message;
- A tailored message that addresses behaviors or concerns specific for the client;
- Correction of misconceptions about risk; and/or
- Reinforcement of steps the client has already taken to decrease risk for HIV transmission.

Prevention messages stress that the only ways to ensure that HIV is not transmitted are abstinence or sex with a partner of concordant HIV serostatus. However, clients are informed that sex with partners of concordant HIV serostatus does not protect against other sexually transmitted diseases or re-infection with HIV. For sexually active clients, condom use is the safest way to prevent transmission or acquisition of HIV and other sexually transmitted diseases. Clients are also made aware of the importance of disclosing their HIV serostatus to potential sex partners.

Finally, the messages are dynamic. Providers recognize that risk is not static. Clients’ lives and circumstances change, and their risk of transmitting HIV may change from one encounter to another. Therefore, screening and providing risk-reduction messages occur at every visit unless the client has other needs that take precedence.

3. Early Identification of Individuals with HIV/AIDS Strategy

The following is a truncated version of the EIIHA strategy submitted to HRSA in the response to funding opportunity HRSA-13-158.

a. Strategy

Because the Division’s HIV Services section does not allocate Part B funds to conduct case finding activities, it relies on its Special Populations Support Program to identify HIV-positive individuals who were previously unaware of their status. As noted earlier in this section under *Continuum of Care*, DMHA receives an annual award according to Title 45, Part 96, Subpart L of the Code of Federal Regulations. DMHA subcontracts a portion of Indiana’s award to the Division to implement SPSP services. The Division, in turn, grants awards to specific entities in various communities throughout the state to perform the necessary testing and supportive care activities.

SPSP employs certified HIV testing counselors who have been trained to perform comprehensive risk assessments, pre-test counseling, testing, and post-test counseling with the substance-using population. The counselors conduct their activities in a variety of venues where the target population can be found, including the statewide treatment facilities sanctioned by DMHA. Each quarter, SPSP tests nearly 1500 high-risk persons. Using this targeted case identification strategy, the program intends to achieve a positive test rate of at least 1%.

i. Strategy Description

1. Itemization of Goals

Operationally, SPSP aims to accomplish three goals through its targeted HIV testing service. First, understanding that the majority of tests will yield a negative result, SPSP seeks to maximize the service’s potential to reduce the occurrence of new HIV infections among persons with substance abuse concerns. Test subjects are provided thorough pre-test counseling to identify all potential risks for infection and to formulate individual strategies to reduce those risks. After testing, non-reactive subjects are again provided counseling to reinforce the earlier harm reduction messages.

Second, by targeting the testing service to known or assumed substance users (including those having used injection drugs) and by conducting a risk-specific screening during the pre-test counseling session, SPSP seeks to maximize its ability to identify new HIV cases among those who were previously unaware of their status. Test subjects are interviewed to determine if substance use has impacted their risk for HIV infection; those found to be at low risk are provided counseling

and education but are not recommended for testing. Those confirmed as being at high risk are provided an immediate blood test for HIV. Those with concomitant risks for syphilis and Hepatitis C receive those diagnostic tests as well.

Third, by providing these targeted testing services within the larger construct of the HIV service delivery system in Indiana, SPSP seeks to maximize its potential to ensure that newly identified cases of HIV are provided access to care and support services. All of the SPSP testing sites maintain a cooperative relationship with their region's HIV Care Coordinators. In fact, nearly all of the testing sites are physically co-located within the same agency as the HIV Care Coordination programs. Following the post-test counseling session, those detected as positive are immediately referred to the local HIV Care Coordinator who will begin the process of assessing the subject's needs and any barriers to accessing medical care. Once the client's initial care plan has been established, the case manager makes the appropriate referrals for medical care and other needs and, thereafter, monitors the plan's progress, making adjustments as necessary to ensure optimal health outcomes for the client. HIV Care Coordinators are specifically trained to assess at each contact the client's ability to obtain medical care and adhere to prescribed medications.

a. Consistency with National HIV/AIDS Strategy

In July of 2010, the Obama Administration issued the National HIV/AIDS Strategy. This comprehensive document detailed three primary goals for impacting the HIV epidemic in the United States. The strategy's three goals are: reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV-related health disparities.

Though established earlier than the National HIV/AIDS Strategy goals, the SPSP goals are clearly aligned with the intent of the national strategy. Both are interested in reducing risk through education, engaging individuals in the healthcare system as immediately as possible in hopes of realizing optimal health outcomes, and focusing efforts on those most at risk for infection and least likely to receive care without intervention.

b. Consistency with EIIHA Mission

Of SPSP's three primary goals, the second is exclusively concerned with the identification of new cases. It is designed to maximize resources as well as the potential for case discovery. The first goal is more strongly related to prevention and education concerns. The third is focused on post-discovery referrals and linkages to care.

2. Community Coordination

By design, SPSP outreach, education, and testing services are regularly offered in community settings. Examples of common traditional and non-traditional venues for outreach include drug courts, probation and parole offices, neighborhoods with high rates of drug crime, neighborhoods with high rates of sex trafficking, and locations identified by another newly seropositive person in the course of contact tracing. Examples of common forums for conducting risk-awareness education include addiction treatment centers, methadone clinics, mental health treatment centers, and correctional facilities.

As a condition of award, SPSP testing counselors are required to offer testing services to all known persons seeking substance abuse treatment in the regional DMHA-certified facilities. All newly admitted patients are provided with the full range of Early Intervention Services (as defined in CFR Title 45, Part 96), which includes a comprehensive risk assessment, HIV pre-test counseling, HIV testing, specimen submission to the state laboratory for processing, HIV post-test counseling, submission of positive case reports to OCDR, appropriate referrals dependent on the test results, and diligent follow-up on all such referrals. The average pre-test counseling session's duration is to be no less than 20 minutes; the average post-test counseling session is to be no less than 15 minutes. The testing counselor may also offer testing to diagnose the extent of immune system deficiency and testing to provide information on the appropriate therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from HIV disease. All tests administered by the testing counselor are provided free of charge to the patient. Examples of beneficial additional tests include those designed to detect syphilis, Hepatitis C, tuberculosis, Hepatitis B, CD4 level, viral load level, genotype, and phenotype.

The testing counselors also offer testing services to persons seeking substance abuse treatment in other facilities (including private methadone clinics) and to any person determined to be at risk for HIV infection and substance use. All persons seeking testing are provided with the full range of

Early Intervention Services and any appropriate additional tests (as described in the preceding paragraph). Again, all tests administered by the testing counselor are provided free of charge.

3. Requests for Proposals

Because the Division's Part B award is allocated exclusively to the provision of HIV medications and insurance assistance, the EIIHA strategy described herein has no impact on Part B-related Requests for Proposals.

4. Provider Contracts

Similarly, because the Division's Part B award is allocated exclusively to the provision of HIV medical services, the EIIHA strategy described herein has no impact on Part B-related contracts.

5. ADAP Considerations

Based on the nominal impact that rapid testing and federal prevention initiatives have made on enrollment, the Division hesitates to predict an immediate sizeable increase in assistance requests due to the development of this EIIHA strategy. (This is also partly due to the fact that SPSP testing services and subsequent referrals to care pre-date the development of this strategy by nearly a decade.) Considering that the number of new cases reported to OCDR between 2010 and 2011 has increased by only 1% and that the HIV Medical Services Program is currently operating without a waiting list and appears to be capable of absorbing an increase in new applicants, the appreciable effect of the EIIHA strategy on ADAP is expected to be minor.

6. Subpopulation Disparities

The targeted case finding activities performed by the SPSP testers are coordinated to enhance the program's ability to reach marginalized subpopulations and underserved groups. In the third quarter of FY 2012, the majority of test subjects indicated active substance use, and 50% identified injection drug use as their primary risk factor. Subjects were severely impoverished (with 82% earning less than \$10,000 annually), and most (69%) presented with concomitant risks for Hepatitis C. Twenty-eight percent of the subjects were non-White, and 36% were female. Only 15% revealed a sex-related risk other than heterosexual activity.

7. Challenges

For SPSP, the primary challenge associated with identifying those at risk due to substance use is the illicit nature of the behavior itself. As an illegal activity, there is a natural reluctance to disclose it. Contact tracing presents its own challenges as both sexual and needle-sharing partners must be considered. Anonymous partners and the frequent lack of definitive locating information pose serious limitations to exhaustive contact tracing efforts for initial testing.

Lack of sufficient, accurate locating information (collected during the pre-test counseling session) is also the most common challenge faced by staff when attempting to locate and deliver a positive HIV test result to someone – regardless of subgroup – who has failed to return to the test provider. In accordance with Indiana Administrative Code 410 IAC 1-2.2-7, all newly identified HIV cases are reported to OCDR and then assigned to a regional DIS. The specialist is then responsible for ensuring that the individual is aware of the result and is offered Partner Counseling and Referral Services, which include referrals to HIV Care Coordination, explanation of Indiana Code 16-41-7-1 (the "Duty To Warn" law), partner notification assistance, and partner testing. DIS staff will pursue several avenues including seeking additional information from the test provider, neighbors, the U.S. Postal Service, and social media websites. However, if the subject cannot be located within 30 days, the case is necessarily closed.

Indiana currently does not have a coordinated system to notify individuals of negative HIV test results if they do not return to the test provider for the post-test counseling session. This is true for all subpopulations and is primarily a function of limited funding, limited capacity, and a reluctance to initiate delivery of results by telephone.

A final challenge concerns referrals. Within the context of targeted testing, staff must be cognizant of subjects' readiness to engage the care system. Often, the subject has not actively sought testing and, therefore, has not fully prepared for the possibility of an unfavorable result. Without the proper monitoring, referrals made under these circumstances can be prone to failure.

8. Promotion of Routine Testing

The CDC recommends that diagnostic HIV testing and opt-out HIV screening be a part of routine clinical care in all healthcare settings. The recommendations are intended for providers in all healthcare settings, including hospital emergency departments, sexually transmitted disease (STD) clinics or other venues offering clinical STD services, tuberculosis clinics, substance abuse treatment clinics, public health clinics, correctional healthcare facilities, and primary care settings. SPSP supports the CDC recommendations by providing testing services primarily in substance abuse treatment settings throughout the state.

9. Coordination with Part C Counterpart

In Indiana, the Part C grantee is MCPHD which also administers the Part A grant. MCPHD has blended its Part A and Part C funding sources to create a single, comprehensive program. The Division's coordination with MCPHD is best understood in the context of the Part A service model and is, therefore, described later under *Identifying, Informing, Referring, and Linking*.

ii. Estimate

The number of living HIV-positive individuals who were unaware of their status as of 31 December 2010 can be calculated as " $(p/1-p) \times N$ " where **p** equals the national proportion of undiagnosed HIV cases (21%), and **N** equals the number of individuals living with HIV as of 31 December 2010 (9837). The calculation for Indiana is: $(.21/.79) \times 9837 = 2615$.

b. Plan

Through its narrowly targeted HIV testing efforts, SPSP aims to impact high-risk substance-using individuals. The subgroups which are specifically addressed are injection drug users and individuals identified by other newly seropositive persons in the course of SPSP contact tracing.

i. Promotion of HIV Testing

1. Coordination

Through the contracting process, SPSP testing activities are coordinated with the Division's HIV Prevention Program to avoid duplication of service and effort. SPSP grantees include not-for-profit entities, county health departments, and mental health treatment centers. Each works within its local community to market and deliver testing services to the target population. This is achieved by close collaboration between the grantees and local correctional facilities, drug courts, probation and parole offices, and other venues where high-risk individuals may be located.

2. Role of Early Intervention Services

As noted earlier, Early Intervention Services (as defined in CFR Title 45, Part 96) are fully incorporated into the SPSP service delivery model and have served as an important framework to promote effective HIV screening and referral activities..

3. Role of Outreach

In Indiana, no Part B funds are allocated for Outreach as defined by HRSA. However, SPSP services are designed to achieve a similar goal: to identify those who are HIV-positive but not accessing the full array of available services for which they may be eligible. Through its close connection with the Division's HIV Care Coordination Program, it also shares many of the objectives of HRSA's Outreach service category which include decreasing the number of individuals who know their status but are not in care, reducing any barriers to entry into medical treatment, and improving follow-up and retention.

ii. Identifying, Informing, Referring, and Linking

Since its inception, the SPSP service model has been based on the concept of identifying those most at risk, informing them of their status, referring them to the appropriate resources, and linking those found to be HIV-positive to the HIV Care Coordination Program and, thereafter, medical care.

1. Identifying

The subgroups which are specifically addressed by the Division's SPSP activities are limited to high-risk individuals with drug-related risks of contracting HIV and individuals identified by other newly seropositive persons in the course of contact tracing. This strategy of intensely targeted testing is currently applied by the Division's HIV Prevention Program for other high-risk groups, including those engaging in high-risk sexual activity; however, it is not immediately applicable to the subgroups of untested individuals with low-to-moderate risks or to the population of tested individuals who have not been notified of their status.

To address the low-to-moderate risk subgroup, the HIV Prevention Program strongly supports universal testing as a component of routine medical care. To address those who have been tested but not informed of the result, the Division employs its DIS network to ensure that the individual is made aware of the result and offered Partner Counseling and Referral Services. In the interest of space, the remainder of this EIIHA plan will focus only on the specific subgroups targeted by the SPSP testing counselors.

a. Essential Activities

The activities listed below are considered to be essential to the process of identifying those at high risk due to drug use. All of these activities are currently being implemented by the SPSP testing counselors. No proposed activities have been delayed.

- **Venue Identification.** The SPSP testing counselor identifies all of the DMHA-certified treatment facilities within the local service region; identifies other treatment facilities or venues where individuals at high risk of HIV infection and substance abuse may be encountered; and identifies various traditional and non-traditional locations in diverse communities where high-risk individuals can be targeted for intensive outreach activities.
- **Targeted Individual Outreach.** The counselor delivers individualized, focused behavioral intervention and prevention messages in an effort to lower the risk of persons identified as being at disproportionately high-risk and provides these same individuals with access to additional education, HIV testing, and substance treatment referrals.
- **Group Educational Presentations.** The counselor performs regular educational presentations to small and large groups in each of the local DHMA-certified treatment facilities. Similar presentations are frequently given to groups in non-certified treatment facilities and other appropriate venues.
- **Counseling and Testing.** The counselor regularly offers testing services to all new patients of the local DHMA-certified facilities, preferably within five working days of notice of admittance; offers testing services to individuals in other facilities or venues in an expeditious manner; conducts comprehensive individual pre-test counseling interviews to determine actual risk and need for HIV testing; assesses other potential risks and the subsequent need to receive additional STD testing and refers accordingly; elicits preliminary partner information; utilizes a venipuncture technique to collect the test specimen; and immediately submits each blood specimen to the state laboratory for processing.

b. Coordination with Part A Counterpart

The Division enjoys a close relationship with the state's Part A grantee. The Part B Director recently completed his term as chair of the Part A planning council while the Part A Director has been an active, voting member of the Part B advisory council. The Part A grantee is fully aware of the SPSP testing services and makes concerted efforts to avoid any service duplication.

Because the HIV Services section's EIIHA efforts are exclusively aimed at the identification of new cases among the state's high-risk substance-using population, coordination with the Part A grantee has been accomplished with minimal effort. Where SPSP activities are narrowly focused but broadly implemented, the Part A grantee targets a wider array of individuals at risk but does so in a much smaller geographic region (the transitional grant area). Within this area, SPSP testers and the Part A grantee each target a different set of venues for outreach, education, and testing, but both adhere to the procedural guidelines established for HIV testing by the HIV Prevention Program at ISDH.

c. Coordination with State Prevention Programs

Annually, the Division submits a funding proposal to the CDC under funding opportunity #CDC-PS10-1001 for HIV Prevention Projects. The Division's HIV Prevention Program strives to promote health and enhance quality of life for Indiana residents through the prevention, intervention, and early treatment of HIV and other sexually transmitted diseases. Because the HIV Prevention Program and SPSP are both housed within the Division, internal coordination without supplanting funds is possible through a pro-active, cooperative planning process.

The HIV Prevention Program is charged with conducting large-scale activities to detect and prevent new HIV infections. With guidance from its Community Planning Group, the program has established five priority populations for 2013: people living with HIV; Black heterosexual women; and Black, White, and Hispanic homosexual men. In an effort to identify these

individuals, the HIV Prevention Program supports a number of statewide initiatives through its CDC allocations. Current CDC-approved projects and activities include Counseling, Testing and Referral (CTR) Services; Partner Counseling and Referral Services; Comprehensive Risk Counseling and Services and other programs targeting HIV-infected persons; Health Education and Risk Reduction activities; a unique perinatal HIV transmission prevention project; and an assortment of public information programs.

Contractors working in the HIV Prevention Program performed nearly 17,000 HIV tests between 1 July 2011 and 30 June 2012 and discovered 100 new cases. During the same period, SPSP staff performed 5475 tests and discovered 11 new cases.

2. Informing

All subgroups tested in Indiana – including high-risk individuals with drug-related risks of contracting HIV and individuals identified by other newly seropositive persons in the course of contact tracing – are ultimately informed of a positive HIV test result in the same manner. Even for those individuals who had previously received the result directly from the test provider, OCDR requires the local DIS staff to contact and interview all new cases of HIV and to offer Partner Counseling and Referral Services.

a. Essential Activities

The activities listed below are considered to be essential to the process of providing test results to those identified during the pre-test counseling session as high-risk due to drug use. All of these activities are currently being implemented by the SPSP testing counselors. No proposed activities have been delayed.

- **Return Appointment.** As a component of the pre-test counseling session, the SPSP testing counselor schedules with the subject a date and time for the post-test counseling session.
- **Documentation of Results.** The counselor regularly reviews all test results as they are released via the electronic system used by ISDH to deliver such information.
- **Post-Test Counseling.** When the subject presents for the return appointment, the counselor conducts an individual post-test counseling interview to deliver the test results, assess retention of prevention messages, reiterate those messages, and provide any necessary referrals. In the event that the subject fails to present, the counselor makes repeated attempts to locate and notify those who have a positive result before the case is submitted to OCDR.
- **Partner Notification.** Working with the subject, the counselor attempts to provide counseling and testing services to individuals named as partners of any person whose test results return positive.

b. Coordination with Part A Counterpart

Guidelines for providing notification of positive results to test subjects have been established by the HIV Prevention Program at ISDH. Both SPSP and the projects supported by the Part A grantee are expected to comply with the ISDH policies which require test results to be provided to subjects privately, in person, and in the context of a post-test counseling session. Additionally, all newly identified HIV cases are reported to OCDR and assigned to a DIS who is responsible for ensuring that the individual is aware of the result and offered Partner Counseling and Referral Services.

c. Coordination with State Prevention Programs

All testing providers funded by the Division are expected to deliver results to subjects privately, in person, and in the context of a post-test counseling session. All newly identified HIV cases are reported to OCDR and then assigned to a DIS who is responsible for ensuring that the individual is aware of the result and offered Partner Counseling and Referral Services as explained earlier. Internal program coordination between the HIV Prevention Program and SPSP is achieved each year without supplanting funds through a cooperative planning process. Of the 100 new cases discovered by HIV Prevention contractors between 1 July 2011 and 30 June 2012, results were provided directly to 88 of these individuals. Of the 11 new cases discovered in the same period by SPSP staff, results were delivered to ten individuals.

3. Referring

ISDH requires testing providers to ensure that all persons testing HIV-positive are immediately referred to care. This referral is a routine component of the post-test counseling session. Providers are expected to arrange for a local HIV Care Coordinator to be available for the session whenever possible. If an HIV Care Coordinator is unavailable, the provider is expected to issue a written referral to HIV Care Coordination and to actively monitor the referral to ensure its success. Once linked to the HIV Care Coordination system, the person will receive the full range of case management services according to the individual's level of need. These services will include, but are not limited to, a complete bio-psycho-social assessment and monitored referrals to medical care.

a. Essential Activities

SPSP testing counselors follow the standard program guidelines when making a referral to HIV Care Coordination. During the post-test counseling session with a newly identified HIV-positive person, the counselor is expected to introduce the concept of HIV Care Coordination services. Following the session, the patient is immediately referred to a local HIV Care Coordinator who will begin the process of assessing the subject's needs and any barriers to accessing medical care. Once the client's initial care plan has been established, the case manager makes the appropriate referrals for medical care and other needs and, thereafter, monitors the plan's progress, making adjustments as necessary to ensure optimal health outcomes for the client. All of these essential activities are currently being implemented by the SPSP testing counselors. No proposed activities have been delayed.

b. Coordination with Part A Counterpart

ISDH requires testing providers (including those funded through Part A) to ensure that all persons testing HIV-positive are immediately referred to care. This referral is a routine component of the post-test counseling session. Additionally, the Part A grantee's MAI project is available in the transitional grant area to further assist in ensuring that newly diagnosed individuals are successfully connected to care. Whenever a tester is unable to confirm a successful referral to HIV Care Coordination, the MAI project can be employed to locate the subject and, when appropriate, escort them to care. Since last year, the Part A grantee also has increased its support of non-medical case management services within the transitional grant area. This additional funding has been used to supplement the area's existing HIV Care Coordination services. Finally, the DIS network provides the subject a redundant opportunity to connect to the care system during the legally required offering of Partner Counseling and Referral Services.

c. Coordination with State Prevention Programs

The Division has strategically funded many agencies throughout the state to provide both HIV Care Coordination and CTR or SPSP services. Co-location of services is considered a "best practice" for ensuring that all persons testing HIV-positive are immediately referred to care. This referral continues to be a routine component of the post-test counseling session. The CTR and SPSP providers who are not co-located are expected to initiate referrals to the local HIV Care Coordination agency according to ISDH policy as detailed in the preceding section. Once linked to the HIV Care Coordination system, the person will receive the full range of case management services, including a complete bio-psycho-social assessment and monitored referrals to medical care.

In 2010, a newly strengthened protocol was enacted, requiring all DIS staff and HIV testing counselors to actively arrange for the HIV Care Coordination referral for newly diagnosed persons and to follow up on every referral to ensure its success. A new referral card was developed specifically for this purpose, and the program's database was updated to allow for these referrals to be documented. Since the implementation of this single protocol, successful referrals have increased by 3% (from 31% to 34% of all informed HIV-positive test subjects).

For high-risk persons testing HIV-negative, the HIV Prevention Program has developed a specific policy requiring the testing counselors to refer any HIV-negative person who presents for repeated testing with no indication of risk-mitigating behavior change to risk counseling services. Such services are provided free of charge and concentrate on harm reduction and risk management.

4. Linking

For any of the identified subgroups, the single most important element to ensure a successful referral is follow-up on the part of the test provider. Timely follow-up allows each provider additional opportunities to redirect the subject to the intended service.

a. Essential Activities

Following the initial referral, SPSP testers are expected to contact the HIV Care Coordination site within ten working days to determine the success of the referral. Because a Release of Information is always obtained from the potential client during the post-test counseling session, unsuccessful referrals can be investigated further by the local HIV Care Coordination provider or the DIS. Once enrolled, the client's ability to access care will be assessed by the HIV Care Coordinator, and eligible clients are referred to the HIV Medical Services Program. The HIV Care Coordination Program is the exclusive gateway to these services, and all new applications must originate from a sanctioned care site where quality control measures can be enforced. HIV Care Coordinators are notified by ISDH when clients in their care are approved for service benefits.

All of these essential activities are currently being implemented by the SPSP testing counselors and the HIV Care Coordinators. No proposed activities have been delayed.

b. Coordination with Part A Counterpart

ISDH policy stipulates that referrals to care are monitored for successful completion. In the context of the post-test counseling session, providers (including SPSP testers and the Part A grantee) are expected to complete the following steps: provision of information about the importance of early entry into care; contacting the HIV Care Coordination site of the subject's choice to schedule an initial appointment; provision of a printed referral card; collection of a signed Release of Information to be provided to the HIV Care Coordination agency; contacting the subject by telephone prior to the appointment as a reminder; and re-contacting the HIV Care Coordination site within ten working days of the scheduled appointment to determine the success of the referral. With a valid Release of Information, unsuccessful referrals can be investigated by the local HIV Care Coordination provider or DIS, if necessary. Throughout the implementation of the ISDH testing policies, coordination between the Division and the Part A grantee has remained exemplary.

c. Coordination with State Prevention Programs

ISDH policy – which applies equally to SPSP and CTR providers – stipulates that referrals to care are monitored for successful completion as described in the paragraph above. Coordination of efforts between the programs remained strong throughout the past year. As evidence, OCDR estimates that 75.1% of the HIV-positive persons identified, informed, and referred have also been linked to care.

5. Post-Referral Verification

Post-referral verification is a component of the current protocol. Specifically, counselors are trained to contact the newly identified HIV-positive individual by telephone prior to the scheduled HIV Care Coordination appointment as a reminder and to answer any additional questions. Counselors also contact the HIV Care Coordination site within ten working days of the scheduled appointment to determine the success of the referral. Again, these essential activities are currently being implemented by the SPSP testing counselors. No proposed activities have been delayed.

6. Post-Referral Provider Relationships

Most persons testing HIV-positive are referred to the HIV Care Coordination Program first. A referral for medical care is usually made following a full assessment of the client's needs and resources. Like all referrals made by the HIV Care Coordinator, those for medical care are closely monitored to ensure successful completion. Staff remind clients of upcoming appointments, confirm that transportation arrangements have been made, and immediately evaluate the success of the referral through direct contact with the client. In the event of incomplete or unsuccessful referrals, alternate arrangements can be made for the client. Case managers are expected to make no fewer than three reasonable attempts to follow-up on all referrals and to document these attempts in the program's electronic database. These essential activities are currently being performed by the HIV Care Coordination staff. No proposed activities have been delayed.

7. Potential Legal Barriers to Routine Testing

The Division has identified no legal barriers to the type of targeted testing conducted by the SPSP providers.

Statewide Comprehensive Plan Evaluation*

Based on the review completed by the Part B grantee and its advisory council's Evaluation Committee in April 2013, the grantee – working in collaboration with the consumers and providers serving on the council – achieved 119 (93.97%) of its 128 primary objectives identified for 2012. Another five (3.90%) objectives were partially achieved, most of which are scheduled to be addressed in the next fiscal year in order to fully complete. Only four objectives (3.13%) were not achieved, three of which were suggested for removal. To create the most useful document possible, these and any other objectives identified as superfluous have been removed for 2013.

Major successes include the creation of a concise, user-friendly HIV Services brochure for the Division, new adherence materials incorporated into the HIV Medical Services Program, and the implementation of a new oral health care solution. Some minor challenges remain in the areas of seamless coordination of materials between the Ryan White grantees and the education of certain providers by Part F based on information supplied by the Part B grantee. To overcome these challenges, the Part B grantee intends to continue working closely with the Part A, C, and F providers. Efforts will first be concentrated on the distribution of the new combined service brochure that includes Part A and C programs along with those offered by the Part B grantee. Concurrently, the Part B and F grantees will develop procedures to conduct individual training and education with identified medical professionals following the Part B's annual quality management review.

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Section 2 – OPTIMAL SYSTEM OF CARE

Guiding Principles

The Ryan White Program grantees and providers are committed to conscientiously addressing Indiana's Statewide Coordinated Statement of Need and to improving the continuum of care. Providing the highest quality services in a cost-effective and equitable manner is a primary concern. Equally important is a commitment to serving those with the least resources, both in monetary terms and with respect to access to services.

Recommendations for System Improvements

In 2006, HRSA issued a new list of allowable services, divided into 13 "core medical services" and 16 approved "support services." The core medical services consist of: outpatient and ambulatory health services; ADAP treatments; local AIDS pharmaceutical assistance; oral health care; early intervention services; health insurance premiums and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community-based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services. HRSA's support services include: non-medical case management; child care services; emergency financial assistance; food bank and home-delivered meals; health education and risk reduction efforts; housing; legal services; linguistic services; medical transportation services; outreach services; psychological support services; referral for healthcare and supportive services; rehabilitation services; respite care; treatment adherence counseling; and residential substance abuse treatment. The optimal continuum of care would address each of these areas of need by providing the most comprehensive services possible to the greatest number of high-need HIV-positive individuals.

While Indiana has successfully provided for some of these needs, significant barriers and limitations still exist. Advisory board members have developed the following recommendations to help service providers address the identified barriers to care for the underserved populations and to provide better quality services. Six of HRSA's 13 core medical services and three of their 16 supportive services are included in these recommendations. Together, the nine listed areas represent the state's priority service needs as described in Section 1 of this document.

1. Outpatient and Ambulatory Health Services

- a. The Part B grantee should work to expand its insurance continuation component to provide comprehensive major medical health insurance coverage to the largest number of eligible individuals possible within its funding constraints. To this end, the Part B grantee should continue collaborations with the Part A grantee to coordinate the payment of insurance premiums for eligible Part A service enrollees.
- b. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to identify additional infectious disease specialists and to adequately educate other providers regarding HIV disease symptoms, testing guidelines, and treatment. Efforts should include non-HIV specialists such as family practitioners, internists, obstetricians, gynecologists, mental health professionals, and those practicing outside of metropolitan areas.
- c. The Part B grantee should continue to refine its HIV Medical Services Programs to minimize confusion for both consumers and providers in the areas of program utilization (i.e., how consumers can use the services) and reimbursement (i.e., how providers can obtain authorization and bill for the services rendered). The Part B grantee should continue to work closely with training partners to ensure that case management staff members are provided training that addresses strategies to help improve consumer's experiences with the HIV Medical Services Program. The Part B grantee should ensure that its HIV Medical Services Program is marketed and explained to consumers in a culturally appropriate manner in order to minimize confusion and to maximize utilization among ethnically diverse populations.
- d. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure consumers' access and adherence to treatment, despite barriers caused by poor health, mental illness, stigma, fear, or adverse socioeconomic circumstances.
- e. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that all clients are assisted with appropriate resource identification and navigation of the healthcare system.
- f. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that consumers are able to apply for Indiana Medicaid with as few complications as possible. Special assistance should be provided to non-citizens to mitigate Immigration and Naturalization Service concerns and to locate appropriate, available resources.
- g. The Part B grantee and its advisory board should continue conducting its regional meetings to facilitate effective communication between providers and consumers.
- h. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that consumers are able to retain any state and federal benefits for the maximum allowable duration but are also encouraged to reduce reliance on such benefits by re-entering the workforce whenever possible.

- i. The Part B grantee should continue collaborations with the HIV Care Coordination Program to ensure that incarcerated consumers continue to experience an efficient transition from one service component to the next upon release.
- j. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that case managers are well-versed in all aspects of Indiana Medicaid and are able to advise clients appropriately regarding the management of the Medicaid benefits.

2. AIDS Drug Assistance Program Treatments

- a. The Part B grantee should work to expand its insurance continuation component to provide comprehensive major medical health insurance coverage to the largest number of eligible individuals possible within its funding constraints. To this end, the Part B grantee should continue collaborations with the Part A grantee to coordinate the payment of insurance premiums for eligible Part A service enrollees.
- b. The Part B grantee should continue to offer ADAP during any residency waiting period for comprehensive health insurance coverage.
- c. The Part A and B grantees and their respective advisory councils should work to develop, maintain, and disseminate to the HIV Care Coordination Program an exhaustive listing of county and private hospitals in Indiana which offer indigent care.
- d. The Part A, B, and C grantees should continue to provide intensive training to the HIV Care Coordination grantees to ensure that case managers are able to assist consumers in the efficient navigation of the Medicaid enrollment process and in obtaining prescribed drugs through the managed care programs (which may restrict access to certain medications).
- e. The Part B grantee should continue to explore the feasibility of assisting eligible consumers with costs associated with the Medicaid “spend-down” policy. The Part A, B, and C grantees also should continue collaborations with other service providers to ensure that emergency financial assistance funds for medications are available statewide to eligible consumers without access to other resources.
- f. The Part B grantee should continue to collaborate with its training partners (including the Part F grantee) to provide specialized training to the HIV Care Coordination providers to ensure that clients are able to efficiently access the assistance available through manufacturer-sponsored indigent drug assistance programs.
- g. The Part F grantee should continue to include information regarding side effects, drug interactions, and strategies to increase adherence to prescribed regimens in its education of physicians and social service providers. The Part B grantee should continue collaborations with the HIV Care Coordination providers to assess consumers’ barriers to adherence during the regular quarterly reviews and to reinforce adherence messages using the *Partnership for Health* intervention.
- h. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that case managers are well-versed in all aspects of Medicare Part D and are able to advise clients appropriately regarding the management of the Part D plan benefits.

3. Oral Health Care

- a. The Part A and C grantees should continue to provide dental services as a wrap-around benefit to HIV Medical Services Program enrollees in central Indiana.
- b. The Part A, B, and C providers should continue collaborations with other providers to guarantee that emergency financial assistance remains available for dental expenses which are not covered by the applicable formulary or which are incurred after any applicable cap has been reached by the enrollee.
- c. The Part A, B, and C grantees should support the HIV Care Coordination providers in advocating with dental providers for the acceptance of Medicaid as payment for their clients in need.
- d. The Part F grantee should increase the training opportunities targeted to dentists to expand the number of providers willing and qualified to serve those with HIV.
- e. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that consumers are aware of the need for proper dental hygiene and that appropriate referrals are offered as necessary.
- f. In an effort to identify the most appropriate resources for clients, the Part B grantee should continue to include “HIV-friendly” dental providers and those who accept the HIV Medical Services dental plan (i.e., Delta Dental) in its *Practical Guide to HIV Resources*. The Part A and C grantees should work to ensure that area physicians, HIV Care Coordination grantees, and consumers are aware of the availability of their Part A and C oral health services.

4. Medical Case Management, including Treatment Adherence Services

- a. The Part B grantee should continue to work to mitigate the negative effect of continued funding cuts. This may include seeking additional sources of support or reducing funding in areas with less need.

- b. In order to control growing caseloads, the Part B grantee should continue collaborations with the HIV Care Coordination to promote self-sufficiency among clients and to reduce their reliance on case management once identified goals have been achieved.
- c. In collaboration with its training partner, the Part B grantee should continue to offer intensive educational workshops for its case management staff. These workshops should provide uniform strategies to help staff manage the changing needs of the client population in a state with limited resources. They should be designed to help case managers empower their clients to make autonomous life decisions, should include components to motivate and encourage the staff, and should address the stress and frustrations inherent in working with a disabled and needy population.
- d. In collaboration with its training partner, the Part B grantee should continue to provide the most comprehensive skills-building trainings possible for its case management staff. Topics should include the management of clients with mental illness, substance abuse, and domestic abuse issues. Issues regarding women and families, homelessness, poverty, and financial management should also be continually addressed.
- e. In addition to the cultural competencies that are incorporated into the current training program, the Part B grantee should consider offering (or reimbursing projects for the cost of) Spanish classes as a part of the standard curriculum.
- f. The Part B grantee with its training partner should provide the necessary educational opportunities to ensure that the case management services being provided by the state satisfy the definition of “medical case management” as it would apply to a Part A, B, or C grantee.
- g. The Part B grantee should continue to conduct outreach efforts on behalf of the HIV Care Coordination providers to ensure that physicians and social service agencies in underserved areas are aware of the available services.
- h. The Part B grantee should continue to support HIV Care Coordination agencies efforts to secure additional resources for the development of programs for their specialized populations (such as women and families, ethnic minorities, and detainees).
- i. The Part B grantee should continue to monitor and train HIV Care Coordination providers to ensure that in-house training programs are uniform and thorough and that services are delivered to all clients in a consistent fashion.
- j. The Part B grantee should continue its collaboration with the HIV Care Coordination Program to ensure that adequate mechanisms are in place to address after-hours client emergencies.

5. Mental Health Services

- a. The Part A and C grantees should continue to provide mental health services as a wrap-around benefit to HIV Medical Services Program enrollees in central Indiana.
- b. The Part A, B, and C providers should continue collaborations with other providers to ensure that emergency financial assistance remains available for mental health expenses which are not covered by the applicable formulary or which are incurred after any applicable cap has been reached by the enrollee. The Part B grantee also should encourage additional agencies to apply for Part C funds (when available) to improve access to appropriate mental health services statewide.
- c. The Part A, B, and C grantees should support the HIV Care Coordination providers in advocating with mental health providers for the acceptance of Medicaid as payment for their clients in need.
- d. The Part F grantee should increase the training opportunities targeted to mental health providers to expand the number of providers willing and qualified to serve those with HIV. In an effort to identify the most appropriate resources for clients, the Part B grantee should continue to include “HIV-friendly” treatment providers in its *Practical Guide to HIV Resources*.
- e. The Part B grantee will continue to collaborate with the HIV Care Coordination Program to ensure that case managers can successfully assist consumers in overcoming the stigma associated with mental health treatment and to help HIV Care Coordinators locate providers who are familiar with the unique issues facing those living with HIV.

6. Substance Abuse Outpatient Care

- a. The Part A and C grantees should continue to provide substance abuse services as a wrap-around benefit to HIV Medical Services Program enrollees in central Indiana.
- b. The Part A, B, and C providers should continue collaborations with other providers to ensure that emergency financial assistance remains available for substance abuse treatment expenses which are not covered by the applicable formulary or which are incurred after any applicable cap has been reached by the enrollee. The Part B grantee also should encourage additional agencies to apply for Part C funds (when available) to improve access to appropriate addictions treatment statewide.
- c. The Part B grantee should continue to expand SPSP to ensure that each region in the state has access to the program’s supportive care component.

- d. The Part B grantee, SPSP, and the Part F grantee should collaborate with local substance abuse treatment facilities to increase the use of harm reduction techniques and strategies.
- e. The Part A, B, and C grantees should support the HIV Care Coordination providers in advocating with substance abuse treatment facilities for the acceptance of Medicaid as payment for their clients in need. The Part B grantee and its Special Population Support Program should continue working with local substance abuse treatment facilities to ensure that HIV-positive patients receive priority when treatment barriers exist.
- f. The Part B grantee should continue to collaborate with the HIV Care Coordination Program to ensure that case managers can successfully assist consumers in overcoming the stigma associated with substance abuse treatment and to help HIV Care Coordinators locate providers who are familiar with the unique issues facing those living with HIV. The Part F grantee should increase the training opportunities targeted to additional treatment providers to expand the number of providers willing and qualified to serve those with HIV. In an effort to identify the most appropriate resources for clients, the Part B grantee also should continue to include "HIV-friendly" treatment providers in its *Practical Guide to HIV Resources*.

7. Emergency Financial Assistance

- a. The Part B grantee should continue to collaborate with the HIV Care Coordination Program to provide information about Indiana Medicaid's *Ticket to Work* and other programs that transition consumers to employment without the loss of benefits or entitlements. HIV Care Coordination providers also should continue to include budget management in the care plans for low-income clients.
- b. The Part B grantee should continue to collaborate with the HIV Care Coordination Program to locate additional agencies and programs that provide food to low-income individuals and to maintain adequate in-house emergency financial assistance programs for food and nutritional needs.
- c. The Part B grantee should continue to collaborate with the HIV Care Coordination Program to locate agencies that assist with weatherization of homes for low-income individuals to decrease utility costs. The HIV Care Coordination Program grantees should advocate for their clients at the local utility providers to facilitate access to budget billing programs. The HIV Care Coordination Program grantees also should seek out additional sources for client assistance in their service areas whenever HOPWA assistance caps are reached for enrolled clients.
- d. The Part B grantee and the HIV Care Coordination agencies should continue collaborations with other providers to ensure that emergency financial assistance remains available for daily living needs after other resources are exhausted.

8. Housing

- a. The Part A, B, C, and F grantees should support and assist the Indiana Housing and Community Development Authority in its efforts to implement the recommendations described in the Indiana HIV/AIDS Housing Plan. The Part A, B, and C providers should continue collaborations with other providers to ensure that emergency financial assistance remains available for housing-related costs which are not covered by other assistance programs or which are incurred after any applicable cap has been reached by the enrollee. The Part B grantee should continue to collaborate with the HIV Care Coordination Program to ensure that sites in each region are well connected with their local public housing providers and are able to efficiently navigate those systems.
- b. The Part B grantee should support the HIV Care Coordination providers as they research ways to improve access to adequate housing assistance for marginalized populations such as the mentally ill, substance users, those without citizenship status, and ex-offenders and to improve access to "appropriate" housing for the disabled and women with children.
- c. The Part B grantee should continue to collaborate with the Indiana Housing and Community Development Authority to determine the feasibility of providing housing-specific training and technical assistance to all of the state's HIV Care Coordination staff.

9. Medical Transportation

- a. The Part A, B, and C providers should continue collaborations with other providers to ensure that emergency financial assistance remains available for transportation costs which are not covered by other assistance programs (e.g., Part A, township trustee, etc.) or which are incurred after any applicable cap has been reached by the enrollee.
- b. Where public transportation is available, the Part A, B, and C grantees should work to ensure that area agencies are aware of the available services (including Medicaid transportation services) and support systems for those with disabilities or small children.
- c. The Part B grantee should continue to explore ways to provide medical transportation for HIV Medical Services Program enrollees through the existing HIV Care Coordination network (particularly for marginalized groups such as the mentally ill, substance users, women with children, and detainees).

The following additional points represent those areas designated by HRSA as core medical services which do not appear in Indiana's list of identified priority service needs as described in Section 1 of this document. Likewise, these categories will not be found in the earlier discussion of gaps and barriers. They are included here only to provide additional context regarding Indiana's HIV service delivery system.

10. Local AIDS Pharmaceutical Assistance

- a. The Part A program should continue to fund its limited emergency drug access program in the TGA.
- b. Because drug assistance is covered under the HIV Medical Services Program's insurance plan and Indiana Medicaid, the Part B and C grantees are encouraged to focus attention and resources on other service areas.

11. Early Intervention Services

- a. The Marion County Part C program should continue to fund its Early Intervention Services which provide HIV counseling, testing, and education activities at two community health centers.
- b. The Part B grantee should continue to offer its early intervention benefits (through EIP) to ensure access to outpatient services during the HIV Medical Services Program's residency waiting period for insurance coverage.
- c. The Part B grantee should continue to require HIV Care Coordination providers to collaborate with the ISDH Disease Intervention Program to expedite referrals of newly diagnosed clients into case management services.
- d. The Part A grantee should continue to explore the benefits of emergency room testing and referrals as a means to improve the linkages between testing, case management, and medical care; the Part B grantee should collaborate with ISDH prevention programs on similar initiatives.

12. Health Insurance Premiums and Cost-Sharing Assistance For Low-Income Individuals

- a. In addition to the recommendations noted above in the *Outpatient and Ambulatory Health Services* and *AIDS Drug Assistance Program Treatments* categories, the Part B grantee should continue its efforts to verify the eligibility of every HIV Medical Services Program enrollee to ensure that the program serves only those without access to other resources and to minimize the impact of any potential waiting list.
- b. In anticipation of implementation of the Affordable Care Act, the Part B grantee should begin to explore the feasibility of providing premium and cost-sharing assistance through multiple insurance carriers and (possibly) Indiana Medicaid.
- c. Should the Affordable Care Act result in fewer individuals seeking assistance from the HIV Medical Services Program, the Part B grantee should assess the feasibility of increasing the income cap for eligibility.

13. Home Health Care

- a. Part A, B, and C grantees should encourage additional agencies to apply for Part C funds (when available) to improve access to home health care services statewide.
- b. Because home health care services are covered under the HIV Medical Services Program's insurance plan and Indiana Medicaid, the Part A, B, and C grantees are encouraged to focus financial resources on other service areas.

14. Medical Nutrition Therapy

- a. The Marion County Part C grantees should continue offering its nutrition counseling service to eligible enrollees, utilizing a dietician placed in the HIV clinics who can provide information about nutritional supplements as well as overall nutritional health and exercise.
- b. The Part B grantee should continue collaborations with the HIV Care Coordination Program to ensure that case managers understand that Medicaid will cover nutritional supplements with a physician's prescription and pre-authorization.
- c. The Part B grantee should continue to encourage the HIV Care Coordination grantees to use unobligated grant funds to stock limited supplies of supplements for emergency situations.
- d. The Part A, B, and C grantees should continue collaborations with other service providers to ensure that emergency financial assistance funds for nutritional supplements are available statewide to consumers without the necessary resources.

15. Hospice Services

- a. Because hospice services are covered under the HIV Medical Services Program's insurance plan and Indiana Medicaid, the Part A, B, and C grantees are encouraged to focus attention and resources on other service areas.
- b. In an effort to identify the most appropriate resources for clients, the Part B grantee should include "HIV-friendly" hospice services in its *Practical Guide to HIV Resources*.

16. Home and Community-Based Health Services

- a. Because home-based services are covered under the HIV Medical Services Program's insurance plan and Indiana Medicaid, the Part A, B, and C grantees are encouraged to focus attention and resources on other service areas.
- b. In an effort to identify the most appropriate resources for clients, the Part B grantee also should continue to include "HIV-friendly" community-based services in its *Practical Guide to HIV Resources*. These may include mobile health services, community health fairs and events offering screenings for various health issues, and local free or sliding fee scale clinics offering health services to those with limited or no income.

Other Recommendations

Beyond its core and support service recommendations, the Part B grantee and its advisory council have developed a number of additional suggestions related to the identification and engagement of individuals and cross-program coordination.

1. Unmet Need Estimate

- a. The Part B grantee should continue to collaborate with the HIV Care Coordination Program to conduct activities to identify HIV-positive individuals who are not actively seeking care.
- b. The Part B grantee should continue to collaborate with the Part A's MAI projects to re-capture consumers who have been "lost to care," bringing them back into the HIV Care Coordination system to receive necessary social and medical services.
- c. The Part B grantee should continue to collaborate with the DIS network to ensure that all specialists and HIV testing counselors actively arrange for an HIV Care Coordination referral for newly diagnosed persons and follow-up on every referral to ensure its success.
- d. The Part B grantee should continue to require that all new applications originate from – and all recertification interviews be performed by – sanctioned HIV Care Coordination sites where quality control measures can be enforced.

2. Unaware of Status Estimate

- a. The Part B grantee should continue to collaborate with its Part A counterpart, SPSP, and the state's HIV Prevention Program to conduct outreach, education, and testing activities to identify persons at high-risk for HIV infection.
- b. The Part B grantee should continue to collaborate with its Part A counterpart, SPSP, and the state's HIV Prevention Program to conduct thorough post-test counseling and partner notification activities to inform persons of HIV infection.
- c. The Part B grantee should continue to collaborate with its Part A counterpart, SPSP, and the state's HIV Prevention Program to conduct activities to refer persons with newly identified HIV infection to the HIV Care Coordination Program.
- d. The Part B grantee should continue to collaborate with its Part A counterpart, SPSP, and the state's HIV Prevention Program to conduct referral monitoring activities to ensure that persons with newly identified HIV infection are linked into the system of care.

3. Coordination Efforts

- a. The Part B grantee should continue to convene Part A, B, C, and Part F grantees at least three times annually to review the eligibility requirements for all Part A, B, and C service components for consistency; to review the benefit information for all Part A, B, and C service components to identify and eliminate any duplicative services; and to coordinate the skills-building training efforts of the Part A, B, and C grantees with the advice of the Part F grantee.
- b. The Part B grantee should continue to include non-Ryan White service providers on its advisory council, particularly those delivering HIV Care Coordination services.
- c. The Part B grantee should continue to foster collaborations between the state's HIV Prevention Program, SPSP, the Disease Intervention network, and other STD programs in an effort to identify and link to care those at greatest risk of HIV infection.
- d. The Part B grantee should continue to foster collaborations between SPSP and the state's network of DMHA-certified substance abuse treatment facilities.
- e. The Part B grantee should seek to develop a collaborative relationship with the Office of Medicaid Policy and Planning, particularly for the purposes of planning for the implementation of the Affordable Care Act.
- f. The Part B grantee should continue its efforts to coordinate payment activities with the Center for Medicare and Medicaid Services (CMS) for those HIV Medical Services Program enrollees receiving MDAP benefits.
- g. The Part B grantee should continue working with the State's Office of Primary Care to ensure that community healthcare center staff persons are aware of available HIV services, referral standards, and treatment guidelines as applicable.

Section 3 – SERVICE DELIVERY PLAN

Administrative Goals and Objectives

In order for Indiana to realize an improved system of care, achievement of the following administrative goals and objectives will be necessary. These goals are presented according to four major administrative areas: systems, planning, evaluation, and service. The administrative goals and objectives are designed to be long-term and to span the three-year period of this plan. They will be fully reviewed and updated every three years (i.e., for the period beginning 1 April 2015). Unless otherwise indicated, responsibility for achieving the stated goals rests with the Division.

- 1. Systems Goal: To improve coordination between major Ryan White Program grantees.**
 - Objective 1. To maintain at least 60% of the full membership level on average for CHSPAC.
 - Objective 2. To convene Part A, B, C, and Part F grantees at least three times annually.
 - Objective 3. To annually review the eligibility requirements for all Part A, B, and C service components to ensure consistency.
 - Objective 4. To annually review the benefit information for all Part A, B, and C service components to identify and eliminate any duplicative services.
 - Objective 5. To coordinate the skills-building training efforts of the Part A, B, and C grantees with the advice of the Part F grantee.

- 2. Planning Goal: To maintain a dynamic Statewide Comprehensive Plan.**
 - Objective 1. To annually evaluate the necessity to conduct a new needs assessment and respond as appropriate.
 - Objective 2. To obtain and incorporate updated epidemiological information into the Statewide Comprehensive Plan as necessary.
 - Objective 3. To incorporate changes in available services and the service delivery system into the Statewide Comprehensive Plan as necessary.
 - Objective 4. To create an annual revision of pertinent sections of the Statewide Comprehensive Plan, incorporating the Statewide Coordinated Statement of Need.

- 3. Evaluation Goal: To document that funded interventions improve health outcomes for the target population.**
 - Objective 1. To complete the collection of service utilization data from ICHIA at least quarterly.
 - Objective 2. To maintain database structures to archive and analyze all HIV Medical Services Program utilization information.
 - Objective 3. To annually review benchmark health indicators against which to measure health outcomes.
 - Objective 4. To annually compare current health and service utilization information for participants against the established benchmarks to evaluate the effectiveness of the HIV Medical Services Program.

- 4. Service Goal: To maintain HIV services statewide at current or expanded levels.**
 - Objective 1. To continue to request the maximum amount allowable under the ADAP 340B rebate program.
 - Objective 2. To annually review all Part B budget items to determine if funds can be diverted from administrative costs to services.
 - Objective 3. To document qualifying expenditures for HIV services at the level necessary to satisfy the annual federal funding match and Maintenance of Effort requirements.
 - Objective 4. To support new Part C and D applications as funds are available.
 - Objective 5. To prepare for the implementation of the Affordable Care Act and any associated impacts on the continuum of care.

Provision of Care Goals and Objectives

While the state's administrative goals and objectives are framed in terms of management activities, those for the provision of care are categorized according to the priority service needs. In some cases, single objectives apply to more than one goal and, therefore, may be repeated. These goals and objectives are primarily those of the Part B grantee and its advisory council. Other Ryan White Program Parts have developed their own unique goals which should be complementary to those listed here.

All of Indiana's priority service need areas are considered. These include six of HRSA's 13 core medical services and three of its 16 supportive services. Six of the remaining core medical services (local AIDS pharmaceutical assistance, early intervention services, home health care, medical nutrition therapy, hospice services, and home and community-based health services) are not described in this section because they have not been determined to be high priority service needs and are not currently funded by Part B. They will, however, continue to be considered in

future assessments of need. The final core medical service (health insurance premiums and cost-sharing assistance for low-income individuals) is funded by Part B but is not described here as its goals and objectives are fully incorporated into the *Outpatient and Ambulatory Health Services* and the *AIDS Drug Assistance Program Treatments* descriptions. Timeframes are indicated where applicable. In general, goals may be read as applying to the three-year plan period, while objectives may apply to individual fiscal year periods.

1. Outpatient and Ambulatory Health Services

- a. Goal 1. To continue EIP as a transitory or “safety net” plan for coverage of HIV-related outpatient care for eligible HIV-positive persons without adequate health coverage.
 - Objective 1. To require all new EIP applicants to simultaneously apply for HIAP.
 - Objective 2. To transition all eligible enrollees from EIP into HIAP for comprehensive insurance coverage within 12 months of the EIP effective date.
 - Objective 3. To maintain EIP benefits for those unable to transition to HIAP due to legal status.
- b. Goal 2. To continue HIAP as a long-term solution for HIV-related outpatient care for eligible HIV-positive persons without adequate health coverage.
 - Objective 1. To require all new HIAP applicants to simultaneously submit applications for Medicaid, high-risk insurance, Medicaid, HIP, and private insurance.
 - Objective 2. To monitor all active enrollees for evidence of access to private insurance.
 - Objective 3. To monitor all active enrollees for access to Indiana Medicaid.
 - Objective 4. To recertify all active enrollees for continued eligibility at least twice annually.
- c. Goal 3. To continue to provide efficient and cost-effective EIP and HIAP benefits for all eligible applicants.
 - Objective 1. To annually renew the contract for third-party administration of the EIP and HIAP benefits.
 - Objective 2. To ensure that the third-party administrator will maintain processing time at 15 working days or less for 90% of the claims.
 - Objective 3. To ensure that providers are able to bill for EIP and HIAP services without undue complications by continuing to disseminate the “Cardholder and Provider Information” billing fact sheets.
- d. Goal 4. To promote client access and adherence to medical treatments.
 - Objective 1. To maintain the relationship between the Part B and Part F grantees in order to ensure that all providers seeking reimbursement under any component of the HIV Medical Services Program receive (at minimum) updated versions of the DHHS guidelines and other information related to recommended HIV care.
 - Objective 2. To continue to offer access to information (including via the toll-free HIV Medical Services telephone line) and educational opportunities to providers, HIV Care Coordinators, the Indiana Department of Corrections, and consumers related to the HIV Medical Services Program including information regarding eligibility, enrollment, and the proper reimbursement procedures to ensure successful access of services.
 - Objective 3. To continue to implement the modified *Partnership for Health* intervention at all HIV Care Coordination agencies in order to reinforce messaging to HIV-positive clients about the importance of remaining engaged in primary care.
- e. Goal 5. To continue to improve HIV medical services through diligent quality management.
 - Objective 1. To collect the full complement of utilization data for regular review and analysis.
 - Objective 2. To complete the Clinical Quality Management (CQM) report on at least an annual basis, documenting trends in patient health resulting from the services provided.
 - Objective 3. To coordinate CQM and contract compliance efforts with Parts A and C to the extent possible.
 - Objective 4. To complete the *HIV Core Clinical Performance Measurement* activities (Group 1) to ascertain the extent to which HIV Medical Services Program enrollees receive CD4 counts, medical visits, highly active antiretroviral therapy (HAART), pneumocystis pneumonia (PCP) prophylaxis, and ARV therapy during pregnancy.
- f. Goal 6. To continue to work to eliminate disparities in access to HIV medical services for disproportionately affected subpopulations and underserved communities.
 - Objective 1. To determine the extent of the disparity by annually creating the Unmet Need Estimate.
 - Objective 2. To annually analyze the Unmet Need Estimate results by subpopulation to determine any disproportionate impact.
 - Objective 3. To increase the awareness of Part A, B, and C programs – in cooperation with HIV Care Coordination and HIV prevention programs – in disproportionately affected populations.

- Objective 4. To monitor the demographic composition (by race, gender, and age) of the HIV Medical Services Program enrollees in comparison to the prevalence population.
- g. Goal 7. To efficiently manage and minimize the impact of any potential waiting list for the HIV Medical Services Program.
- Objective 1. To continue to require re-application to Indiana Medicaid for HIV Medical Services Program enrollees below 100% FPL and receiving Social Security benefits.
 - Objective 2. To communicate enrollment information to the Part A grantee to prevent service duplication.
 - Objective 3. To coordinate the management of any waiting list with the Part A grantee.

2. AIDS Drug Assistance Program Treatments

- a. Goal 1. To continue ADAP as a transitory or “safety net” plan for coverage of HIV-related prescription drugs for eligible HIV-positive persons without adequate health coverage.
- Objective 1. To require all new ADAP applicants to simultaneously apply for HIAP.
 - Objective 2. To transition all eligible enrollees from ADAP into HIAP for comprehensive insurance coverage within 12 months of the ADAP effective date.
 - Objective 3. To maintain ADAP benefits for those unable to transition to HIAP due to legal status.
 - Objective 4. To provide to all ADAP-eligible applicants who are over the age of 65 and enrolled in a Medicare Part D plan a limited benefit designed to cover the Part D co-insurance and deductible expenses for pharmaceuticals.
- b. Goal 2. To continue HIAP as a long-term solution for HIV-related pharmaceuticals for eligible HIV-positive persons without adequate health coverage.
- Objective 1. To require all new HIAP applicants to simultaneously submit applications for Medicaid, high-risk insurance, Medicaid, HIP, and private insurance.
 - Objective 2. To monitor all active enrollees for evidence of access to private insurance.
 - Objective 3. To monitor all active enrollees for access to Indiana Medicaid
 - Objective 4. To recertify all active enrollees for continued eligibility at least twice annually.
- c. Goal 3. To continue to provide efficient and cost-effective pharmacy benefits management for all eligible applicants.
- Objective 1. To annually renew the contract for third-party administration of the ADAP, MDAP, and HIAP benefits.
 - Objective 2. To ensure that the third-party administrator will maintain processing time at 15 working days or less for 90% of the claims.
 - Objective 3. To ensure that providers are able to bill for ADAP, MDAP, and HIAP services without undue complications by continuing to disseminate the “Cardholder and Provider Information” billing fact sheets.
- d. Goal 4. To promote client adherence to ARV combination therapy regimens.
- Objective 1. To maintain the relationship between the Part B and Part F grantees in order to ensure that all providers seeking reimbursement under any component of the HIV Medical Services Program receive (at minimum) updated versions of the DHHS guidelines and other information related to recommended HIV therapies.
 - Objective 2. To continue to offer access to information (including via the toll-free HIV Medical Services telephone line) and educational opportunities to providers, HIV Care Coordinators, the Indiana Department of Corrections, and consumers related to the HIV Medical Services Program including information regarding eligibility, enrollment, and the proper reimbursement procedures to ensure successful access of services.
 - Objective 3 To continue to implement the modified *Partnership for Health* intervention at all HIV Care Coordination agencies in order to reinforce messaging to HIV-positive clients about the importance of adherence to ARV combination therapy regimens.
- e. Goal 5. To continue to improve HIV pharmaceutical utilization through diligent quality management.
- Objective 1. To collect the full complement of utilization data for regular review and analysis.
 - Objective 2. To complete the CQM report on at least an annual basis, documenting trends in patient health resulting from the services provided.
 - Objective 3. To coordinate CQM and contract compliance efforts with Parts A and C to the extent possible.

- Objective 4. To document at least 95% ARV therapy compliance among HIV Medical Services Program enrollees.
- f. Goal 6. To continue to work to eliminate disparities in access to HIV pharmaceuticals for disproportionately affected subpopulations and underserved communities.
- Objective 1. To determine the extent of the disparity by annually creating the Unmet Need Estimate.
 - Objective 2. To annually analyze the Unmet Need Estimate results by subpopulation to determine any disproportionate impact.
 - Objective 3. To increase the awareness of Part A, B, and C programs – in cooperation with HIV Care Coordination and HIV prevention programs – in disproportionately affected populations.
 - Objective 4. To monitor the demographic composition (by race, gender, and age) of the HIV Medical Services Program enrollees in comparison to the prevalence population.
- g. Goal 7. To efficiently manage and minimize the impact of any potential waiting list for the HIV Medical Services Program.
- Objective 1. To continue to require re-application to Indiana Medicaid for HIV Medical Services Program enrollees below 100% FPL and receiving Social Security benefits.
 - Objective 2. To communicate enrollment information to the Part A grantee to prevent service duplication.
 - Objective 3. To coordinate the management of any waiting list with the Part A grantee.
- 3. Oral Health Care**
- a. Goal 1. To maximize utilization of the existing oral health resources in the state.
- Objective 1. To ensure enrollment materials highlight the availability of the EIP dental services during the residency waiting period for insurance.
 - Objective 2. As funding permits, to continue to offer dental insurance benefits under HIAP (through Delta Dental).
 - Objective 4. To continue to identify HIV- and program-friendly providers (including those located in local community health centers) in the state's Resource Guide.
 - Objective 5. To work with potential funders of financial assistance to ensure that dental and other oral health expenses are eligible for reimbursement.
- b. Goal 2. To develop new oral health resources for HIV-positive persons in the state.
- Objective 1. To support new Part F applications for dental service provision as funds are available.
- 4. Medical Case Management, including Treatment Adherence Services**
- a. Goal 1. To ensure concurrent enrollment in the HIV Care Coordination Program and other major HIV service components.
- Objective 1. To continue to require that each new HIV Medical Services application originates from a state-funded HIV Care Coordination agency.
 - Objective 2. To continue to require that SPSP project staff members continually refer their supportive care enrollees back into the case management program for long-term care planning.
 - Objective 3. To continue collaborations between the Division, the Indiana Housing and Community Development Authority, and the Community Economic Development (Indianapolis) to ensure that HOPWA funds are distributed through the HIV Care Coordination network in an effort to ensure that assistance recipients receive comprehensive case management services.
- b. Goal 2. To improve the quality of the HIV Care Coordination Program in Indiana.
- Objective 1. To continue collaborations between the Division and the training grantee to provide regular skills-building trainings for its case management staff on pertinent topics, such as mental illness, substance abuse, domestic violence, homelessness, poverty, and financial management.
 - Objective 2. To continue to perform annual program audits to review documentation, charting, and appropriateness of interventions.
 - Objective 3. To coordinate the state's HIV Care Coordination Program with any case management activities provided through the Part A and C grantees, including marketing, training, applications, and managing mutual clients.
 - Objective 4. To continue monitoring the HIV Care Coordination Program to ensure that quality vocational rehabilitation services are being offered regularly to clients.
 - Objective 5. To continue monitoring the HIV Care Coordination Program to ensure that quality adherence message reiteration is being performed regularly with clients to improve CD4 and viral load counts.

- c. Goal 3. To continue to work to eliminate disparities in access to case management services for disproportionately affected subpopulations and underserved communities.
 - Objective 1. To determine the extent of the disparity by annually creating the Unmet Need Estimate.
 - Objective 2. To annually analyze the Unmet Need Estimate results by subpopulation to determine any disproportionate impact.
 - Objective 3. To increase the awareness of Part A, B, and C programs – in cooperation with HIV Care Coordination and HIV prevention programs – in disproportionately affected populations.
 - Objective 4. To monitor the demographic composition (by race, gender, and age) of the HIV Care Coordination Program enrollees in comparison to the prevalence population.
- d. Goal 4. To continue to identify individuals who know their HIV-positive status but are not in care and to work to engage them in the care system.
 - Objective 1. To ensure that local HIV Care Coordination providers have promotional materials available at area physician and social service provider offices.
 - Objective 2. To re-assess the feasibility of requiring the HIV Care Coordination providers to initiate a disease intervention referral for clients who have become “lost to care.”
- e. Goal 5. To continue to identify individuals who do not yet know their HIV-positive status and to work to engage them in the care system.
 - Objective 1. To continue SPSP’s targeted HIV testing initiative in high-risk communities and subsequent referrals of all newly identified cases to HIV Care Coordination.
 - Objective 2. To continue collaborations with the state’s HIV Prevention Program and the Disease Intervention network to ensure that all newly identified cases are referred to HIV Care Coordination.
 - Objective 3. To collaborate with MATEC and local emergency rooms to increase the likelihood of HIV Care Coordination referrals whenever a new HIV-positive individual is discovered.

5. Mental Health Services

- a. Goal 1. To maximize utilization of the existing mental health resources in the state.
 - Objective 1. To ensure HIV Medical Services Program enrollment materials highlight the availability of the psychotropic drugs on the ADAP formulary during the residency waiting period for insurance.
 - Objective 2. To work with potential funders of financial assistance to ensure that mental health expenses are eligible for reimbursement.
- b. Goal 2. To develop new mental health resources for HIV-positive persons in the state.
 - Objective 1. To annually review the existing EIP formulary to ascertain the feasibility of offering access to mental health services during the residency waiting period for insurance.

6. Substance Abuse Outpatient Care

- a. Goal 1. To maximize utilization of the existing addictions treatment resources in the state.
 - Objective 1. To ensure HIV Medical Services Program enrollment materials highlight the availability of the withdrawal management drugs on the ADAP formulary during the residency waiting period for insurance.
 - Objective 2. To work with potential funders of financial assistance to ensure that addictions treatment expenses are eligible for reimbursement.
 - Objective 4. To continue to promote the availability of SPSP supportive care to clinics, treatment facilities, and case management agencies throughout the state.
- b. Goal 2. To develop new substance abuse treatment resources for HIV-positive persons in the state.
 - Objective 1. To annually review the existing EIP formulary to ascertain the feasibility of offering access to addictions treatment during the residency waiting period for insurance.

7. Emergency Financial Services

- a. Goal 1. To maximize utilization of existing financial assistance resources in the state.
 - Objective 1. To encourage the HIV Care Coordination Program grantees to work with other local, county, and statewide service providers to ensure that case managers are aware of weatherization, budget billing, food, and other assistance programs that may be available.
 - Objective 2. To include in the state’s Resource Guide a directory of regional financial assistance resources that can be distributed to case managers.
 - Objective 3. To work with potential funders of financial assistance to ensure that utility, food, and other non-shelter-related expenses are eligible for reimbursement.

- b. Goal 2. To continue collaborations between the Division, Family and Social Services Administration, the Social Security Administration, and Indiana Medicaid.
 - Objective 1. To continue training of case management staff and education to consumers regarding *Ticket to Work* and other programs designed to help clients stabilize income and reduce dependence on emergency financial assistance.

8. Housing

- a. Goal 1. To maximize utilization of the existing housing resources in the state.
 - Objective 1. To include in the state's Resource Guide a directory of regional low-cost housing options that can be distributed to case managers.
 - Objective 2. To work with potential funders of financial assistance to ensure that housing and shelter-related expenses are eligible for reimbursement.
- b. Goal 2. To continue collaborations between the Division, Indiana Housing and Community Development Authority, and the Community Economic Development Council (Indianapolis).
 - Objective 1. To remain available to participate in the annual application review for HOPWA awards.
 - Objective 2. To work to ensure that HOPWA funds are distributed through the HIV Care Coordination network in an effort to improve housing stability.
 - Objective 3. To encourage the HIV Care Coordination Program grantees to work with other local, county, and statewide service providers through the *Regional Planning Council on the Homeless* (where applicable) to ensure that the HIV service provider perspective is represented as the problem of homelessness is addressed.
 - Objective 4. To continue the Division's active participation on the *Indiana Planning Council on the Homeless*.

9. Medical Transportation

- a. Goal 1. To maximize utilization of the existing transportation resources in the state.
 - Objective 1. To include in the state's Resource Guide a directory of regional low-cost transportation options that can be distributed to case managers.
 - Objective 2. To work with potential funders of financial assistance to ensure that transportation-related expenses are eligible for reimbursement.

Other Related Goals and Objectives

In addition to its administrative and service goals, the Part B grantee and its advisory council have proposed a number of related goals which address the identification and engagement of individuals, cross-program coordination, and the needs of special populations.

1. Unmet Need Estimate

- a. Goal 1. To document a continual decrease in the number and percentage of persons in the Division's annual Unmet Need Estimate.
 - Objective 1. To continue to collaborate with the HIV Care Coordination Program and the Part A grantee's MAI project to conduct activities to identify HIV-positive individuals who are not actively seeking care.
 - Objective 2. To continue to collaborate with the DIS network to ensure that all specialists and HIV testing counselors actively arrange for an HIV Care Coordination referral for newly diagnosed persons and follow-up on every referral to ensure its success.

2. Unaware of Status Estimate

- a. Goal 1. To document a continual decrease in the number and percentage of persons in the Division's annual Unaware of Status Estimate.
 - Objective 1. To continue to collaborate with Part A, SPSP, and the state's HIV Prevention Program to conduct outreach, education, and testing activities to identify persons at high-risk for HIV infection.
 - Objective 2. To continue to collaborate with Part A, SPSP, and the state's HIV Prevention Program to conduct thorough post-test counseling and partner notification activities to inform persons of HIV infection.
 - Objective 3. To continue to collaborate with Part A, SPSP, and the state's HIV Prevention Program to conduct activities to refer persons with newly identified HIV infection to the HIV Care Coordination Program.
 - Objective 4. To continue to collaborate with Part A, SPSP, and the state's HIV Prevention Program to conduct referral monitoring activities to ensure that persons with newly identified HIV infection are linked into the system of care.

3. Coordination Efforts

- a. Goal 1. To ensure that all Ryan White grantees operate efficiently and effectively within the context of the state's larger service delivery system.
 - Objective 1. To continue to include non-Ryan White service providers on its advisory council, particularly those delivering HIV Care Coordination services.
 - Objective 2. To continue to foster collaborations between the HIV Prevention Program, SPSP, the Disease Intervention network, and other STD programs.
 - Objective 3. To maintain the successful relationship between SPSP and the state's network of DMHA-certified substance abuse treatment facilities.
 - Objective 4. To begin a dialogue with representatives from the Office of Medicaid Policy and Planning, particularly for the purposes of planning for the implementation of the Affordable Care Act.
 - Objective 5. To finalize the data-sharing agreement between the HIV Medical Services Program and CMS.
 - Objective 6. To continue working with the state's Office of Primary Care to ensure that community healthcare center staff persons are aware of available HIV services, referral standards, and treatment guidelines as applicable.

4. Special Populations

- a. Goal 1. To ensure that Part B services are uniformly available to all eligible applicants regardless of subpopulation.
 - Objective 1. To strengthen and solidify the relationship between pediatricians treating adolescent patients and the local HIV Care Coordination facilities to assist in securing benefits and, when appropriate, transferring the patient to adult medicine without a gap in care.
 - Objective 2. To continue to offer supportive services through SPSP in an effort to reduce the incidence of substance use, encourage treatment and adherence, and promote engagement in the HIV Care Coordination Program.
 - Objective 3. To strengthen and solidify the relationship between homeless shelter and service providers and the local HIV Care Coordination facilities to assist in identifying those in need and facilitating their entry into care as applicable.
 - Objective 4. To support the Part A grantee in its efforts to identify the retention barriers for transgender persons and to assist in the development of outreach and peer-led strategies that could be used to overcome these barriers and facilitate this population's engagement in HIV Care Coordination.
 - Objective 5. To support HIV Care Coordination providers serving Burmese refugees in the development of strategies to overcome the identified barriers to engagement and retention in care for this population.

Healthy People 2020

Indiana recognizes the importance of the Healthy People 2020 initiative launched by DHHS in December 2010. All of the Division's service components strive to meet the initiative's two major goals as they relate to the HIV-affected population. Paraphrased, these goals are to increase the quality and length of healthy life and to eliminate health disparities. The Division is confident that, by providing free comprehensive health insurance (and, thereby, access to HIV-related medications) in conjunction with intensive case management services to the HIV-positive population most in need (those living below 300% of the poverty level without any other healthcare resources), it can positively affect the length and quality of life of these individuals.

Incorporating the Statewide Coordinated Statement of Need

Indiana's Comprehensive Plan fully incorporates the SCSN (as Section 1, Part 1). As a general statement of the needs of persons living with HIV in the state, the SCSN seeks to describe the epidemiological trends, service history, needs assessments, priority service areas, gaps in and barriers to care for the affected population, unmet need estimates, unaware of status estimates, and prevention collaborations occurring in the state. The needs described in Section 1, Part 1 are reflected and addressed in detail throughout the remainder of this document.

Affordable Care Act

While the passage of the Affordable Care Act in mid-2010 has made healthcare more accessible for millions of Americans, its enactment has created a particular challenge for those relying on Indiana's existing high-risk insurance pool. In July of 2011, the pool issued new eligibility criteria which included documentation of denial from the federal PCIP. Because the HIV Medical Services Program purchases insurance only through the risk pool, the Division was obligated to immediately add this component to its already lengthy application process. The natural result was a significant increase in the workload of case managers assisting clients with the application process. With less time available, other areas of concern (such as housing, mental health, substance abuse, and high-risk sexual activity)

become in jeopardy of receiving less than adequate attention. Circuitously, this has the potential to negatively impact the client's ability to utilize the healthcare benefits once secured.

The creation of PCIP also brought attention to applicants' legal status. The PCIP application is explicit in its request of legal status verification, and Indiana's risk pool soon followed suit, requesting additional documentation for any applicant failing to supply a legitimate Social Security Number or Individual Tax Identification Number. The result of this heightened scrutiny is an increase in the number of individuals who are only eligible for the ADAP portion of the HIV Medical Services Program. By design, traditional ADAP in Indiana is used only as a bridge to insurance when an applicant cannot yet meet the risk pool's 12-month state residency requirement. However, non-citizens who are otherwise completely eligible are now unable to receive insurance coverage through the risk pool and will remain dependant on traditional ADAP benefits for access to necessary medications for an indefinite period of time. Soon, the risk pool's interest in this population may extend to existing members and result in termination of their coverage, leaving ADAP as the only safety net for these individuals as well. While ADAP covers more than 100 drugs including all of the standard antiretroviral medications, it does not compare to the coverage provided by major medical insurance.

Using an estimate of 3% of the current HIV Medical Services Program, the Division anticipates that nearly 60 enrollees will be impacted directly by the risk pool's new restrictions over the coming 12 months. Each one will require additional attention by the case managers in order to secure alternate forms of coverage and financial assistance. With regard to health insurance, clients themselves can expect less uniform care and less access to the infectious disease provider networks best suited to treat HIV. Referrals to second-tier networks such as local community health centers with less treatment experience will increase. The impact on health outcomes is unknown but is not expected to be positive. However, clearly, the shift will result in an increase of effort for both clients and case managers.

As other elements of the Affordable Care Act are enacted, the Division will attempt to work closely with the Office of Medicaid Policy and Planning, the agency responsible for developing the implementation plan for Indiana. To date, the agency has not issued any specific plans or guidance. Therefore, much of this Comprehensive Plan is subject to change in 2014.

National HIV/AIDS Strategy

Like Healthy People 2020, Indiana recognizes the significance of the National HIV/AIDS Strategy for the United States issued by the White House in July 2010. The strategy outlines four major goals: reducing new HIV infections, increasing access to care and improving health outcomes for people living with HIV, reducing HIV-related disparities and health inequities, and achieving a more coordinated national response to the HIV epidemic.

1. Reducing New HIV Infections

As described herein, the Division strives to prevent new infections through its HIV Prevention programming and its targeted SPSP testing initiative. It also works closely with the Part A grantee and supports its efforts to develop community-level collaborations that integrate HIV prevention and care services in order to address the barriers that prevent individuals from learning their HIV status.

2. Increasing Access to Care and Improving Health Outcomes for People Living with HIV

The HIV Care Coordination Program was established to achieve the goal of increasing access to care and, thereby, improving the health outcomes of those living with HIV disease. Current protocols are in place to encourage a seamless linkage from the point of testing to continuous and coordinated quality care for those found to be infected with HIV. The program offers long-term assistance that is designed to support HIV-positive people who have with co-occurring health conditions and those who have challenges meeting their basic needs.

3. Reducing HIV-Related Disparities and Health Inequities

By locating HIV Care Coordination services in regions throughout the state and by offering insurance-based medical care, the Division has been able to overcome a number of barriers related to patient demographics and geographic location. In a recent analysis of the lifespan of HIV-positive Hoosiers, it was found that those enrolled in the Division's care and service programs live 93% longer on average than those who are not connected to these programs. The analysis also showed that enrollees living in rural areas achieved better results than those living in urban areas, demonstrating that the Division's programs provide a leveling effect that impacts the disparity between access to care in rural and urban parts of the state.

4. Achieving a More Coordinated National Response to the HIV Epidemic

While national influence is unlikely, the Division strives to efficiently coordinate the state's response to the epidemic by continuing to provide an avenue for all Ryan White grantees, funded and non-funded service providers, other local and State agencies, and consumers to work together to coordinate guidelines, service

components, and target populations so that redundancy is minimal and impact on affected communities is maximized. The Part B advisory council provides this avenue and has played a critical role in helping the state achieve its goals, provide care and services to an unprecedented number of consumers, avoid a waiting list for HIV drugs, and prepare for future challenges.

Budget Cuts

Funding reductions are not uncommon. Federal, state, and local budget cuts occur with regularity and generally result in more limited access to services. Fortunately, the design of the Division's service delivery system for Indiana is such that modest reductions in funding for access to medical care are often offset by revenue from 340B rebates (which continue to outpace predictions). Support service activities are more sensitive to funding reductions, and it is in these areas (HIV Care Coordination, for example) that cuts result in shrinkage of the workforce and fewer service opportunities for clients. The Division continually monitors its funding streams and makes adjustments whenever necessary to avoid such consequences. It also is aggressive in advocating for its programs and – because of its documented accomplishments in improving health outcomes – has achieved some success in retaining funding that had been subject to reduction.

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Section 4 – PROGRESS MONITORING

Implementation Plans

The major service component discussed in this plan, the HIV Medical Service Program, has been in continual operation for several years. The implementation of any changes to this or any other program discussed herein will occur according to the timeframes identified in the Service Delivery Plan (Section 3).

Monitoring Plans*

The Division continually monitors its Part B and state-funded contracts through the use of site visits, programmatic audits, and utilization analyses. Each of these is performed at least annually. In addition, Part B claim reviews are conducted on a monthly basis, and quarterly HIV Care Coordination service provision is analyzed to determine compliance with quantitative guidelines.

Monitoring the achievement of Part B goals and objectives is critical for knowing which elements of the program need to be modified or improved. Part B goals and objectives are monitored by the providers and consumers serving on the Evaluation Committee of the advisory council.

Beginning in 2013, the chair of the Evaluation Committee council, in consultation with Division Staff, will prepare a short annual "Part B Goals and Objectives Progress Summary." The summary is due by 15 February of the year and shall cover the preceding fiscal period. The summary is to be submitted to the Evaluation Committee which will consider objectives not achieved within the specified time frame for their continued relevance. Within 45 days of the due date (i.e., 1 April), the Evaluation Committee will issue a brief "Part B Goals and Objectives Progress Report" to the Division with recommended adjustments to the goals and objectives for the next fiscal period. Resources will be refocused as needed to address any outstanding issues, and timeframes will be adjusted accordingly. Over the three years covered by this Monitoring Plan, these reports will be studied to determine trends in progress.

The Evaluation Committee's 2012 Part B Goals and Objectives Progress Report was issued to the Division on 1 April 2013, and its recommendations are reflected in the revisions to this document's Service Delivery Plan (Section 3).

Evaluation Plans*

In accordance with Section 2618(b) of the Public Health Services (PHS) Act, the Part B grantee has established a CQM program to assess the extent to which HIV health services provided to patients are consistent with the most recent DHHS guidelines for the treatment of HIV disease and related opportunistic infections and, as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and the quality of HIV health services.

1. The HAB Perspective

The HIV/AIDS Bureau (HAB) defines quality as "the degree to which a health or social service meets or exceeds established professional standards and user expectations." In order to continuously improve systems of care for individuals and populations, HAB expects evaluations of the quality of care to consider the quality of the inputs, the service delivery process, and the outcomes.

Further, HAB expects quality management programs to recognize three primary purposes:

- To assist medical providers funded through the Ryan White Program in ensuring that funded services adhere to established HIV clinical practice standards and DHHS guidelines to the extent possible;
- To ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access and adherence to HIV medical care; and
- To ensure that available demographic, clinical, and healthcare utilization information is used to monitor the spectrum of HIV related illnesses and trends in the local epidemic.

Finally, HAB believes that quality management programs should:

- Be a systematic process with identified leadership, accountability, and dedicated resources available to the program;
- Use data and measurable outcomes to determine progress toward evidenced-based outcomes;
- Focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement;
- Be a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement activities; and
- Ensure that data collected is directed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes.

In 2007, HAB issued its first group of *HIV Core Clinical Performance Measures for Adult/Adolescent Clients*. The group included five performance measures essential to monitoring the healthcare outcomes of the patient population. These five measures focus on the percentage of:

- Clients with HIV infection who had two or more CD4 counts performed in the measurement year;
- Clients with AIDS who are prescribed HAART;
- Clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year;
- Clients with HIV infection and a CD4 count below 200 who were prescribed appropriate PCP prophylaxis; and
- Pregnant women with HIV infection who are prescribed ARV therapy during the second and third trimesters of pregnancy.

2. ISDH Clinical Quality Management Statement

The Division of HIV/STD within the Indiana State Department of Health is committed to continual quality improvement. In accordance with the PHS Act, the mission of the Division's CQM Plan is to accurately assess the consistency of its HIV Medical Services Program – which includes ADAP – with the DHHS treatment guidelines and to ensure access to high quality health services for HIV-positive individuals in the state. The Division aims to accomplish this mission by gathering and reporting on relevant data elements and by implementing improvement activities based upon careful data analysis.

3. ISDH CQM Objectives

To facilitate achievement of its mission, the Division has developed the following goals and objectives:

a. Goal: To obtain reliable data from valid sources.

- i. Objective: To ensure that data is supplied by the Division's third-party administrator (TPA) and OCDR at ISDH on a routine basis.
- ii. Objective: To review data for accuracy, completeness, and correct formatting.

b. Goal: To facilitate access to and retention in care.

- i. Objective: To monitor internal processing procedures to minimize delays for entry into care.
- ii. Objective: To measure utilization rates and health outcomes as indicated by available lab values.
- iii. Objective: To test improvements to determine impact on utilization and health outcomes.

c. Goal: To optimize the management of resources to achieve maximum health benefits for program participants.

- i. Objective: To coordinate HIV Medical Services improvement activities with the HIV Care Coordination network.
- ii. Objective: To coordinate HIV Medical Services benefits with Ryan White Part A and C providers to minimize duplication and maximize positive health outcomes.

4. ISDH CQM Infrastructure

The Division's HIV Services Coordinator manages all CQM activities and directs a CQM Team. This team is responsible for gathering and reporting data from various sources, evaluating appropriate data elements, systematically reporting findings, and developing and implementing program improvement activities. The CQM Team is comprised of members of the Division's ad hoc CQM committee (which includes consumer and Ryan White Part A grantee representation) and the following ISDH staff:

- The HIV Medical Services Program Manager;
- The HIV Medical Services Enrollment Specialist;
- The HIV Care Coordination Program Manager;
- The HIV Care Coordination Program Specialist;
- The Special Populations Support Program Manager;
- The HIV Advisory Board Liaison;
- The HIV Services Administrative Assistant;
- The OCDR Director; and
- Contracted information technology consultants.

5. ISDH CQM Stakeholder Participation and Communication

The Division's advisory council is the primary conduit for engaging key stakeholders in the CQM Plan. The council consists of representatives from the Ryan White Program (including Parts A, B, C, and F) and the HIV Care Coordination network, as well as other direct service providers and consumers. It meets bi-monthly in Indianapolis to review current activities (including CQM improvement initiatives), to promote collaborations, and

to establish common practices for service delivery and evaluation. Input from members is gathered through formal and informal processes (such as surveys and meeting minutes, respectively), and communication is facilitated by the HIV Services Coordinator in the form of reports, presentations, and conference calls. Those members serving on the ad hoc CQM committee have additional opportunities to provide advice and suggestions regarding the CQM Plan and are often privy to a wealth of preliminary data before final reports are issued.

6. ISDH CQM Annual Process

To address the CQM Plan, the Division completes a series of four distinct activities annually: establishment of health indicators, database analysis, provider education, and supportive service intervention. These activities are conducted by the HIV Services Coordinator in cooperation with the CQM Team.

a. Health Indicators

The Division first established immune system response (CD4 count) and virologic suppression (viral load count) trends as the primary health indicators for its 2005 CQM baseline report on HIV Medical Services Program enrollees. Starting with the 2007 report, the Division also adopted HAB's first group of *HIV Core Clinical Performance Measures for Adult/Adolescent Clients*. All reports have relied on laboratory data obtained from OCDR, which is considered to be the most comprehensive source for such information.

b. Database Analysis

Database analysis is conducted using the Agency Claims Administration Processing System (ACAPS) which was originally developed in 2003 as part of the agency's compliance plan for the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIV Medical Services Program utilization data is retrieved from the Division's TPA, imported into ACAPS at regular intervals, and reviewed by program staff. The Division uses the available utilization and OCDR data to create a variety of reports that describe the extent to which participants are receiving and responding to the care and treatment afforded by the program. This regular analysis is the core of the Division's CQM efforts, and the success of subsequent efforts to improve health outcomes are measured against its findings.

c. Provider Education

Upon analysis, certain trends in the data may indicate that provider education is warranted. However, due to the structure of the HIV Medical Services Program, no physicians or direct service providers are under contract with the Division. Therefore, a strong partnership with the Part F grantee, the Midwest AIDS Training and Education Center (MATEC), is crucial. At minimum, the Division provides MATEC with an annual listing of HIV-reporting providers in the state (using surveillance data from OCDR) to ensure awareness of the most recent DHHS guidelines and updated treatment information. Should the database analysis identify providers who appear to be prescribing regimens inconsistent with these guidelines, additional training may be requested for those providers to ensure future compliance.

d. Support Service Intervention

The Division also targets specialized trainings to areas where clients appear to experience poor health outcomes (again based on the utilization review and other health indicators gathered during the HIV Medical Services Program application and recertification processes). HIV Care Coordinators are currently trained to assist clients in achieving access to medical care and in adhering to prescribed regimens. In geographic areas where the data imply that this is not happening, the Division can take direct action in the form of this support service intervention to improve the level of care and, thereby, the quality of life for clients.

7. Data Elements and Sources

The Division's TPA is required by contract to provide client-level utilization data, per service, to the Division on a routine basis. This includes data for any service covered by any component of the HIV Medical Services Program, including ADAP and insurance assistance. The information is received in a variety of electronic formats depending on the original data source. Details include client and provider identifiers, dates of service and payment, NDC and CPT codes, service descriptions, co-payment and deductible amounts, and net cost. The Division has successfully imported data for all services dispensed since 2001.

The 2011 data analysis focused on the following measures:

- Timeliness of internal processing;
- Compliance with case management engagement;
- Termination reasons codes and recertification failure rates;
- Outpatient visits;
- Emergency room visits;
- CD4 frequency and counts;
- Viral load frequency and counts;

- AIDS status at enrollment and progression;
- HAART indicators;
- PCP prophylaxis indicators;
- Pregnancy indicators;
- Influenza vaccine indicators;
- Pneumococcal vaccine indicators; and
- Reporting physician characteristics.

Demographic, health indication, and service utilization data are collected from the HIV Medical Services Program applications, re-certification interview records, claims data collected by the TPA, and laboratory reports submitted to OCDR. The data are reviewed at least quarterly to identify any areas of concern. Areas requiring attention are studied by the Division and presented to the advisory council's ad hoc CQM committee for its recommendations. Large-scale problems (such as barriers to physician access in rural areas) can be addressed in subsequent planning sessions where funding shifts can be considered. Smaller scale problems (such as suspected physician failure to adhere to DHHS treatment guidelines) are addressed immediately through provider education with the assistance of MATEC. Overall, through this extensive data review, the Division is able to closely monitor HIV-related illnesses and trends among the population being served and to document the extent to which those individuals receiving care through the program are experiencing positive health outcomes.

8. Description of 2010 Quality Indicators

The 2011 data analysis focused on four of the five major indicators for quality care used by the Division in previous CQM reports, as well as HAB's Group 1 performance measures. The Division's CQM indicators included timeliness, compliance, appropriateness, and positive health outcomes. HAB's performance indicators included clinical measures of CD4 count, HAART, medical visits, PCP prophylaxis, and ARV therapy for pregnant women.

a. Division CQM Measures

i. Timeliness

The analysis of timeliness considered the duration between the time the consumer submits an application and the time that services are available to be rendered. Specifically, it compares the application's creation date to the "document completion date" assigned by the Enrollment Specialist. The Division makes the assumption that the shorter the elapsed time, the more timely the service was rendered. This analysis was based on all new applications received in 2011. It does not take into account any wait list as the "document completion date" is assigned before the applicant can be placed on the list. [There was not a wait list in 2011.]

ii. Compliance

The analysis of compliance ascertained the degree to which the enrollees engage the required case management services. Frequency of case management contact with all participating care sites in 2011 was reviewed. The Division makes the assumption that as the frequency of case management contact increases, the chance for improved health outcomes over time improves. This analysis considered all active Health Insurance Assistance Plan (HIAP) enrollees during 2011 (defined as a member with a pre-ex or HIAP start date on or before 1 January 2011 and a HIAP end date on or after 31 December 2011 or null and with at least one positive-value qualifying outpatient service payment within the measurement year). This year, the analysis also included a review of termination reasons and recertification failure rates.

iii. Appropriateness

The analysis of appropriateness compared the utilization trends to components of the DHHS guidelines to determine if adequate care has been provided. Particular attention was placed on evidence of CD4 and viral load tests and frequency of physician appointments. The Division makes the assumption that as adherence to the DHHS guidelines and best practice recommendations increases, health outcomes also will improve. This analysis also considered all active HIAP enrollees in 2011 (as described above). This year, a review of emergency room usage by region was also included in the analysis.

iv. Health Outcomes

The analysis of health outcomes considered recent CD4 result data to place enrollees into one of three tracks: Good Health (with most recent CD4 count at or above 351), Moderate Health (with most recent CD4 count between 201 and 350), and Poor Health (with most recent CD4 count at 200 or less). It also determined a simple community viral load result for the members and reviewed AIDS progression since enrollment. The Division makes the assumption that as access to care continues, adherence

improves and CD4 counts should increase while viral loads decrease. Like the other measures, this analysis was based on all active HIAP enrollees in 2011.

b. HAB HIV Core Clinical Performance Measures (Group 1)

The following measures all reflect important aspects of care that significantly impact survival and mortality. The last measure, ARV therapy for pregnant women, also significantly impacts transmission. Data collection for these measures is currently feasible, and each has a strong evidence base to support its use.

i. HAB 1.1 – CD4 Cell Count

The CD4 count plays a vital role in determining the staging of HIV disease and indicating the need for prophylaxis against opportunistic infections. It is commonly used in decisions regarding initiation or adjustment of ARV treatment. The most recent CD4 count is the strongest predictor of subsequent disease progression and survival, according to clinical trials and cohort studies data on patients receiving ARV therapy.

ii. HAB 1.2 – HAART

Randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating symptomatic patients and patients with CD4 counts under 200.

iii. HAB 1.3 – Medical Visits

Clinicians should schedule routine monitoring visits at least every four months for all HIV-infected patients who are clinically stable. It is believed that greater experience among primary care physicians in the care of persons with AIDS improves survival.

iv. HAB 1.4 – PCP Prophylaxis

PCP is the most common opportunistic infection in HIV-positive people. Without treatment, over 85% of people with HIV eventually develop PCP. It is a major cause of mortality, yet it is almost entirely preventable and treatable. People with CD4 counts under 200 are at greatest risk of developing PCP.

v. HAB 1.5 – ARV Therapy for Pregnant Women

Treatment recommendations for pregnant women infected with HIV-1 have been based on the belief that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus, or infant and unless these adverse effects outweigh the benefit to the woman. ARV therapy can reduce perinatal HIV-1 transmission by nearly 70%.

For 2011, two additional measures were included from Group 3 of HAB's *HIV Core Clinical Performance Measures* (influenza vaccination and pneumococcal vaccination). However, concerns were raised during and following the analysis related to the adequacy of available data. Regardless, the initial results are included in the following section.

4. 2011 Goals and Results

In calendar year 2011, 470 new applications were received, and 1350 enrollees were active for the continuous 12-month report period. For the analysis, the 2011 sample was limited to a subset of 1275 HIAP service recipients who were defined as “members with an open date on or before 1 January 2011, a termination date after 31 December 2011 (or null), and at least one positive-value qualifying outpatient service payment within the measurement year.” The analysis which follows shows the 2011 results in comparison with those found in 2010.

a. Division CQM Measures

i. Timeliness

The goal for timeliness was an average elapsed time of less than 30 days between application date and plan start date. In 2009 and 2010, the result was 2 days.

ii. Compliance

The goals for compliance were an HIV Care Coordination enrollment rate of 100% and an active HIV Care Coordination compliance rate (defined as four or more visits per year) of 85%. The 2010 data showed a 100% enrollment rate and an 82% active compliance rate. The 2011 results also showed a 100% enrollment rate but only a 59% active compliance rate. The data appeared to indicate that a larger percentage of enrollees were categorized as “maintenance” clients (requiring only one annual HIV Care Coordination visit) compared to past reports.

This year, the analysis also included a review of termination reasons and recertification failure rates. It showed that 233 enrollees were removed from HIAP services between 1 January 2011 and 31

December 2011. Of these removals, 83% were coded with “successful” reasons for the termination (e.g., transition to Medicaid, increased income, and moved out of state). The remainder (17%) was coded with “unsuccessful” reasons, including failure to complete the recertification process (13%).

iii. **Appropriateness**

The goals for appropriateness were two or more physician visits and one or fewer emergency room visits for at least 75% of the enrollees; two or more CD4 tests for at least 80% of the enrollees; and two or more viral load tests for at least 65% of the enrollees. The 2010 results showed that the Division exceeded its goals for outpatient visits, ER visits, CD4 counts, and viral load counts (98%, 81%, 80%, and 76%, respectively).

The 2011 results showed that the Division again met or exceeded its goals for outpatient visits and ER visits (99% and 80%, respectively) but regressed somewhat on the CD4 and viral load counts measures (reporting only 76% and 62%, respectively).

To understand the areas where improvements are still possible, the Division performed an additional “appropriateness” query focused on emergency room usage by geographic location and, specifically, by HIV Care Coordination site. Results showed that more than 47% of the enrollees with two or more emergency room visits in the report period lived in Region 7 and received services from one of three primary HIV Care Coordination sites in Indianapolis.

iv. **Health Outcomes**

The goals for health outcomes were:

- An 80% distribution of enrollees to either the Good or Moderate Health groups (those whose most recent CD4 count is above 200);
- Viral load test result of less than 50 copies for 75% of enrollees; and
- An average viral load result below 50 copies.

The 2010 analysis showed that 76% of enrollees were found to be in the Good or Moderate Health groups, and 64% had recent viral load results of less than 50 copies. The simple community viral load result was less than 10,000.

The 2011 results were less positive. Seventy-four percent were shown to be in the Good or Moderate Health groups and only 46% had undetectable viral load results. The average viral load result for all enrollees in the sample stayed relative steady, however, at 10,908 copies (considered to be the “moderate” health range).

This year, a review of AIDS progression since enrollment was also included in the analysis. The results showed that 41% of the enrollees had an AIDS diagnosis at the time of enrollment and that only an additional 3% progressed to an AIDS status within the first 12 months. Another 6% progressed after the first 12 months, and 50% of enrollees in the sample have never received an AIDS diagnosis.

b. **HAB HIV Core Clinical Performance Measures (Group 1)**

i. **HAB 1.1 – CD4 Cell Count**

The national goal for CD4 counts is 90% with two or more counts performed at least three months apart in a report period. The median goal is 63%. Based on HIAP service recipients in CY 2010, excluding new enrollees from July through December, only 59% of the sample group met the measurement criteria. However, when using adjusted inclusion guidelines – i.e., retaining new enrollees in the sample and removing the three-month test spacing criteria – the 2010 result was markedly better (80%).

For 2011, the standard result was slightly lower (53%). This was also true for the alternate query result of 76%; however, the alternate result was comparable to that achieved by the Ryan White Part A Program in Indianapolis for a recent report period (75%).

ii. **HAB 1.2 – HAART**

The national goal for prescribed HAART is 90% for those with AIDS in a report period. The median goal is 100%. Based on HIAP service recipients in CY 2010, excluding new enrollees from October through December and those without at least one CD4 count in history below 200, 98% of the group met the measurement criteria. This result was strong enough to eliminate the need to perform an alternate query with adjusted inclusion guidelines.

For 2011, the standard result was also strong (97%) and required no alternate queries.

iii. **HAB 1.3 – Medical Visits**

No national or median goals have been established for medical visits. However, the program has established its own goal of 75%. Based on HIAP service recipients in CY 2010, excluding new enrollees from July through December, 63% of the sample group met the measurement criteria of two or more physician visits at least three months apart. When using the Division's adjusted inclusion criteria – i.e., retaining new enrollees in and removing the three-month test spacing criteria – the result was significantly better (99%) and exceeded the established goal.

For 2011, the standard result was better than the previous year (68%), and the alternate query yielded the same result as in 2010 (99%).

iv. **HAB 1.4 – PCP Prophylaxis**

The national goal for PCP prophylaxis is 95% prescribed therapy for those with AIDS in a report period. The median goal is 94%. Based on HIAP service recipients in CY 2010, excluding new enrollees from October through December, those without at least one CD4 count in history below 200, and those whose most recent count below 200 was followed within three months by a subsequent count above 200, only 24% of the group met the measurement criteria. When using the Division's adjusted inclusion criteria – i.e., limiting the sample to only those with a CD4 count below 200 in the measurement period – the result was significantly better (78%).

For 2011, the standard query itself was adjusted to include only those with a non-rebounding CD4 count below 200 in the measurement period, and the result was similar to 2010's alternate query (82%). This adjustment removes the impact of the manner in which "those with AIDS" was defined for the original calculation, as it included anyone who had ever had a sustained CD4 count below 200.

v. **HAB 1.5 – ARV Therapy for Pregnant Women**

No national or median goals have been established for ARV therapy for pregnant women. However, the program has established its own goal of 95%. Based on HIAP service recipients in CY 2010, excluding new enrollees from October through December, those without a pregnancy indicator, those with a pregnancy indicator from October through December, and those without a pregnancy termination indicator, 83% of the group met the measurement criteria of prescribed ARV therapy for all pregnant HIV-positive women. An alternate query which accounted for potential short-term coverage through Indiana Medicaid for the pregnancy did not produce superior results.

For 2011, the standard results showed even more improvement (90%), and there was not a need to repeat any alternate queries.

5. Resultant Service Changes To Date

Based on the CQM analyses conducted over the last several years, the Division has taken a number of steps to improve service delivery and health outcomes. The following paragraphs describe highlights of the activities and initiatives prompted by the various CQM reports.

In 2008, the Division developed "Empowerment Cards" for enrollees identified by their HIV Care Coordinator as having difficulty remaining engaged in care. Different cards were created for a number of circumstances (e.g., naïve to treatment, long-term survivor, etc.). Each wallet-size card contains a series of questions to help the client engage their medical providers in conversations about specific health concerns. As these cards were introduced, the Division also began a series of consumer forums around the state. These evening events provided clients and providers an opportunity to learn more about various aspects of the service and care continuum and to participate in a presentation specifically addressing adherence to medical and pharmaceutical treatment plans. Both of these initiatives have continued through 2012.

In the summer of 2009, the CQM committee convened to refine the queries used in this report. Shortly thereafter, Donna Yutzy from the Oregon Department of Human Services visited the Division to provide additional technical assistance. These meetings resulted in the query modifications and additions represented by the tables that first appeared in the CY 2008 report.

In the summer of 2010, the Division launched the first phase of its "active engagement" campaign by conducting a thorough benefits utilization review. Using claims data, all enrollees were screened for lack of evidence of medical visits, CD4 counts, viral load lab tests, or prescription fills. Those found to be in one or more of these categories were issued a letter and brief questionnaire soliciting information regarding the potential reasons for the under-use of the program.

Responses indicated that the lab data supplied by the OCDR may have been incomplete. An investigation was subsequently launched by the OCDR, and a number of non-reporting facilities were identified. Once this issue was resolved, the non-utilization report was repeated and revealed only four enrollees without evidence of medical visits, CD4 counts, viral load lab tests, and prescription fills within the report period. Each of these enrollees was contacted and re-introduced to care in early 2011.

Also in early 2011, the second phase of the “active engagement” campaign began and included the development of a number of new devices designed to continually remind enrollees of the necessity to remain compliant with all medication regimens, medical care plans, and HIV Medical Services Program guidelines. As this second phase was beginning, the Division prepared a baseline “community” viral load report to compare the average viral levels of enrollees to those of the general HIV-positive population in Indiana. The program was pleased to be able to document that the average HIV viral load for enrollees was 9246, while that of the prevalence population was 41,139 (more than four times higher), implying that program enrollees are four times healthier than the larger HIV-positive community. The result also suggests that enrollees are 78% less likely to transmit their infection to another person. This community viral load measurement has since been incorporated into the Division’s standard measure for health outcomes and the most recent results are contained herein.

In late 2011, the Division developed a second community viral load analysis for inclusion in the annual Unmet Need Report. This analysis determined the average viral loads for a number of different (and sometimes overlapping) sub-populations. These included the prevalence population, the Unmet Need population, those receiving Indiana Medicaid, those dually enrolled in the HIV Medical Services Program and the HIV Care Coordination Program, the overall Care Coordination client population, and Care Coordination clients with health care coverage other than the HIV Medical Services Program. The report compares the various groups and ranks them by the percentage receiving regular viral load testing and by the average results.

To date, the Division’s improvement activities also have included the following:

- Technical assistance arranged through HRSA for improved CQM activities (in collaboration with the Part A grantee);
- “Welcome Calls” from the HIV Medical Services Program Manager to all new enrollees to introduce the HIV Medical Services Program and its benefits, to familiarize the client with the available services, and to reinforce treatment plan adherence;
- Edited HIV Medical Services Program recertification forms that emphasize the importance of regular CD4 and viral load testing by prompting the HIV Care Coordinator to remind the client during the interview of the importance of obtaining and reviewing with their physician new CD4 and viral load test results at least annually;
- Refresher courses for HIV Care Coordinators where the importance of full benefit utilization is stressed;
- Focus on lab result entries in the HIV Care Coordination database during annual program audits;
- Regular conference calls with the HIV Medical Services Program’s TPA to ensure accurate and complete data;
- Regular revision to HIV Medical Services Program formularies with the participation of key advisory council members to ensure that all drugs and services considered essential in the guidelines were addressed in the formularies;
- Letters issued to billing providers describing the program and its benefits as they relate to the DHHS guidelines and underscoring the availability of HIV-related services during the pre-existing condition exclusionary period for the insurance assistance component (a three-month window where utilization is traditionally suboptimal);
- Collaborations with MATEC to address irregularities in the provision of treatment by providers, including specialized messages delivered during MATEC’s HIV update conference;
- HIV Care Coordination training on the importance of medication adherence;
- Monthly phone calls from case managers to enrollees to emphasize the importance of medication adherence;
- Creation and distribution of detailed fact sheets explaining how each plan should be used by the consumer and billed by the provider;
- Creation and distribution of recertification “reminder” magnets;
- Creation and distribution of adherence calendars with appointment reminder stickers; and
- Incorporation of adherence materials in the initial mailing (containing enrollment cards, etc.) from the Division’s TPA.

For a more detailed description of previous years’ activities, see the CY2008 Data Analysis Report.

As evidenced by the 2010 and 2011 results, these cumulative efforts have helped the Division maintain the utilization levels for CD4 testing and outpatient visits and to realize vast improvements in the frequency of viral load testing. The Division has continued most of the identified activities throughout FY 2012 and hopes to see further improvements when the next CQM report is issued in FY 2013. At a minimum, the Division expects to find a positive change in the frequency of recommended laboratory testing.

6. Planned Quality Activities

The overall goal of the CQM initiative will continue to be the accurate assessment of the consistency of services provided through the HIV Medical Services Program with the DHHS guidelines for the treatment of HIV disease and related opportunistic infections. Through this process, the Division intends to improve adherence to the guidelines among providers and patients and to positively affect health outcomes.

While the 2011 report demonstrates that many of the goals are being achieved, it remains clear that improvements are still possible. The Division will seek the guidance of its advisory council to determine what further steps will be necessary to realize these improvements.

The current CQM analysis process includes HAB's Group 1 performance measures; future processes will reconsider the inclusion of other relevant HAB indicators. A number of further adjustments and additions to the existing report format are still under consideration. These include analyses of the following:

- Number whose most recent CD4 or viral load test was not within the previous 120 days;
- Number who are dispensed at least one drug per month (to measure adherence consistency rather than treatment appropriateness); and
- CD4, viral load, outpatient visit, HAART indicator, and ER visit rates for those dispensed at least one drug per month.

In addition to the current activities described earlier, a number of potential new improvement activities have been discussed within the Division. These may include:

- Provision of client non-adherence information (e.g., fewer than five ARV claims in a six-month period) to specific HIV Care Coordinators for direct intervention;
- Comparison of data directly from pharmacy partners (e.g., BioScrip and Walgreens) to validate adherence presumptions based solely on ICHIA utilization data;
- Development of new consumer forums to directly outreach to non-English speakers;
- Summit with Community Health Center network leadership to identify key facilities to educate and nurture through MATEC;
- Review of insurance concerns in the HIV Care Coordination database that are not resolved within 90 days;
- Pre-population of recertification forms with recent CD4 and viral load information from OCDR;
- Uniform implementation of the standard model for Chronic Disease Self-Education; and
- Development of a one-page information sheet for consumers regarding the importance of appropriately accessing the health care system and minimizing emergency room usage.

Finally, the Division is preparing for the imminent changes necessitated by the passage of health care reform legislation. Communication with the management of the state's high risk pool, as well as with the National Association of State Comprehensive Insurance Plans and Office of Consumer Information and Insurance Oversight has been frequent and should prove to be invaluable as these reforms are fully enacted between now and 2014.

Special Consideration of Early Identification Initiatives

To better understand and address the population of people with HIV who do not yet know their status, the Division created its EIIHA population estimate in 2010. Because the strategy related to this estimate is still in its infancy, its assessment will be limited to process reviews and provider feedback until such time as testing data can be clearly linked to care data. Without such a connection, it would be speculation to credit the state's EIIHA efforts with any changes in the actual number of newly identified HIV-positive persons entering care.

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CONCLUSION

Indiana's Statewide Comprehensive Plan for FY2012-2015 provides a thorough description of the service delivery system for HIV care funded through Part B of the Ryan White Program and through allocations from the State of Indiana. It highlights the collaborations that the Division of HIV/STD has established with other HIV-related programs in the state to maintain a cohesive continuum of care. By incorporating the Statewide Coordinated Statement of Need, it also provides a description of the needs of persons living with HIV in the state and summarizes the perceived barriers to meeting those needs. The plan recommends a number of actions designed to overcome the identified barriers and summarizes the goals and objectives intended to address each priority service need.

Limitations

Due to the limitations of the funding and of the current healthcare delivery system in Indiana, some of the identified needs (such as transportation services) are not exhaustively addressed in this Statewide Comprehensive Plan. The Division expects to continue its efforts to develop partnerships with other Ryan White Program grantees and other providers to ultimately reduce the impact of these needs on the HIV-positive population in the state.

The Statement of Need portion of the plan relies in part on the state's HIV/AIDS Needs Assessment Report, which was finalized and presented to the Division in February 2002. This and subsequent reports attempted to quantify needs based on direct feedback from consumers and providers of HIV-related services. Because of the subjective nature of the self-reported data from consumers, some areas of need may be under- or over-represented. The information presented in these reports, and thus the needs identified, must be considered in this context.

Future Plans

This document is intended to be updated each year of the three-year plan period as the Division's response to the epidemic improves and expands. During the revision process, the Division will encourage increased involvement from consumers and members of its advisory council. The plan and its goals and objectives are scheduled for a complete revision in April 2015.

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ATTACHMENT A
INDIANA'S 2012 PRACTICAL GUIDE TO HIV RESOURCES

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