DENVER HIV RESOURCES PLANNING COUNCIL

2012 - 2014
Comprehensive Plan
Denver Transitional Grant Area

DENVER

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Denver HIV Resources Planning Council
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Introduction

The Need for a Comprehensive Plan

Comprehensive HIV services planning is an essential part of all Ryan White programs. As such, the Health Resources and Services Administration (HRSA) requires that all Part A grantees develop a plan for the organization and delivery of HIV health and support services in their jurisdictions. Each plan must reflect a system that:

- Delivers quality core medical services
- Eliminates disparities in access to services
- Conducts strategic outreach to people living with HIV/AIDS (PLWHA) not in care
- Assesses results based on clinical quality measures

The comprehensive plan must also include strategies that:

- Identify individuals who know their HIV status but are not in care and inform and link these individuals to HIV-related services
- Eliminate barriers to care and disparities in services for historically underserved populations
- Provide goals, objectives, and timelines (as determined by the needs assessment)
- Coordinate services with HIV prevention programs including outreach and early intervention services
- Coordinate services with substance abuse prevention and treatment programs

Comprehensive planning helps the Planning Council respond to changes in the system of care that address the unique needs and challenges of people living with HIV/AIDS in the Denver Transitional Grant Area (TGA). This is especially critical in light of new legislative and programmatic health initiatives such as the National HIV/AIDS Strategy (NHAS), Healthy People 2020, and the Affordable Care Act (ACA).

The Comprehensive Plan is the TGA's "vision" of how best to deliver HIV services. It is compatible with other local HIV service plans and provides strategies to respond to key issues raised in local needs assessment findings. In envisioning this ideal system of care, the comprehensive planning process required the Planning Council to answer four questions:

1. Where are we now?
2. Where do we need to go?
3. How will we get there?
4. How will we monitor our progress?

Comprehensive Planning Process

In a series of retreats and meetings, the Comprehensive Plan was developed through the collaborative efforts of the:

- Denver HIV Resources Planning Council (DHRPC)

- Denver Office of HIV Resources (DOHR)
- Colorado Department of Public Health and Environment (Part B grantee)
- Members of the following committees and workgroups: Evaluation and Assessment, Leadership (Executive), People of Color Leadership, Rebuilt+ (PLWHA), Metro Denver AIDS Services Coalition, Aging with HIV, and Oral Health
- People living with HIV/AIDS
- Community stakeholders and members

The 2011 Denver TGA Part A Needs Assessment serves as the foundation for the comprehensive plan and was conducted in collaboration with Part B (note that some data will be slightly different from the Part B Needs Assessment and the Statewide Coordinated Statement of Need, as Part A had an earlier return date for surveys, thus in some instances the total number of respondents will be different). In addition to the TGA needs assessment, other important documents and processes that contributed to the plan include:

- Analysis of CAREWare/client service utilization data
- Colorado HIV surveillance reports
- Analysis of Enhanced HIV Reporting System (eHARS) data sets
- Colorado Early Identification of Individuals with HIV/AIDS (EIIHA) report
- Statewide Coordinated Statement of Need (SCSN)
- 2011 HIV/AIDS Care and Treatment Needs Assessment
- 2011 HIV Prevention Needs Assessment
- Part B 2009-2012 Comprehensive Plan for HIV Care and Treatment
- Statewide Quality Improvement Plan
- Part A Standards of Care
- In+care Campaign Measures
- National HIV/AIDS Strategy
- Healthy People 2020 Initiative

Executive Summary

The 2012-2014 comprehensive plan for the Denver TGA is the result of a community planning process involving a wide variety of stakeholders. The plan is based upon the issues identified by PLWHA and providers in the 2011 Denver TGA Needs Assessment. Additional insight was obtained from different sources including surveillance reports, client service utilization data, other local HIV plans, and national programmatic and legislative initiatives. The comprehensive plan is broken down into four sections:

Where are we now?
The purpose of this section is to identify populations in most need of HIV care and services as well as barriers to care, provide an overview of the current state of HIV health care and service delivery in the Denver TGA, and identify progress and shortfalls.

In 2010, there were 8,648 persons in the Denver TGA who were living with HIV or AIDS. In terms of race/ethnicity, Whites continue to account for the largest number of HIV/AIDS cases within the Denver TGA, approximately 64% (5,561).

Estimating unmet need in the TGA is an important part of the comprehensive plan. Unmet need is defined as the need for HIV-related health services by individuals with HIV who are aware of their HIV status but are not receiving regular primary health care. Estimating unmet need in the TGA posed some challenges due to the discrepancy in the estimates derived by the Denver Office of HIV Resources (DOHR) and Colorado Department of Public Health and Environment (CDPHE). Despite the challenges inherent in both estimates, it has been useful to present and consider both. DOHR estimated that 3,086 or 36% of PLWHA in the TGA had not received primary medical care during 2010. CDPHE estimates 53% (4,532) of PLWHA in the TGA were considered "out of care" in 2010. An important element of assessing unmet need is describing the needs of people who are unaware of their HIV status. As of June 30, 2011, there were an estimated 2,312 HIV-positive individuals in the Denver TGA who were unaware of their status.

In regards to the continuum of care, the Denver EMA has a comprehensive service delivery system for PLWHA, funding eight core and four support services through various organizations.

From analysis of the 2011 needs assessment findings and eHARS and CAREWare data, key areas of focus to improve access to care became apparent:

- Linkage – improving linkage to care for newly diagnosed patients is key to reducing unmet need in the Denver TGA.
- Retention – improving retention in care needs to be made on several fronts including improving information about services, reducing systemic barriers, and increasing health literacy and motivation to seek care.
- Oral health – there is a need for increased oral health capacity within the TGA. For many years, PLWHA have reported high rates of unmet dental care needs (ranked #1 in needed but not received services by consumers in the needs assessment).

- Special populations – understanding the needs of special populations within the TGA and the barriers that prevent them from accessing care is a key focus of the DHRPC. These populations include: adolescents, injection drug users, homeless, transgender, African Americans, aging PLWHA, and foreign born (including undocumented).
- Affordable Care Act readiness – understanding the impact of the Affordable Care on people living with HIV and how it will impact Ryan White funding is an important focus of the TGA.

Where do we need to go?

The purpose of this section is to discuss the Denver TGA's vision for an ideal, high quality continuum of care and the elements that shape this ideal system. The comprehensive planning process has identified six goals to assure a coordinated continuum of care for PLWHA:

- Goal 1: ensure that HIV positive individual who are unaware of their status are identified, informed of their status, referred to medical treatment, and linked into care.
- Goal 2: Identify individuals who know their status but are not in care and inform and link these individuals to HIV-related services (linkage to care).
- Goal 3: Increase the proportion of PLWHA retained and/or reengaged in care.
- Goal 4: Monitor and evaluate the impact of the Affordable Care Act on HIV services in the Denver TGA.
- Goal 5: Increase access to affordable dental care.
- Goal 6: Reduce disparities in accessing care for the following special populations: adolescents, injection drug users, homeless, transgender, PLWHA aging with HIV, African Americans, foreign born, undocumented, and African immigrants/refugees.

How will we get there?

The comprehensive plan outlines specific strategies and timelines for achieving identified goals and meeting identified challenges. Additonally, it lays out proposed coordinating efforts with the following programs to ensure optimal access to care: Parts B/C/D/F services, private providers, prevention programs, substance abuse treatment programs, STD programs, Medicare, Medicaid, the Children's Health Insurance Program, and community health centers.

How will we monitor our progress?

Progress on the comprehensive plan will be reviewed on a quarterly basis, using quality indicators where indicated. Individual performance measures will be assessed to determine if current efforts are generating the desired outcome and if additional actions are necessary. Quality measures will be evaluated based on several data sources including: CAREWare data reports, site visit reports, and needs assessment data.

I. Where Are We Now?

The purpose of this section is to identify populations most in need of HIV care and services, as well as barriers to care, to provide an overview of the current state of HIV health care and service delivery in the Denver TGA, and to identify progress and shortfalls.

A. Description of the Local HIV/AIDS Epidemic

2010 Epidemiological Profile

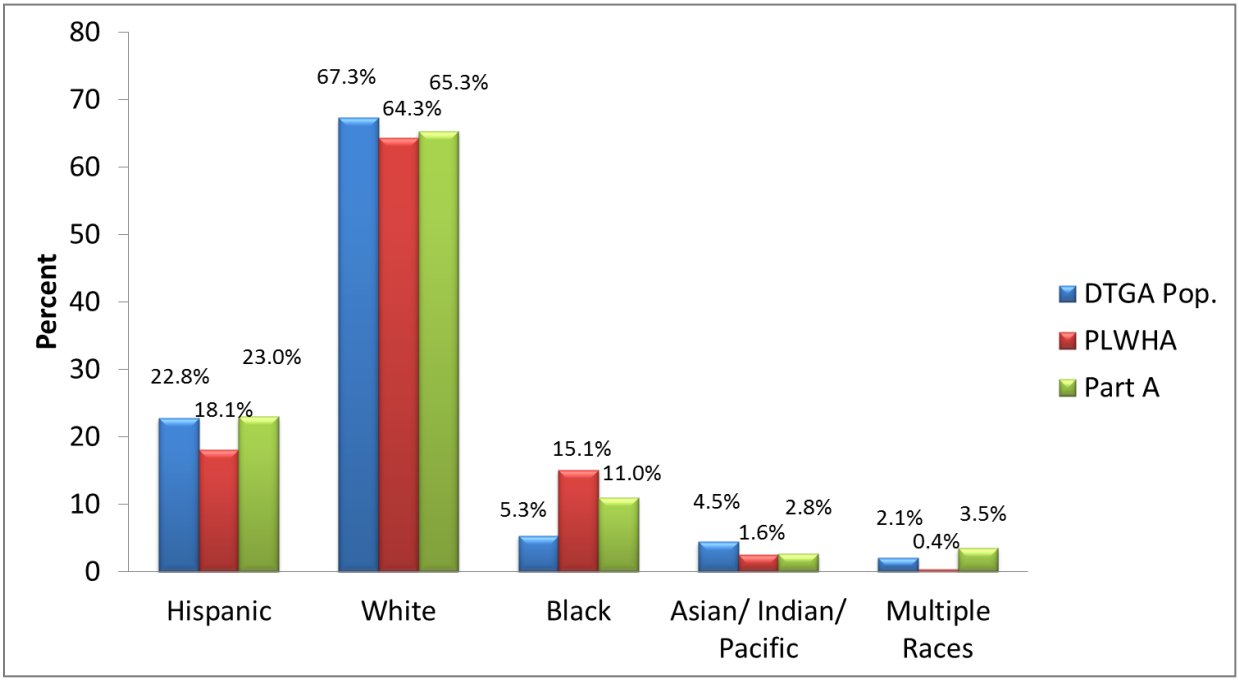
Description of Denver Transitional Grant Area
The Denver TGA is comprised of 6 counties: Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson. In 2010, the population of the TGA was estimated to be 2.49 million.[1] Approximately 49% of Colorado's population resides in the TGA. Within that population, an estimated 3,730 people are living with AIDS and 4,918 with HIV, according to data provided by the Colorado Department of Public Health and Environment (CDPHE). Thus, 8,648 persons in the Denver TGA, or approximately 0.35% of the TGA's population, were living with HIV or AIDS in 2010.

Denver TGA Demographics
In terms of race/ethnicity, Whites continue to account for the largest number of HIV/AIDS cases within the Denver TGA, at approximately 64% (5,561); followed by Hispanics at 18% (1,566); Blacks at 15% (1,304); Asians, Native Americans, and Pacific Islanders (combined) at 1.6% (139); and individuals who identify with multiple races at 0.4% (32).

Graph A compares three distinct populations within the Denver TGA by race and ethnicity: the general population (blue bar); HIV-positive population (red bar); and individuals accessing Part A services (green bar). While illustrative, some caution in interpreting the data is warranted as race and ethnicity are treated differently for Part A services than in the other two data sets.

[1] U.S. Census Bureau, 2010 Census

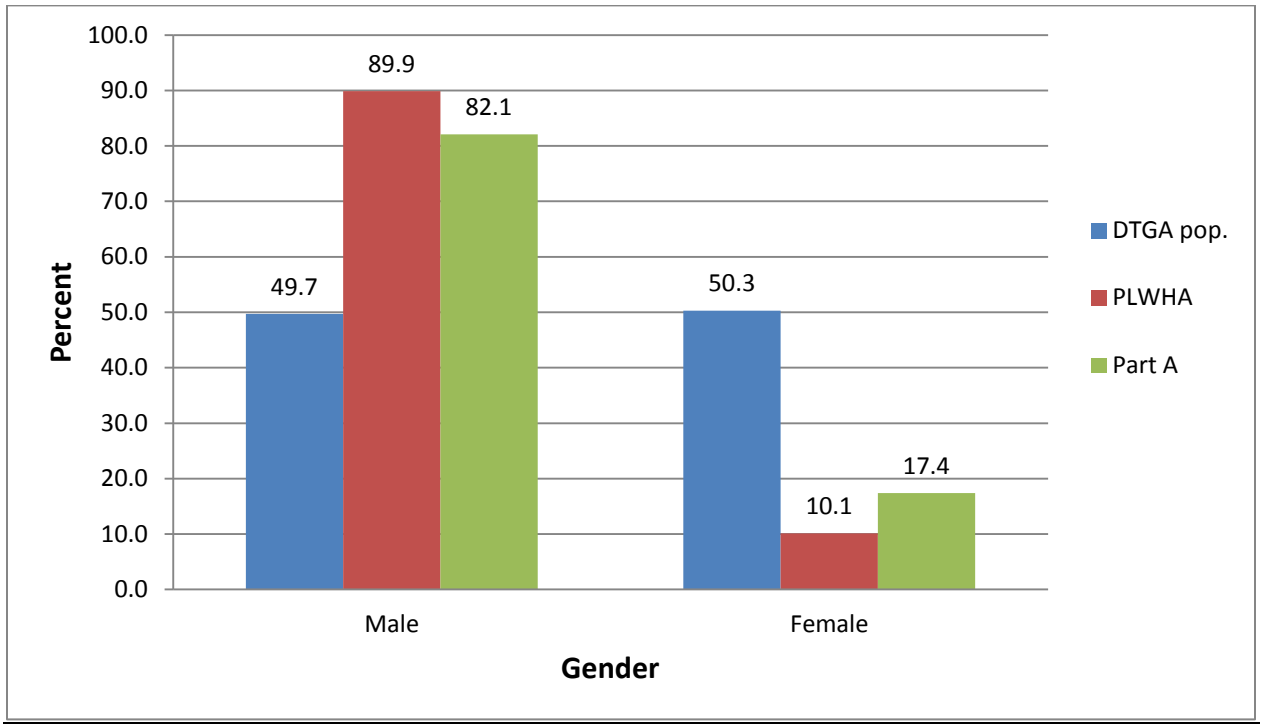
Graph A[2]: Comparison by Ethnicity/Race: Denver TGA General Population, Denver TGA PLWHA and Denver TGA Part A Clients, 2010



It is important to note that Blacks are disproportionately impacted by HIV/AIDS within the TGA, being overrepresented within the HIV-positive population at a rate 2.8 times higher than their representation in the Denver TGA general population. At the same time, Black PLWHAs are under-represented in terms of accessing services. While they comprise 15% of the HIV-positive population, they only account for 11% of those utilizing Part A services. White and Hispanic individuals, on the other hand, appear to be accessing services at a rate proportionate to their representation in the HIV-positive population.

[2] For the DTGA general population, individual races (i.e., White, Black, Asian/Indian/Pacific and Multiple Races) include only those individuals who are non-Hispanic. This is true of the PLWHA population as well. For the Part A participant population, however, individuals within any particular race could be Hispanic or non-Hispanic, so that Hispanics may be reported both as Hispanic and in a race category). Sources: U.S. Census Bureau, 2010 Census; eHARS, provided by CDPHE, May 2011; CAREWare, provided by DOHR

Graph B[3]: Comparison by Gender; Denver TGA General Population, Denver TGA PLWHA, and Denver TGA Part A Clients, 2010



There are also differences when one looks at the HIV epidemic by gender. While the ratio of men to women within the Denver TGA general population is relatively equal (1.24 million males to 1.25 million females), men represent almost 90% (7,774) of the PLWHA population, compared to women who represent only 10% (874) of the PLWHA population (see Graph B). By risk group, men who have sex with men (MSM, including MSM/IDU) remain the most severely impacted by HIV, accounting for 75.6% (6,535) of the PLWHA population.

Denver TGA Prevalence Trends

Overall, the demographic characteristics of persons diagnosed with HIV and AIDS in the Denver TGA are similar to those of persons diagnosed in Colorado as a whole. This may largely be due to the fact that the majority of HIV-positive individuals in the state reside within the Denver TGA. As of December 2010, PLWHA residing within the Denver TGA accounted for approximately 77.8% (8,648) of all PLWHA within the state of Colorado (11,114[4]). The following highlights HIV prevalence trends within the Denver TGA from 2008-2010.

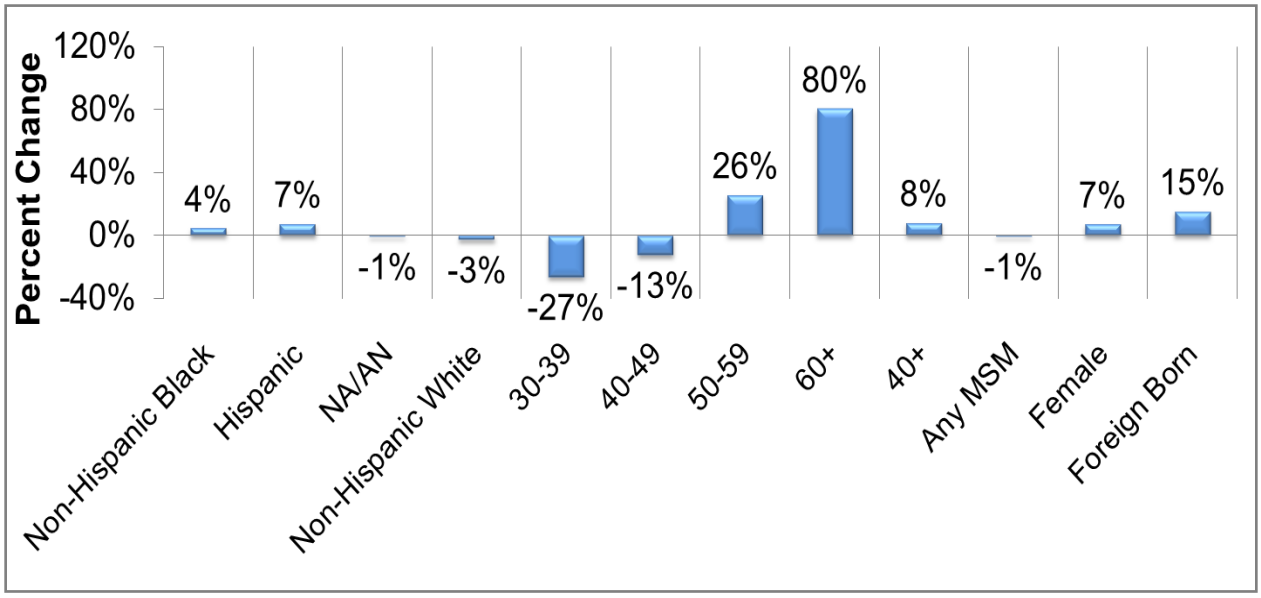
[3] CAREWare male and female populations add up to less than 100% because CAREWare also includes a gender variable for transgender, which is not included in the other two data sources.
Sources: U.S. Census Bureau, 2010 Census; eHARS, provided by CDPHE, May 2011; CAREWare, provided by DOHR

[4] Colorado Department of Public Health and Environment, 2010. "Colorado HIV Surveillance Report; 4th Quarter 2010." Available at www.cdphe.state.co.us/dc/HIVandSTD/HIV_STDSurv/HIV.AIDS.Surv.rpt.4thQuarter.2010.pdf

- The proportion of PLWHA living in the Denver TGA who identified as White decreased slightly, from 65.3% (5,376) in 2008 to 64.3% (5,561) in 2010.
- There was a slight increase in the proportion of PLWHA living in the Denver TGA who identified as Black, from 14.8% (1,214) in 2008 to 15.1% (1,304) in 2010.
- The proportion of PLWHA living in the Denver TGA who identified as Hispanic increased from 17.5% (1,438) in 2008 to 18.1% (1,566) in 2010.
- The HIV-positive population is aging. The proportion of individuals living in the Denver TGA between the ages of 45-64, a demographic which comprises over half of PLWHA in the Denver TGA, increased from 52.9% (4,353) in 2008 to 57.6% (4,977) in 2010.

Graph C provides a trend analysis of the percent change in the proportional representation of specific groups within the PLWHA population for 2006-2010. It should be noted that the figures in Graph C are not a percent change in the volume of individuals comprising a specific population, but rather a percent change in a specific population's representation in the HIV-positive population. For example, while the volume of HIV-positive individuals aged 60 and above residing in the Denver TGA rose 101.9% (from 474 in 2006 to 957 in 2010), the proportional representation of HIV-positive individuals aged 60 and above rose by only 80.3% (from 6.1% or 474 of the total HIV-positive population in 2006 to 11.1% or 957 of the total HIV-positive population in 2010).

Graph C[5]: Percent Change in Denver TGA PLWHA Population Representation, 2006-2010



[5] Source: eHARS. Provided by CDPHE, May 2011.

Table A summarizes the representation of key populations among PLWHA in the

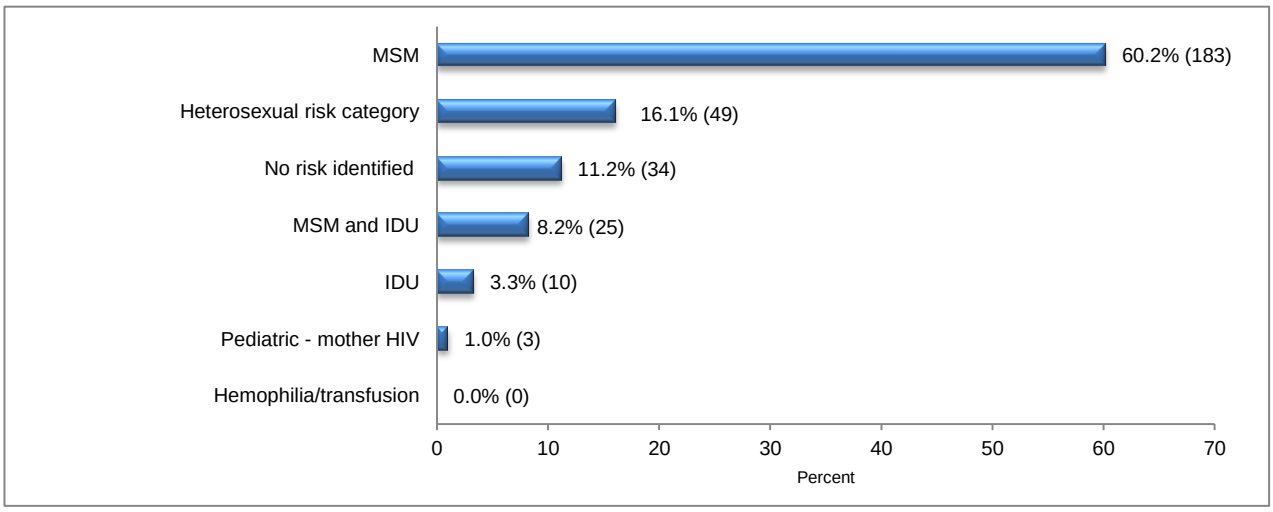
Risk/Population Group	Percent	(n)
Any MSM	75.6 %	6,535
MSM 40+	59.4 %	5,140
White MSM	54.6 %	4,725
MSM of Color	20.7 %	1,790
Any IDU	15.2 %	1,317
Women	10.1 %	874
Foreign Born	9.4 %	815
Adolescents (13-24 yrs.)	2.0 %	173

Denver TGA. MSM remain the most severely impacted by HIV.

Table A: Summary of Key Populations Among PLWHA in the Denver TGA

Denver TGA HIV Incidence by Risk Category
In 2010, 304 new cases of HIV were reported within the Denver TGA (see Graph D below). The majority of new infections (60.2% or 183) were among MSM. Heterosexuals accounted for about 16.1% (49) of all new infections, with injection drug users accounting for about 3.3% (10).

Graph D[6]: Denver TGA HIV Incidence by Risk Category, 2010, N=304



[6] Note: For this and all remaining graphs, the figure next to individual percentages identifies the number of persons represented.

Unmet Need Estimate

Definition of Unmet Need for HIV-Related Health Services
The Health and Resources Administration defines unmet need as the need for HIV-related health services by individuals with HIV who are aware of their HIV status but are not receiving regular primary health care. An individual is considered "not in care" when s/he has not received any of the following within a 12-month period:

1. Viral load (VL) testing
2. CD4 count
3. Provision of antiretroviral therapy (ART)

Thus the estimate of unmet need is the number of people living with HIV and AIDS in the TGA who know they are HIV-positive but are not receiving primary medical care.

Challenges in Estimating Unmet Need
Estimating unmet need in the TGA is a complex undertaking. This is made more challenging due to the discrepancy in the unmet need estimates derived by the Denver Office of HIV Resources (DOHR) and Colorado Department of Public Health and Environment (CDPHE). DHRPC has found it useful to consider both estimates, each of which have limitations. Key limitations of the DOHR unmet need estimation are tied to CAREWare. As CAREWare data is not real time, a limitation is that client information may be outdated. It is also possible that demographic data on clients may be entered differently by providers. Currently, CAREWare does not collect foreign born data, one of the special subpopulations identified by the TGA. A key limitation of the CDPHE estimation is that the surveillance program does not track doctors' visits. Additionally, Veterans Administration and clinical trials viral load testing are not reported.

Each of these estimates is outlined in the Unmet Need Framework Tables B and C. Both were calculated using the HRSA Unmet Need Framework. The framework estimates unmet need by taking the difference between the total population of HIV-positive and aware individuals and the total number of HIV-positive and aware individuals who are receiving primary care.

As we move forward, a true estimate of the number of HIV-positive people in the TGA who are not receiving primary medical care will need to resolve the discrepancies between these two data sets.

Unmet Need Estimate: DOHR
In the first estimation of unmet need in the TGA, provided by DOHR (see Table B), the number of HIV-positive persons in the TGA was based on data from the HIV/AIDS reporting system (eHARS). It was assumed that in-migration equals out-migration and no adjustments were made in this area. The estimates of people in care were obtained from CAREWare, Veterans Administration (VA), Medicaid, and private practice (Rose

Medical Center and Kaiser) data. However, using the most recent data from these sources, it is estimated that 3,086 or 36% of PLWHA in the TGA had not received primary medical care during 2010.

Table B. Unmet Need Estimate: DOHR

Column 1	Column 2	Column 3	Column 4	Column 5
Population Sizes		**Value**		**Data Source(s)**
Row A	Number of persons living with AIDS (PLWA), as of 12/31/10	3,703		eHARS data, as provided by Colorado Department of Public Health and Environment
Row B	Number of persons living with HIV (PLWH)/non-AIDS/aware, as of 12/31/10	4,918		eHARS data, as provided by Colorado Department of Public Health and Environment
Row C	Total number of HIV+/aware as of 12/31/10	8,621		
Care Patterns		**Value**		**Data Source(s)**
Row D	Number of PLWA who received the specified HIV primary medical care during the 12-month period from 1/1/10 through 12/31/10	2,110		Part A primary care data (recorded in CAREWare); most recent VA HIV report; most recent Colorado Medicaid data team report; private care data from interviews with private providers
Row E	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period from 1/1/10 through 12/31/10	3,425		Part A primary care data (recorded in CAREWare); most recent VA HIV report; most recent Colorado Medicaid data team report; private care data from interviews with private providers
Row F	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period from 1/1/10 through 12/31/10	5,535		

Calculated Results		Value	Percent	Calculation
Row G	Number of PLWA who did not receive the specified HIV primary medical care	1,593	43%	Value: A – D = G (3,703 – 2,110 = 1,593) Percent: G/A = Percent (1,593/3704 = 43%)
Row H	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	1,493	30%	Value: B – E = H (4,918 – 3,425 = 1,493) Percent: H/B = Percent (1,493/4918 = 30%)
Row I	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	3,086	36%	Value: C – F = I (8,621 – 5,535 = 3,086) Percent: I/C = Percent (3,086/8621 = 36%)

Unmet Need Estimate: eHARS/CDPHE

The second unmet need estimate was provided by CDPHE and based on eHARS data (see Table C). In 2010, there were 4,918 prevalent cases of HIV and 3,703 prevalent cases of AIDS, resulting in a total of 8,621 PLWHA in Colorado. The analysis defined "out of primary medical care" as those individuals who did not receive a viral load or CD4 count between January 1 and December 31, 2010. There were 2,420 individuals living with AIDS who were in care (had either a VL or CD4 count between January 1 and December 31, 2010); 1,669 individuals living with HIV that had either a VL or CD4 count; for a total of 4,089 PLWHA with at least one monitoring test.

Unmet need is calculated as the difference between the PLWHA population from eHARS data (8,621 PLWHA) and the number who received a VL test or CD4 count (4,089 PLWHA). This means that 53% (4,532) of PLWHA did not receive a VL or CD4 count in 2010 and were considered "out of care." There was lower unmet need among PLWA (35% or 1,283) than PLWH (66% or 3,249).

Table C. Unmet Need Estimate: eHARS/CDPHE

Column 1	Column 2	Column 3	Column 4	Column 5
Population Sizes		**Value**		**Data Source(s)**
Row A	Number of persons living with AIDS (PLWA), as of 12/31/10	3,703		eHARS data, as provided by Colorado Department of Public Health and Environment
Row B	Number of persons living with HIV (PLWH)/non-AIDS/aware, as of 12/31/10	4,918		eHARS data, as provided by Colorado Department of Public Health and Environment
Row C	Total number of HIV+/aware as of 12/31/10	8,621		eHARS data, as provided by Colorado Department of Public Health and Environment
Care Patterns		**Value**		**Data Source(s)**
Row D	Number of PLWA who received the specified HIV primary medical care (at least one VL or CD4 count) during the 12-month period from 1/1/10 through 12/31/10	2,420		CD4/VL monitoring database, linked to eHARS by patients' unique identification numbers
Row E	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care (at least one VL or CD4 count) during the 12-month period from 1/1/10 through 12/31/10	1,669		CD4/VL monitoring database, linked to eHARS by patients' unique identification numbers
Row F	Total number of HIV+/aware who received the specified HIV primary medical care (at least one VL or CD4 count) during the 12-month period from 1/1/10 through 12/31/10	4,089		CD4/VL monitoring database, linked to eHARS by patients' unique identification numbers
Calculated Results		**Value**	**Percent**	**Calculation**
Row G	Number of PLWA who did not receive the specified HIV primary medical care	1,283	35%	Value: A – D = G (3,703 – 2,420 = 1,283) Percent: G/A = Percent (1,283/3,703 = 35%)
Row H	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	3,249	66%	Value: B – E = H (4,918 – 1,669 = 3,249) Percent: H/B = Percent (3,249/4,918 = 66%)
Row I	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	4,532	53%	Value: C – F = I (8,621 – 4,089 = 4,532) Percent: I/C = Percent (4,532/8,621 = 53%)

The eHARS data include information on gender, disease status, risk category, race/ethnicity, age, and year of diagnosis, allowing for an estimate of the level of unmet need for individuals by subgroups. There was lower unmet need among those newly diagnosed (diagnosed with HIV in 2010 or progressed to AIDS in 2010), those diagnosed in the 2000s, and younger age groups.

The socio-demographic profile of those with unmet need was compared with the eHARS prevalence data for 2010. Compared to the eHARS prevalence data, those with unmet need were more likely to be: male, older (age 50+), non-Hispanic White race, diagnosed in the 1980s, not have progressed to AIDS, and from Denver county.

Trends in Unmet Need Percentages

In the DOHR estimate, the percent of unmet need in the Denver TGA remained fairly stable from 2007 to 2008 (32%) but decreased to 28% in 2009, a drop of 12.5%. In 2010, the percentage increased to 36%, a rise of 28.5%. This reflects a 12.5% net increase over four years.

Denver TGA Unmet Need Trends

	CY 2008	CY 2009	CY 2010
DOHR Unmet Need	32%	28%	36%
eHARS Unmet Need	No analysis	No analysis	53%

This increase in unmet need can be attributed to the TGA's efforts to refine its client-level data. During 2010, the TGA concentrated on cleaning up data in the CAREWare system and eliminating duplicated clients. This effort was spearheaded by the Clinical Quality Management Program and assisted by the site visit process. After the refinements, the number of reported clients served in primary care decreased by 16% from 2009, which increased the total unmet need.

Likewise, CDPHE believes the eHARS estimate of unmet need to be more complete than in prior years. In previous years, due to Board of Health (BOH) regulations, only CD4 counts below 500 cells per cubic millimeter of blood, or below 29% of lymphocytes that are CD4 cells, were required to be reported. In March 2010, the BOH revised its regulations around the reporting of viral loads results to those considered undetectable.

Addressing Unmet Need/Next Steps

Acknowledging the discrepancies in the different estimates for unmet need, the DHRPC has identified the following next steps in moving forward to address unmet need in the TGA: Updated process for verification of data, focus on getting PLWHA in and retained in care, and better include site visit assessments.

Early Identification of Individuals with HIV/AIDS (EIIHA) Unaware Estimate

Unaware Estimate

An important element of assessing unmet need is describing the needs of people who are unaware of their HIV status. The goal of the EIIHA initiative is to ensure that individuals who are unaware of their HIV-positive status are identified, referred to services, and linked to care. As of June 30, 2011, there were an estimated 2,312 HIV-positive individuals in the Denver TGA who were unaware of their status. This estimate was calculated using the Estimated Back Calculation (EBC) methodology below:

National Proportion Undiagnosed ***= 21%***

$$\frac{.21}{(.79)} \quad X \quad 8{,}699 \text{ (diagnosed living)} = 2{,}312 \text{ (undiagnosed)}$$

Consistent with the statewide EIIHA strategy, the primary goal of the Denver TGA EIIHA strategy is to ensure that HIV positive individuals who are unaware of their status are identified, informed of their status, referred to medical treatment, and linked into care. To this end, the strategy has two main objectives:

1. Increase the number of individuals who are aware of their HIV status.
2. Increase the number of HIV positive individuals in medical care. By increasing awareness and increasing the number of HIV+ persons in care, the strategy directly supports the second National HIV/AIDS Strategy goal of optimizing health outcomes for people living with HIV. Increasing awareness and treatment will also help reduce infection rates (NHAS goal #1) and health disparities (NHAS goal #3).

B. Description of Current Continuum of Care

Ryan White Part A Resource Inventory

The Denver EMA has a comprehensive service delivery system for PLWHA, funding eight core and four support services through various organizations identified in Table C.

Table D: Denver TGA Resource Inventory: Organizations Funded by Ryan White Part A*

Clinic/office/ practice	RW funding source(s)	Total individuals served in CY 2010	HIV-positive individuals served in CY 2010	Other major funding sources	Service area
ARTS Outpatient Special Services Clinic/UCD	Part A	42 non HIV-positive individuals	98	SAMHSA - Mercy Housing Apartments, CDPHE	Denver TGA
Children's Hospital HIV Program	Part A Part B Part D	506	250	Research funds (Westat, Impact, ATN) CHAPP funds, donations and private foundations	Colorado primarily (serves entire Rocky Mountain Region)
Clinica Tepeyac	Part A	14920 total patients	35-50	Federal (WWC, Coleman, Avon), Private donations Tobacco excise tax	All of Colorado - no boundaries, as long as the client is not insured
Colorado AIDS Project	Part A Part B	Only serves HIV-positive individuals	2459	HUD (HOPWA), Private funds for prevention programs, foundations, donations	Metro Denver, Part A service area

Denver Health Medical Center	Part A Part B Part C		1500-1600	The City of Denver (public health funding), Medicaid, Medicare	City and County of Denver
Empower-ment Program - Women's AIDS Project	Part A	2400	120	SAMHSA, HUD (HOPWA), CDPHE	Metro Denver; Adams, Arapahoe, Jefferson, Denver, Douglas
Howard Dental	Part A Part F	846	844	The Colorado Foundation, Caring for CO, Denver Foundation, Anschutz Family Foundation, A.V. Hunter Trust, Johnson Foundation, Season to Share, Delta Dental, Berkley Risk, Colorado Prosthodontic Society	Adams, Arapahoe, Denver, Jefferson, Douglas, Broomfield
It Takes A Village	Part A	1605	132	CDC (Empowerment program), CDPHE SAMHA, CHAPP Church World Service, Walmart Foundation, Minority HIV/AIDS Initiative	Colorado, Denver TGA - 6 counties, working with AIDS Projects
Jewish Family Service	Part A	>1,000	35 (Specific to the home-maker program)	Broadway Cares/Equity Fights AIDS, Mac AIDS Fund	Denver TGA

MCC of the Rockies (for the benefit of Rocky Mountain CARES)	Part A	Only serves HIV-positive individuals	150	Mainly Ryan White Part A, Public donations	Colorado (but only have a few people from Ft Collins and one or two outside the TGA)
Mental Health Center of Denver (MHCD)	Part A	15,400 120 (HIKE program)	80 (Living and learning with HIV)	Medicaid, Medicare, State General funds, miscellaneous grants	Denver County
Metro Community Provider Network	Part A	37,800		Patient generated revenue, Federal HHS grant for the uninsured, Other Federal grants, other non-Federal grants, charitable donations	Arapahoe and Jefferson counties as well as portions of Adams
Mile High Council on Alcoholism and Substance Abuse	Part A Part B				
Project Angel Heart	Part A	1886	222	Donations Community Service Block Grant, Susan P. Coleman Foundation	Denver Metro, Colorado Springs
Servicios de La Raza	Part A	Approximately 1,500	77	Colorado Health Foundation, CDHS, WIA, MHUW among others	Colorado

Sisters of Color United for Education	Part A				
University of Colorado Hospital Infectious Disease Group Practice	Part A Part B Part C	1513	1513	Medicaid, Medicare, Private insurance	All of Colorado with a couple of exceptions: CICP clients from Denver County typically go to DHMC, undocumented HIV+ clients typically go to MCPN Aurora
University of Colorado Hospital Infectious Disease Group Practice Pharmacy	Part A				

*All information in this table was collected via interviews with personnel representing a particular organization. Some figures may not be exact. Where cells are highlighted in gray, information was either unavailable or not obtained.

Ryan White Part A and Non-Ryan White Part A Funded Resource Inventory by Category

Core and support HIV/AIDS services are accessible to clients throughout the Denver TGA (Table E). The majority of service providers are located in Denver and Arapahoe counties.

Table E: Denver TGA Resource Inventory

Service	Provider			
	Part A		Non-Part A*	
Core medical services	**Organization**	**County**	**Organization**	**County**
Outpatient/ ambulatory medical care	Children's Hospital	Arapahoe	Caritas Community Clinic, Exempla St. Joseph Hospital	Denver

Service	Provider			
	Part A		**Non-Part A***	
	Clinica Tepeyac	Denver	Clinica Family Health Services	Denver
	Denver Health	Denver	Kaiser Permanente	Denver
	Metro Community Provider Network	Jefferson, Arapahoe & Adams	Urban Peak	Denver
	University of Colorado Hospital Infectious Disease Group Practice	Arapahoe	Veteran's Affairs Medical Center	Denver
AIDS pharmaceutical assistance (local)	Children's Hospital	Arapahoe		
	Denver Health	Denver		
	University of Colorado Hospital Infectious Disease Group Practice Pharmacy	Arapahoe		
Oral health (dental) care	Howard Dental	Denver	Denver Indian Health and Family Services, Inc.	Denver
	Denver Health Medical Center	Denver	University of Colorado Denver School of Dental Medicine	Arapahoe
			Denver Rescue Mission	Denver
Early intervention services (EIS)	Children's Hospital	Arapahoe		
	Denver Health	Denver		
	MCC of the Rockies (for the benefit of Rocky Mountain CARES	Denver		
	University of Colorado Hospital Infectious Disease Group Practice	Arapahoe		
Health	Colorado AIDS	Denver		

Service	Provider			
	Part A		**Non-Part A***	
insurance premium & cost-sharing assistance	Project			
Home health care	Visiting Nurse Association	Denver		
Home and community-based health services	Jewish Family Services	Denver		
Mental health services	Children's Hospital	Arapahoe	Arapahoe House	Adams
	Colorado AIDS Project	Denver	Behavior Service Institute	Denver
	Denver Health	Denver	Denver Area Youth Services	Denver
	Mental Health Center of Denver	Denver	Denver Indian Health and Family Services, Inc.	Denver
	Servicios de la Raza	Denver	Denver Psychotherapy Care	Denver
	Sisters of Color United for Education	Denver	El Futuro	Denver
	University of Colorado Hospital, Infectious Disease Group Practice	Arapahoe	Harm Reduction Action Center	Denver
			Kaiser Permanente	Denver
			Rainbow Alley	Denver
			Urban Peak	Denver
			Veteran's Affairs Medical Center	Denver
Medical case management	Colorado AIDS Project	Denver		
	Empowerment Program	Denver		
	It Takes a Village	Arapahoe		

Service	Provider			
	Part A		**Non-Part A***	
	MCC of the Rockies (for the benefit of Rocky Mountain CARES	Denver		
	Sisters of Color United for Education	Denver		
	Servicios de la Raza	Denver		
Substance abuse services – outpatient	Asian Pacific Development Center	Denver	Arapahoe House	Thornton
	Colorado AIDS Project	Denver	Behavior Service Institute	Denver
	Denver Health	Denver	Denver Indian Health and Family Services, Inc.	Denver
	Empowerment Program	Denver	Urban Peak	Denver
	It Takes a Village	Arapahoe	Veteran's Affairs Medical Center	Denver
	Mile High Council on Alcoholism and Substance Abuse	Denver		
	Sisters of Color United for Education	Denver		
Support Services	**Organization**	**County**	**Organization**	**County**
Food bank/home delivered meals	Colorado AIDS Project	Denver		
	Project Angel Heart	Denver		
Emergency financial assistance	Colorado AIDS Project	Denver		
Housing services	Colorado AIDS Project	Denver	African Community Center	Denver
			Urban Peak	Denver
			Harm Reduction Action Center	Denver

Service	Provider			
	Part A		**Non-Part A***	
Medical transportation services	Colorado AIDS Project	Denver	LogistiCare of Colorado	Arapahoe
	Denver Health	Denver		
	Empowerment Program	Denver		
	Servicios de la Raza	Denver		
Health Education/ Risk Reduction	N/A		Asian Pacific Development Center	Denver
			Denver Area Youth Services	Denver
			Denver Indian Health and Family Services, Inc.	Denver
			Harm Reduction Action Center	Denver
Hospice services	N/A		Namaste Hospice	Denver
Legal services	N/A		Urban Peak	Denver
Other services**	**Organization**	**County**	**Organization**	**County**
Refugee resettlement	N/A		African Community Center	Denver
HIV testing	Colorado AIDS Project	Denver	Peer Assistance Services, Inc.	Denver
	Children's Hospital	Arapahoe	Arapahoe House	Adams
	Denver Health	Denver	Caritas Community Clinic, Exempla St. Joseph Hospital	Denver
	MCC of the Rockies (for the benefit of Rocky Mountain CARES	Denver	Denver Indian Health and Family Services, Inc.	Denver
	University of Colorado Hospital	Arapahoe	El Futuro	Denver
			Peer Assistance	Denver

Service	Provider			
	Part A		**Non-Part A***	
	Infectious Disease Group Practice		Services, Inc.	
			Rainbow Alley	Denver
			Urban Peak	Denver
			Youth HIV Advocacy Coalition	Arapahoe
Hepatitis C testing	Denver Health	Denver	Hep C Connection	Denver
	Empowerment Program	Denver	Arapahoe House	Adams
			Harm Reduction Action Center	Denver
			Peer Assistance Services, Inc.	Denver
			Jefferson County Health Department	Jefferson
Prison and/or jail re-integration	Empowerment Program	Denver	Behavior Service Institute	Denver
	Denver Health	Denver	Denver Works - 2nd Chance Program	Denver

*This listing of non-Part A organizations is not intended to be comprehensive. Information is based off the AIDS Coalition for Education (ACE) Colorado HIV/AIDS Resource Directory as well as the 2010 Colorado Directory of Resources, produced by the Hep C Connection.
**Part A organizations listed as providing prison reintegration, hepatitis C testing and HIV testing are not funded by Part A to do so.

Interaction between Ryan White and Non-Ryan White Funded Services – Continuity of Care

In an era of declining resources, in order to ensure that the widest range of services are available to consumers, it is imperative that Part A services within the Denver TGA coordinate with non-Ryan White services to ensure continuity of care for PLWHA and their families. As a result, Part A clients are routinely linked to non-Ryan White funded programs. Medical case managers continuously assess and refer clients to services that meet their specific need. This process ensures that Ryan White funds are the payor of last resort.

State and Local Budget Cuts – the Effect on the Continuum of Care/Ryan White Adaptations

Colorado is one of many states nationwide which has incurred large budget shortfalls due to the recession's impact on tax revenues. As a result of this drop in revenue, the state has cut funding in the following services: public health, K-12 education, higher education, and state workforce. Specifically in the public health arena, cuts have been made to Medicaid and the Colorado Children's Health Insurance Program (CHIP), including reduced or frozen reimbursements to health care providers. Additionally, the state is cutting payment rates for mental health providers and eliminating funding for residential treatment in the state's mental health institutes for an estimated 626 patients each year. [7]

State cuts in HIV/AIDS funding has impacted the system of care over the last few years. In FY 2009, Colorado was one of 45 jurisdictions that together sustained a cut of more than $170 million from HIV/AIDS and viral Hepatitis budgets. Additionally in 2010, it was one of 32 states that incurred cuts in HIV/AIDS or viral Hepatitis funding streams, totaling approximately $60 million. Fortunately, in the same year, Colorado was one of 19 states that saw an increase in ADAP funding, enabling the TGA to continue addressing the needs of the increasing number of clients requiring services.

States that have endured HIV/AIDS funding cuts often see reductions in core surveillance activities and reduced funding to AIDS service organizations (ASOs), serve fewer clients, and have longer wait times for medical care.[8] Although there is not specific data on each of these outcomes for the TGA, one ASO (the Women's Lighthouse Project) was forced to shut its doors in FY 2010 due to funding constraints.

The Ryan White Part A Program has adapted to these statewide budget cuts by constantly reassessing the changing nature of the epidemic and the needs of PLWHA in the TGA. This information allows the Denver TGA to allocate resources towards the most significant needs and gaps. Anticipation of various funding scenarios will also impact the priorities planning process.

[7] www.cbpp.org/cms/index.cfm?fa=view&id=1214
[8] www.nastad.org/Docs/Public/InFocus/2011223_State%20Budget%20Cuts%202010%20FINAL.pdf

C. Description of Need

Care Needs

Outpatient Ambulatory Care
Most PLWHA in the TGA are able to access outpatient primary medical care. In the 2011 Part A Needs Assessment, 87.5% of consumer survey respondents indicated they were currently in care. This data is supported by service utilization numbers, which show that 64% of Part A clients receive outpatient medical care. In addition, those not receiving medical care through Part A are more likely to have private medical insurance, and thus likely accessing care outside of the system.

However, some specific gaps related to primary care were identified by providers and/or consumers. These include assistance paying for health insurance, medical transportation assistance, the need for primary care services in geographic areas outside of the city of Denver, and more culturally/linguistically appropriate services.

The aging of the population living with HIV/AIDS, the shift in risk categories among PLWHA to include more with combined MSM/IDU risk, and the continued disproportionately high representation of Blacks within the PLWHA population compared to the general population have implications for the design and delivery of HIV/AIDS prevention and care services. Gaps in care continue for certain populations, such as homeless, recently incarcerated, undocumented, and monolingual Spanish-speaking populations.

Demographics of Those Not Accessing Part A Outpatient Ambulatory Care
CAREWare service utilization data provides some insight into which clients are more likely to cease utilizing Part A outpatient ambulatory (OA) services for an extended period of time. There are some limitations to the data to keep in mind however.For example, it cannot be assumed that an individual who ceased utilizing OA through Part A has dropped out of care, as that individual may have seen a provider not funded through Part A. Regardless, the data does indicate some interesting trends among individuals who had not accessed OA in the last 9 months of 2010 despite having previously accessed the service.

Below are highlights from the CAREWare data about the demographic characteristics of PLWHA most likely to be out of care:

- Whites were least likely to have dropped out of OA than other racial groups
- PLWHA without permanent housing dropped out of OA at higher rates than individuals with stable/permanent housing
- Individuals with private insurance were less likely to have dropped out of OA than any other insurance categories
- PLWHA between the ages of 13 and 24 dropped out of OA at higher rates than any other age group

- PLWHA between the ages of 45 and 64 tended to drop out of OA at lower rates than any other age group

In addition, PLWHA not accessing OA have a different demographic makeup than the Part A service client population as a whole (see Table F below). When compared to all Part A service clients, individuals not accessing OA are less likely to have AIDS or no insurance than the overall population accessing Part A services and are more likely to be transgendered, be non-permanently housed, and be above 100% of the Federal Poverty Level (FPL).

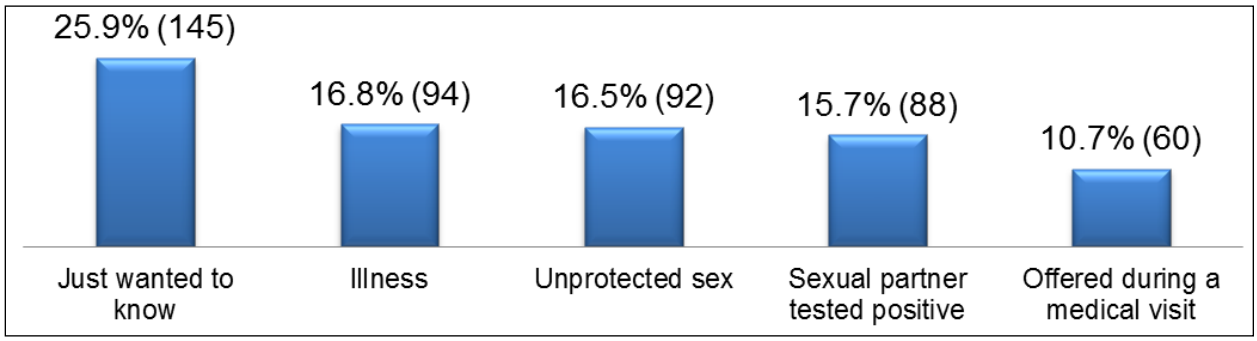
Table F: Individuals Not Accessing Part A Outpatient Ambulatory Services, Compared to All Part A Service Clients

Compared to All Part A Service Clients, those NOT ACCESSING OA are:	All Part A Service Clients		Not Accessing OA	
	%	N	%	N
Three times as likely to be transgendered	**0.6%**	22	**1.8%**	20
Substantially less likely to have AIDS	**50.2%**	1998	**39.2%**	432
Substantially more likely to be HIV-positive	**48.8%**	1942	**59.3%**	653
More likely to be non-permanently housed	**10.8%**	428	**13.8%**	152
Substantially less likely to have no insurance	**34.4%**	1309	**16.9%**	176
Substantially more likely to be above 100% FPL	**29.7%**	1182	**37%**	408

Because access to quality primary medical care affects outcomes for HIV disease, it is important that PLWH are linked, engaged and retained in care. To understand and define core issues surrounding linkage to and retention in care, survey resondents in the 2011 Needs Assessment were asked a series of questions pertaining to their initial diagnosis.

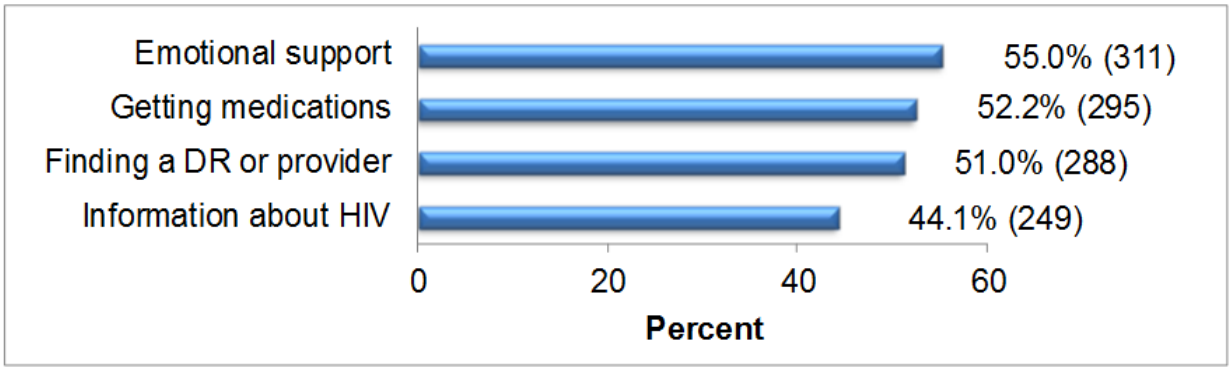
First, clients were asked to indicate the reason they were tested at the time they first learned of their HIV diagnosis. The top five reasons are included in Graph E below.

Graph E: Top 5 Reasons To Get Tested Or Learn Your Status, N=559



Respondents were then asked to identify their top three needs upon learning of their initial HIV diagnosis (see Graph F below). While access to medications or a medical provider ranked high, the most commonly indicated need was emotional support. This underscores key findings from client interviews and may indicate that access to emotional support may be a key component to retaining newly diagnosed individuals in care.

Graph F: Top Issues Needing Help With After HIV Diagnosis, N=565



Survey respondents were also asked to indicate how long it took them to access HIV medical care services upon their initial diagnosis. Of the 558 respondents who answered this question, the majority of respondents (52.3%, 292) indicated that they received care services within one month of their diagnosis (see Graph G below).

Graph G: Time to Care After HIV Diagnosis, N= 558

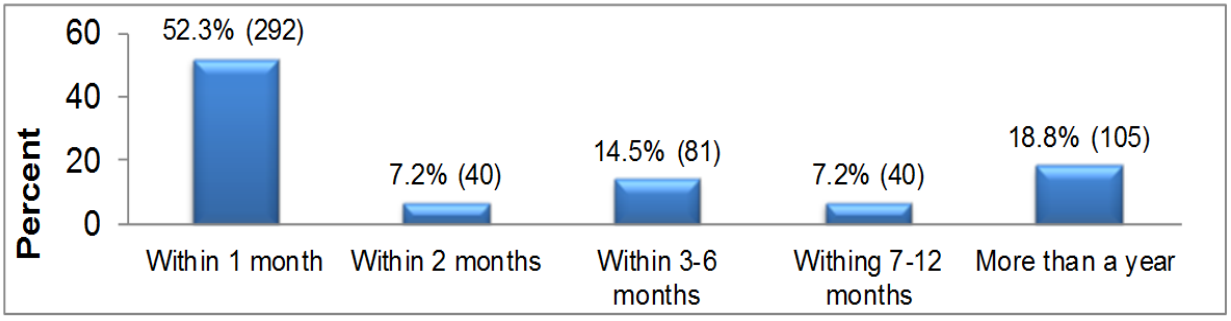


Table G below provides further analysis of time to care by population. When analyzing such data it is important to bear in mind that conclusions cannot always be made because of the small number of individuals within each demographic. These figures indicate, however, that women generally enter care at faster rates than the general HIV-positive population. It also appears that formerly incarcerated and homeless individuals take longer to enter care than the overall HIV-positive population.

Table G: Time to Care After HIV Diagnosis by Population

Population	Total N	Within 1 month			More than a year		
		%	n	Avg.	%	n	Avg.
Newly Dx (2011)	*4*	*100.0%*	*4*	*52.3% (292)*	*0.0%*	*0*	*18.8% (105)*
Newly Dx (2010)	**38**	**57.9%**	**22**		**2.6%**	**1**	
Women	**94**	**55.3%**	**52**		**12.8%**	**12**	
MSM over 40	274	51.8%	142		24.1%	66	
Anglo MSM	230	51.7%	119		20.4%	47	
MSM of Color	123	49.6%	61		23.6%	29	
Monolingual Spanish Speakers	*22*	*50.0%*	*11*		*18.2%*	*4*	
Formerly Incarcerated	**118**	**44.9%**	**53**		**22.9%**	**27**	
Homeless	**99**	**43.4%**	**43**		**27.3%**	**27**	
Out of Care	*13*	*38.5%*	*5*		*15.4%*	*2*	
Foreign Born	**59**	**37.3%**	**22**		**20.3%**	**12**	

Taking the findings of the needs assessment into account, predictors of poor linkage to and retention in care become readily apparent. Retention in care is more likely to occur when clients are more engaged in the care process, when they receive proper emotional and social support, and when structural barriers are eliminated.

Capacity and Capacity Development Needs

Generally speaking, PLWHA are able to access the services they most need, and the Denver TGA has made progress in addressing service gaps identified in prior years and implementing early intervention and linkage to care services. However, work remains to be done.

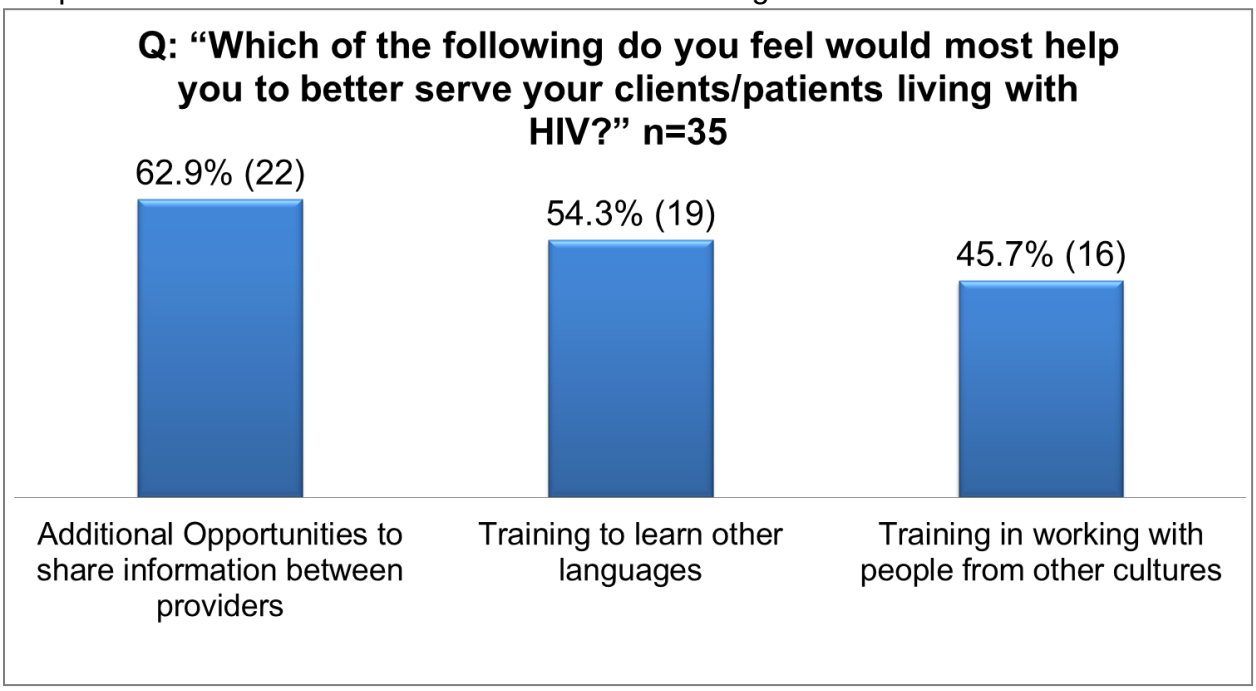
Unmet need for oral health care remains high in the Denver TGA; it was most frequently reported as needed by survey respondents in the 2011 Needs Assessment. Likewise, the SCSN identifies oral health care as problematic in Colorado overall, and is particularly problematic for low-income, uninsured PLWHA with ongoing need for specialized dental care. PLWHA face many barriers in accessing dental care, but lack of

providers and capacity within the TGA are major factors. The Oral Health Workgroup has been tasked with conducting a more focused needs assessment around oral health needs and creating a strategy for dealing with capacity issues.

Much capacity development needs to center around increasing organizational capacity to respond to emerging programmatic, legislative, and policy issues. The changing health care environment and the implementation of national requirements and strategies will require that prevention and care services for PLWHA continue to evolve. Part A providers will need assistance in addressing issues such as the National HIV/AIDS Strategy, health care reform, and Health People 2020.

While providers do feel that they have sufficient time to provide all HIV-related information to their patients (63% in the needs assessment findings reported that they had), there appear to be other capacity development needs. Providers appear eager to better serve PLWHA(?) in the TGA and have identified specific needs for achieving this, as listed in Graph H.

Graph H: Provider Identified Needs for Better Serving PLWHA



Similarly, among provider respondents (N=31) in the Needs Assessment, the three most commonly reported capacity development needs were:

- Building community linkages (41%, 13)
- Training on risk reduction counseling (41%, 13)
- Working with diverse populations (28%, 9)

The importance of other Ryan White programs and initiatives to meet that need is demonstrated. Among provider respondents (N=34) in the Needs Assessment, the AIDS Education and Training Center was listed as the most used capacity building

resource (53%, 18). Other reported resources included HIV QUAL (20%, 7), the National Quality Center (16.7%, 6), and the Target Center (3%, 1).

D. Description of the Priorities for the Allocation of Funds

Size and Demographics of the Population of Individuals with HIV/AIDS Utilizing Part A Services

The DHRPC sets priorities for the allocation of resources based on several factors including needs assessment findings from PLWHA both in and out of care, PLWHA demographics, and service utilization data.

As illustrated in Table H, the volume of individuals accessing Part A services increased 12% from 2008 to 2010, from 3554 to 3979, respectively. Some population groups stand out. While women only account for approximately 10% of the entire HIV-positive population, they account for almost 18% (691) of all Part A service clients. Also, while MSM account for 75% of the HIV-positive population, they account for only 56.6% (2253) of all Part A service clients. Importantly, almost 70% of all Part A service clients in 2010 lived below 100% of the Federal Poverty Level (FPL), and almost 35% of all Part A service clients were uninsured in 2010. This carries significant implications for the Denver TGA, as health care reform will extend Medicaid access to individuals under 133% of the FPL in 2014.

Table H: Volume of Individuals Accessing Part A Services

	Populations are a Proportion of All Clients Accessing any Part A Service	**2008**		**2010**		**Change**
		%	**N**	**%**	**N**	
1	**Total Part A clients** accessing services	**100%**	3554	**100%**	3979	**+ 12 %**
2	25-44 y.o.	**48.2%**	1714	**44.6%**	1774	**-**
3	Females	**17.7%**	628	**17.4%**	691	**-**
4	Stable or permanently housed	**91.3%**	3245	**83.9%**	3337	**-**
5	Non-Permanently housed	**8.0%**	285	**10.8%**	428	**+**
6	No Insurance	**46.7%**	1661	**34.4%**	1309	**-**
7	Other Public Insurance	**11.9%**	424	**24.1%**	917	**+**
8	Below 100% FPL	**72.5%**	2575	**68.5%**	2724	**-**
9	MSM	**54.4%**	1932	**56.6%**	2253	**+**
10	Heterosexual	**17.9%**	636	**17.7%**	704	**-**

Table I below provides an overview of the rate at which certain PLWHA populations access other key services. Three particularly key services (outpatient ambulatory, emergency financial assistance, and housing) were delineated by specific demographic access.

Table I: Overview of the Rate at Which Populations Access Key Services

	Populations are a Proportion of Same Population Accessing *Any* Service	2008		2010		Direction of % Change
		%	N	%	N	
1	**All Part A clients accessing Outpatient Ambulatory services**	**76.3%**	2712	**72.2%**	2877	-
2	25-44 y.o.	**78.5%**	1345	**74.2%**	1317	-
3	45-64 y.o.	**74.2%**	1162	**72%**	1359	-
4	Females	**79.3%**	498	**76%**	525	-
5	HIV-positive (not AIDS)	**73.2%**	1210	**66.4%**	1289	-
6	Non-permanently housed	**81.1%**	231	**64.5%**	276	-
7	No insurance	**83%**	1379	**86.6%**	1113	+
8	Below 100% FPL	**76.9%**	1979	**75.1%**	2046	-
9	Black	**71.5%**	308	**67.5%**	295	-
10	White	**75.2%**	1718	**71.9%**	1867	-
	Populations are a Proportion of Same Population Accessing *Any* Service	**2008**		**2010**		**Direction of % Change**
		%	**N**	**%**	**N**	
11	**All Part A clients accessing Emergency Financial Assistance**	**17.3%**	609	**18.1%**	717	+
12	25-44 y.o.	**16.3%**	279	**18.7%**	331	+
13	45-64 y.o.	**17.9%**	281	**18.8%**	354	+
14	Females	**27.2%**	171	**20%**	138	-
15	Males	**14.9%**	432	**17.4%**	569	+

16	Non-permanently housed	**16.5%**	47	**21.5%**	92	**+**
17	Other public insurance	**21.5%**	91	**32%**	293	**+**
18	Below 100% FPL	**18.1%**	466	**21.1%**	574	**+**
19	Heterosexual	**24.2%**	154	**19.6%**	138	**-**

	Populations are a Proportion of Same Population Accessing *Any* Service	**2008**		**2010**		**Direction of % Change**
		%	**N**	**%**	**N**	
20	**All Part A clients accessing Housing Services**	**15.9%**	565	**13.5%**	539	-
21	25-44 y.o.	**19%**	326	**17.2%**	305	**-**
22	45-64 y.o.	**13.6%**	213	**11.2%**	211	**-**
23	Females	**17.8%**	112	**11.4%**	79	**-**
24	Non-permanently housed	**33.7%**	96	**27.3%**	117	**-**
25	No Insurance	**17.2%**	285	**8.5%**	111	-
26	Below 100% FPL	**17.2%**	444	**15.9%**	432	**-**
27	Heterosexual	**17.9%**	114	**12.4%**	87	**-**
28	IDU	**28.5%**	78	**18.1%**	50	**-**

	Populations are a Proportion of All Clients Accessing any Part A Service	**2008**		**2010**		**Direction of % Change**
		%	**N**	**%**	**N**	
29	Accessing medical case management	**48.6%**	1729	**50.5%**	2009	**+**
30	Accessing medical transportation services	**29.3%**	1041	**26.8%**	1065	**-**
31	Accessing mental health services	**26.7%**	949	**25.8%**	1027	**-**
32	Accessing oral health care	**27%**	961	**29.7%**	1181	**+**
33	Accessing substance abuse: outpatient	**9.7%**	344	**8.3%**	332	**-**

Needs of Individuals with HIV/AIDS

From analysis of the 2011 Needs Assessment findings and eHARS and CAREWare data, key areas of focus to improve access to care became apparent: linkage, retention, oral health, special populations, and Affordable Care Act readiness. Funding priorities are based on improving access to care and identifying PLWHA with the greatest needs.

Linkage

Improving linkage to care for newly diagnosed patients is key to reducing unmet need in the Denver TGA. Understanding the issues surrounding linkage to care was a key focus of the 2011 needs assessment. While the majority of newly diagnosed PLWHA (53.3%) accessed medical care within the first month of diagnosis, a quarter (26%) did not access care for over seven months, with 18.8% waiting more than a year.

Key reasons for not linking to care given by PLWH in the Needs Assessment were:

- There was no one to help me figure how to access care (10.1%)
- No one told me that I needed to get medical care for HIV (3.1%)
- Did not want anyone to find out I had HIV (18.6%)

Including Early Intervention Services (EIS) as a funded category under both Part A and Minority AIDS Initiative (MAI) during the priorities process is part of the commitment to developing a strong linkage to care model in the TGA.

Retention

Retention in care is an important aspect of health determinants for HIV disease, including medical adherence, self-management, health literacy, and positive lifestyle changes. With unmet need at 36% in 2010, improving retention in care is critical in the Denver TGA.

In reviewing the 2011 Needs Assessment data, it is becomes clear that many PLWHA do not have adequate system literacy or an understanding of the services provided by Ryan White in the Denver TGA. Top reasons given by PLWHA for not accessing care included: could not afford it (35.7%), insufficient insurance (27.1%), and did not qualify for services (10.1%).

In addition there are indicators that systematic barriers might also be contributing to retention in care issues. PLWHA in the Needs Assessment listed “too many requirements/too much paperwork” (15.5%) and lack of transportation (10.9%) as reasons for not accessing care.

The data also highlights health literacy issues that contribute to PLWH(A?) not seeking care. “Did not think that I needed care because I wasn’t sick” (20.9% of respondents) and “did not think medical care would do me any good” (14.7%) indicate a lack of health literacy and awareness of the importance of regular primary medical care.

It becomes clear from the Needs Assessment findings that improvement in retention in care needs to be made on several fronts, including improving information about services, reducing systemic barriers, and increasing health literacy and motivation to seek care.

Oral Health

As indicated before, there is a clear need for increased oral health capacity within the Denver TGA. For many years, PLWHA have reported high rates of unmet dental care needs (ranked #1 in needed but not received services by consumers in the 2011 Needs

Assessment). At the same time, lack of adequate dental care can put PLWHA at increased risk for oral diseases.

In making this a high priority area of focus, the DHRPC has tasked the Oral Health Workgroup with conducting a more focused needs assessment around the oral health needs of consumers and creating a strategy for dealing with capacity issues.

Special Populations
Understanding the needs of special populations within the TGA and the barriers that prevent them from accessing care is a key focus of the DHRPC. These populations include:

- Adolescents: Between January 1, 2006 and December 31, 2010, there were 2125 newly diagnosed cases of HIV in Colorado. Of those, 15% were among youth between the ages of 13 and 25, 22 percent of whom were diagnosed with AIDS within the first 12 months of their initial HIV diagnosis. Over three-quarters of these cases (77%) occurred in the Denver TGA. Additionally, after reviewing epidemiological and other information focusing on younger populations, the HIV Prevention Advisory Committee decided to focus the 2011 HIV prevention needs assessment on youth aged 12-24.

  Providing comprehensive psychosocial and medical care to young adults and youth who are living with HIV/AIDS reveals that this population experiences especially challenging circumstances and unique challenges. Often there is a cyclical pattern seen with youth; the issues and behaviors that can contribute to a youth being vulnerable to acquiring HIV are often the same issues that create barriers to good management of the disease once acquired.

  In practice it is documented that youth living with HIV and AIDS often have a history of family fracture or parental rejection. This rejection can occur due to clashing generational or cultural norms and expectations, a youth's LGBTQQI identification, or the youth's HIV status itself. Family fracture and parental rejection can result in youth's vulnerability to homelessness, which can then, in turn, contribute to a youth's risk for exposure to violence and exploitation, HIV, and substance use or abuse. This phenomenon is due to youth being forced to engage in survival sex and other risky behaviors in order to ensure that basic needs like housing and food are met.

  Homelessness and unemployment are also common barriers to medical adherence for youth living with HIV/AIDS. If a youth is living a transient lifestyle or struggles with limited resources, it is difficult for youth to attend regular medical appointments and adhere to a daily medicine regime. Obviously, a lapse in adherence to HIV medicines renders youth vulnerable to resistance to medicines which ultimately reduces the medicines that are available to that particular patient.

Another major challenge facing youth living with HIV/AIDS is substance use and abuse. This phenomenon is often linked to a chaotic childhood and a personal history of trauma. Not only is substance use and abuse detrimental to good mental and physical health, particularly to individuals living with HIV/AIDS, but it also interferes with patients' ability adherence to medicines.

Normal developmental characteristics also can present a challenge to youth living with HIV/AIDS. Adolescents' less developed capacity to attach future consequences to present actions, and the characteristic feeling of invincibility renders youth vulnerable to acquiring HIV, and can also lead to youth being resistant to take HIV medicines unless or until they "feel sick".

Additionally, normal social development of adolescents presents unique challenges for those living with HIV and AIDS, as youth begin to develop an interest in dating and sexual activity. Issues of sexual identity, gender identity, shame, stigma, disclosure, and critical responsible choices arise at this time. Mental health challenges also can arise at this time, as young adults are differentiating from family and/or are often dealing with premature, sometimes forced, independence.

- Injection Drug Users: Research indicates that IDUs benefit significantly from ART but that mortality remains higher in HIV-positive ART-treated IDUs as compared with non-drug user ART-treated patients. Several factors contribute to the overall lower impact of ART on mortality in HIV-positive IDUs, including delayed initiation to treatment, poor adherence to treatment regimens, interruptions in medical care, and continuing drug use.

  According to a 2008 report from the Denver Office of Drug Strategy, there are approximately 5,000 injection drug users in the City and County of Denver alone. Complex problems of social stigma, homelessness, unemployment, limited society reintegration after incarceration, poor physical/mental health, and unresolved historical trauma are all factors that contribute to ongoing substance abuse.

- Homeless: The 2011 Needs Assessment identified homelessness as a barrier to care, particularly as it pertained to medication adherence. HIV and homelessness are highly correlated. First, living with HIV puts people at increased risk of homelessness for several reasons. Employment may be put at risk due to periodic absenses due to illness, health care appointments, and hospitalizations. Substance use and mental illness are more common among PLWHA and are also risk factors for homelessness. An HIV diagnosis may also destabilize domestic or family relationships, which may result in homelessness. Gay, bisexual, and transgender youth are at greater risk for homelessness due to family rejection, and they are also at greater risk of HIV infection due to survival sex. Secondly, for homeless PLWHA, the conditions of homelessness

are dire. Homelessness not only puts PLWHA at high risk of contracting infections, but also makes obtaining and adhering to medications more difficult.

- Transgender: HIV-infected transgender patients face many barriers to care, including fear of exposure, lack of culturally competent medical settings, provider insensitivity, and social stigma and isolation. Transgender health needs are also very complex. Increased provider competency to address transgender health issues is needed.

- African Americans: African Americans are disproportionately impacted by HIV in the TGA(accounting for 15.1% of HIV/AIDS cases while only constituting 5.5% of the overall TGA population), and tend to utilize Part A services at lower rates. To reduce the disparities associated with HIV/AIDS among African Americans, the DHRPC will develop a strategy to remove barriers to care that lead to underutilization of services.

- Aging population: The Denver TGA has one of highest rates of older PLWHA among metropolitan areas nationally (64% of the PLWHA population in the TGA is 45 and over). According to eHARS data, there has been a 26% (743) increase in the 50-59 age group in the last four years and an 80% (546) increase in the 60+ age group over the last five years.The aging of the HIV population has presented new challenges, and understanding the evolving care needs of this population is key.

- Foreign born: The rates of new HIV diagnoses among the foreign born in the TGA has increased by 15% over the last three years. Foreign born PLWHA present with special care considerations, and for the undocumented, impact of the Affordable Care Act is especially pertinent.

Affordable Care Act

Understanding the impact of the Affordable Care Act (ACA) on people living with HIV and how it will impact Ryan White funding is an important focus of the TGA. As of now, 75% of Part A clients are under 133% of the FPL, making them eligible for Medicaid under the ACA. The DHRPC will continue to monitor the ACA and the review of the law by the Supreme Court, and develop and/or adapt strategies to meet the need of PLWHA accordingly.

The Patient Centered Medical Home (PCMH) model of providing comprehensive primary care is one way the TGA's system of care can evolve along with the ACA. Despite potential structural barriers for the TGA, the model is an innovative way of improving and looking at primary care.

In 2009, the Colorado legislature passed the Colorado Health Care Affordability Act, designed to expand coverage to more than 100,000 uninsured individuals by 2014. While the state of Colorado has moved forward on high risk pools and looking at the

possibility of implementing Medicaid expansion early, budget cuts and high need have limited the impact these actions have had on PLWHA in the Denver TGA thus far.

E. Description of Gaps in Care

The 2011 Needs Assessment highlighted gaps in the Denver TGA's continuum of care from both client and provider perspectives.

Overall Service Gaps Identified by Clients
As illustrated in Table J below, the top services needed but not received among survey respondents were dental care, emergency financial assistance, and help getting or paying for health insurance. For homeless individuals, access to emergency financial assistance was the top need. Other top service needs for various subpopulations included medical care, over the counter medication, alternative care, nutritional counseling, transportation, laboratory tests, and housing.

Table J: Top 3 Services Needed, but Not Received

	1	2	3
Women	Dental care	Financial assistance	Housing
Monolingual Spanish	Dental care	Health insurance	Medical visits
Homeless	Financial assistance	Dental care	Over-the-counter medication
Formerly Incarcerated	Dental care	Financial assistance	Over-the-counter medication
White MSM	Dental care	Financial assistance	Alternative care
MSM over 40	Dental care	Financial assistance	Nutritional counseling
Foreign Born	Dental care	Nutritional counseling	Financial assistance
MSM of Color	Dental care	Financial assistance	Transportation
Newly Diagnosed	Dental care	Health insurance	Nutritional counseling

Table K below compares the ratio of individuals receiving a service to those needing but not having received a particular service. For example, for every 17.5 individuals who indicated that they received a medical visit, one individual indicated that they needed that service but did not receive it. Similarly, for every 1.3 PLWHA who indicated that

they received emergency financial assistance, one PLWHA indicated that he/she needed but did not receive it.

Table K: Ratio of Individuals Reporting to Have Received a Service to Those Reporting to Need But Not to Have Received a Service

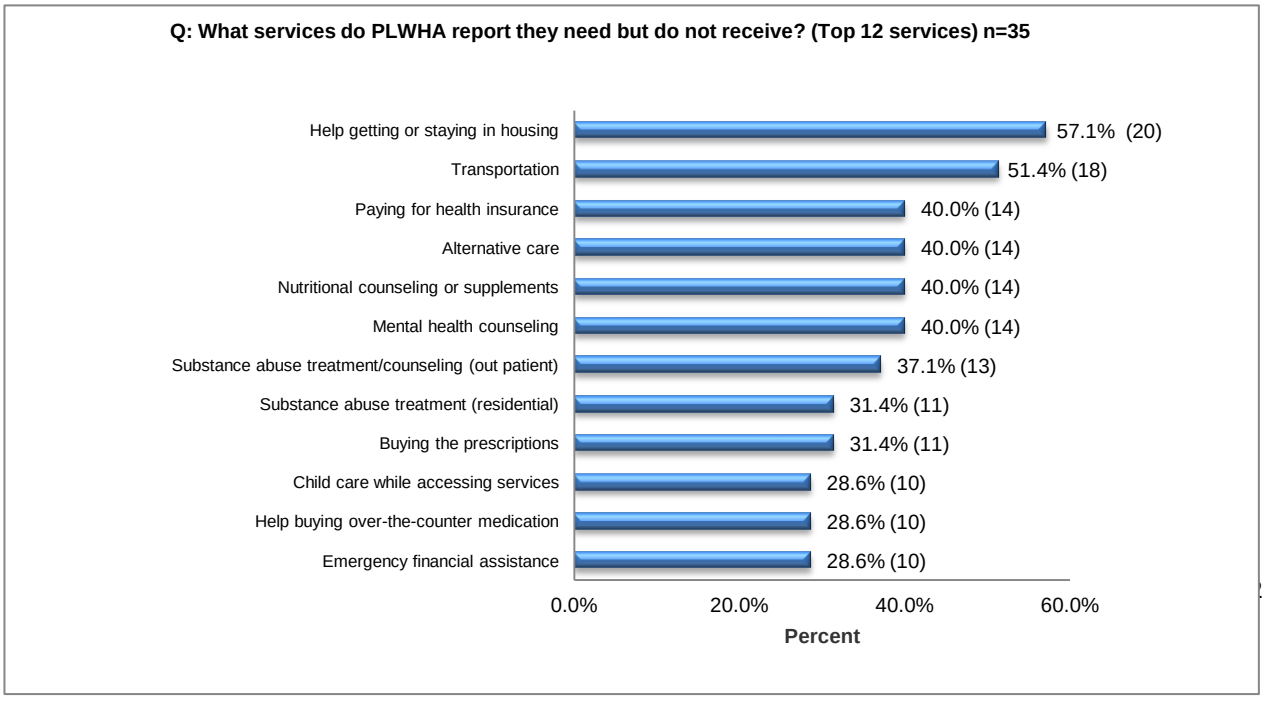
Service	Ratio Received to Not Received	N
Medical Visits	(17.5 : 1)	459
Laboratory tests	(16.6 : 1)	454
Buying prescriptions	(10.6 : 1)	385
Case management	(3.7 : 1)	235
Getting or paying for health insurance	(3.0 : 1)	271
Mental Health counseling	(3.0 : 1)	178
Groceries or prepared meals	(2.3 : 1)	163
Housing	(2.2 : 1)	149
Dental care	(1.9 : 1)	339
Transportation	(1.5 : 1)	140
Emergency financial assistance	(1.3 : 1)	168

This table demonstrates that the Denver TGA is relatively adept at ensuring that individuals are able to access medical care. However, gaps in accessing housing, dental care, transportation, and financial assistance remain.

Provider Perspectives

The service that providers felt PLWHA most needed but did not receive was housing services. Also commonly reported were transportation assistance, help getting or paying for health insurance, alternative care, nutritional counseling, and mental health counseling (see Graph I below).

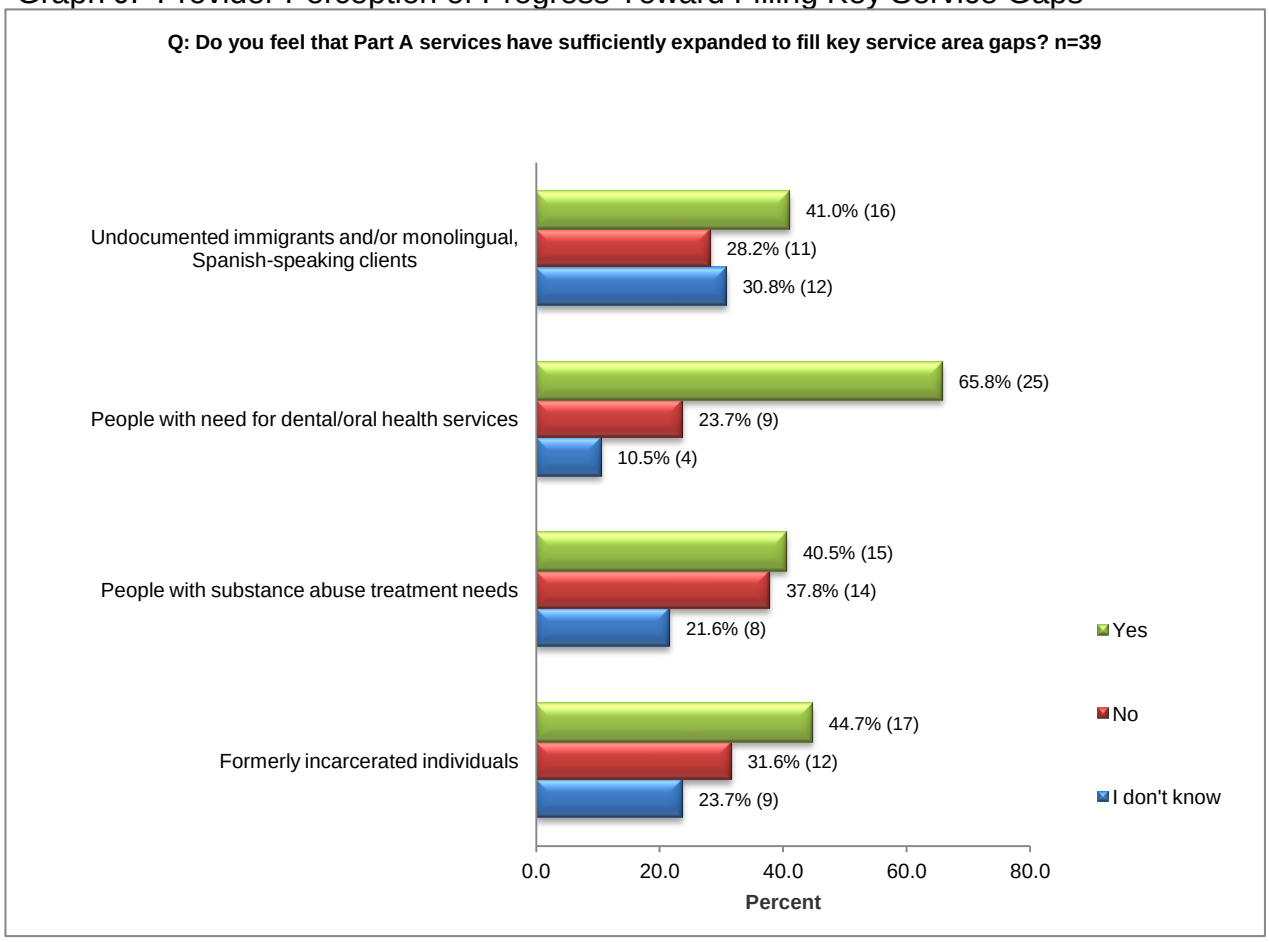
Graph I: Services That Denver TGA Providers Felt PLWHA Most Reported They Need But Do Not Receive



Providers were also asked about a range of services targeted to specific populations for which substantial new programming has been implemented in the past five years. Specifically, providers were asked if they felt that services had sufficiently expanded to fill key gaps pertaining to undocumented immigrants and/or monolingual Spanish-speaking clients, unmet need for dental or oral health care, substance abuse treatment needs, and reaching the formerly incarcerated.

Interestingly, while clients expressed an unmet need for dental care, 68.8% of providers in the needs assessment survey felt that the gap had been addressed. This obvious discrepancy will need to be explored further in the planned oral health survey.

Graph J: Provider Perception of Progress Toward Filling Key Service Gaps



F. Description of Prevention and Service Needs

HIV prevention covers a wide range of services for both at-risk and HIV-infected persons to reduce the risk of transmission. Many prevention services are compatible with, and are already being implemented within, Part A care settings in the TGA. Part A providers can affect HIV transmission rates by screening patients for risk behaviors, communicating prevention messages, discussing sexual and substance use behaviors, referring clients to mental health and substance abuse counseling, and identifying and treating sexually transmitted infections (STI).

The HIV Prevention Advisory (Council?) is the group tasked with advising CDPHE on prevention issues in Colorado. In the 2011 HIV Prevention Needs Assessment, with a focus on high-risk youth, the following needs were identified: education around HIV, social and emotional support, increased number of culturally competent counselors, and wide-spread availability of free condoms.

In the Denver TGA, we recognize the following HIV prevention service needs:

- Need for earlier testing and linkage to care
- HIV testing within the jail system
- Need for increased testing among the foreign born population
- HIV/STI education and risk assessment
- Risk reduction counseling
- Prevention case management
- HIV pre and post test counseling
- Peer group support
- STI diagnosis and treatment
- Substance abuse treatment
- Mental health counseling
- Partner counseling and referral
- Occupational post exposure prophylaxis for HIV
- Perinatal HIV screening, counseling, and treatment

The TGA will collaborate with the Colorado STI/HIV Prevention Program to support the current prevention activities.

G. Description of Barriers to Care

Routine Testing

Colorado HIV Testing Laws
The CDC recommends HIV testing for all patients ages 13 to 64 in health care settings as part of routine medical care.

In Colorado, there are few regulations around HIV testing. The regulations that do exist are likely to reduce barriers and encourage widespread testing, such as opt-out testing for pregnant women and the ability for minors to consent to an HIV test.

Components of CDC Recommendations	Colorado Laws
Informed Consent	Informed consent required
Counseling	Post-test counseling required with HIV positive test results
Testing Provision Anonymous	Testing must be made available anonymously
Rapid	No specific provisions
Routine	No specific provisions
Disclosure	No specific provisions
Minor/Adolescent Testing	Minors may consent to HIV testing Physicians may, but are not required to, notify parents of HIV test result
Prenatal	First trimester opt-out testing of pregnant women Third trimester no specific provisions
Labor and Delivery	Opt-out testing required for women who have not had a test during pregnancy

Source: www.nccc.ucsf.edu/docs/Colorado.pdf

Program Related Barriers (Structural Barriers)

Several program barriers have been identified through the Needs Assessment and other activities that impact both providers and clients. While many of these issues are out of the direct control of the Denver TGA, their impact is no less real and frustrating. Below is a list of structural barriers:

Funding Cuts: While the Denver TGA has received only minimal cuts in Part A funding over the last several years, when compared to the newly diagnosed population that enters the system each year, providers are being asked to provide more services with fewer overall resources. Though the rate of new clients to Part A is somewhat predicable, how providers and the system continue to provide quality care for more PLWHA with less funding is the real challenge. While health care reform may address some of these shortfalls, there is some worry that an uncertain future for Ryan White funding may erode many of the support services that keep PLWHA stable and retained in care.

Funding Early Intervention Services. Funding of Early Intervention Services (EIS) has historically fallen to Part B/CDPHE. The required funding of EIS in the Part A allocation process has meant fewer resources for other core and support services.

Increased Eligibility Requirements. New strategies around the new HRSA Universal, Fiscal and Programmatic Standards released in 2010 (six month reassessment vs. annual and insurance screening), while seen as increasing service quality, have also proven to be a barrier for providers, as it has meant increased time and capacity devoted to fulfilling the new requirements, which some view as having limited benefit to clients or the system.

Technology. While CAREWare has many benefits, it is limited as a clinical tool for providers. With the new requirements around eligibility data, sharing of information is more important than ever. However, the monthly lag in data means that patient information may not be up-to-date. Additionally, because case managers do not have ready access to medical data such as VL and CD4 count without a release, information sharing is compromised and sometimes poses continuity of care issues.

Integrated Care Model. One of the key challenges in the current system is finding opportunities to move to a more collaborative model of care, in line with concepts such as the patient centered medical home model, which will likely become more prevalent due to health care reform. Having a diversity of providers (locations, specialties, services) is one of the Denver TGA's biggest strengths; however, it presents some structural challenges when looking at a model like medical homes. While collaboration has always been a key focus within the Denver TGA, formalizing these relationships has proven to be challenging due to different organizational cultures and operations. While realizing the benefits of a medical home model are obvious, finding a path to evolve the current system of care will be a challenge over the next several years.

Transportation. Transportation has long been identified as a key way to increase medical adherence and improve health outcomes. While additional funding has been put into this category over the last several years, realistically it is unable keep pace with increasing demand and increasing cost of public transportation.

A number of additional challenges were cited qualitatively by providers. These challenges include: waiting lists for mental health services, managing large numbers of

newly identified clients as a result of expanded testing efforts, and identifying HIV-positive and undocumented individuals. Specifically mentioned were:

- An increase in the number of uninsured clients
- Cumbersome financial assistance programs
- Insufficient housing assistance opportunities
- Limited options for clients who want substance abuse treatment or counseling
- A lack of coordination of funding and priorities between Ryan White Parts A and B, leading to duplication of efforts and a lack of seamless systems of care
- The delineation of geographic county lines can pose significant problems to accessing services. This is especially true for undocumented or uninsured individuals in cases where free or sliding-fee-scale services are available only to residents of the county where the service provider is located.
- The lack of insurance and financial resources continue to play a major inhibitive role for many individuals

Provider Related Barriers

Several provider related barriers were identified through the Needs Assessment, site visits, and general feedback from providers and clients. While none of these issues are particularly new and some progress has been made in addressing them, these barriers remain key issues for the Denver TGA to consider over the next three years.

Oral Health Care. As the number of PLWHA increases over time and funding remains flat or decreases, the capacity of the Denver TGA's oral health system has been pushed to its limit. Providers, DHRPC, and DOHR have attempted various strategies to decrease waiting lists and improve access; however, the systematic reality is that more clients will need to be served with limited resources. Key issues impacting oral health care in the TGA:

1. The capacity of current providers is maximized and waiting lists can extend several months. While much attention has been paid to the waiting list issue, existing providers have been unable to keep pace with increased demand due to space limitations and other factors.
2. Emergency services have put a strain on provider capacity as many clients wait until levels of acuity for dental needs are high before seeking services.
3. Currently there are only two funded dental providers in the Denver TGA. While there have been efforts and funding put towards creating partnerships with other oral health providers, these have only had a minimal impact on system ability to handle regular and emergency dental needs.

In response to the identified issues, an oral health workgroup has been established to discuss and seek creative ways of serving more clients and improve coordination between providers.

Medical Case Management Case Loads. As with oral health, the number of Medical Case Management (MCM) clients has grown steadily over recent years without the funding to keep up. Currently, the largest MCM provider has case loads of over 130 clients per MCM. Caseload sizes and the associated paperwork (service plans and eligibility requirements) have put a strain on the existing system.

DHRPC has taken on a large improvement process to look at these issues and overall improvement in MCM. Based on a white paper (?) completed by DOHR in 2009, some of the strategies suggested were: a system-wide acuity assessment, co-location with primary care, case conferencing, training, and increased use of technology. The hope is that even with decreased funding, the system will find creative ways to maintain high quality care for clients.

Language and Cultural Competence. For monolingual Spanish-speakers, a significant barrier has been the lack of information about services in Spanish. It was commonly felt that information made available on many websites in Spanish was either missing, hard to find, or insufficient. And with new refugee and immigrant populations arriving in Denver, this challenge has extended to a new set of cultures and languages that providers must develop competence around.

Client Related Barriers

Tables L and M summarize key client related barriers in the Denver TGA from the 2011 Needs Assessment . Data for both tables were summarized from the following question asked of survey respondents: If you have ever gone without receiving HIV medical care or HIV medications for more than 12 months, or have never had them since your HIV diagnosis, what were the reasons?

The most prominent structural barriers for clients centered around financial concerns, whether it be the inability to afford medical care, or not having sufficient insurance to help pay for medical care (see Table L). Paperwork also presented a barrier for a substantial number of respondents, as did transportation concerns.

Table L: Common Barriers – Out-of-Care Respondents

Structural Barriers	(N=129) %	n
Could not afford it	35.7%	46
Insufficient insurance	27.1%	35
Too many requirements/too much paperwork	15.5%	20
Lack of transportation	10.9%	14
Did not qualify for services	10.1%	13
Long wait times for appointments	6.2%	8
A doctor or nurse told me I didn't need medical care	6.2%	8
No appropriate services available	3.1%	4

Client focus groups helped to provide further context. In fact, across all focus groups, transportation concerns became increasingly apparent. Providers also agreed that the most common structural level barrier for clients was lack of transportation services. In terms of more individually focused barriers, health literacy issues and stigma (particularly for the Black and heterosexual populations) play key roles (see Table M below).

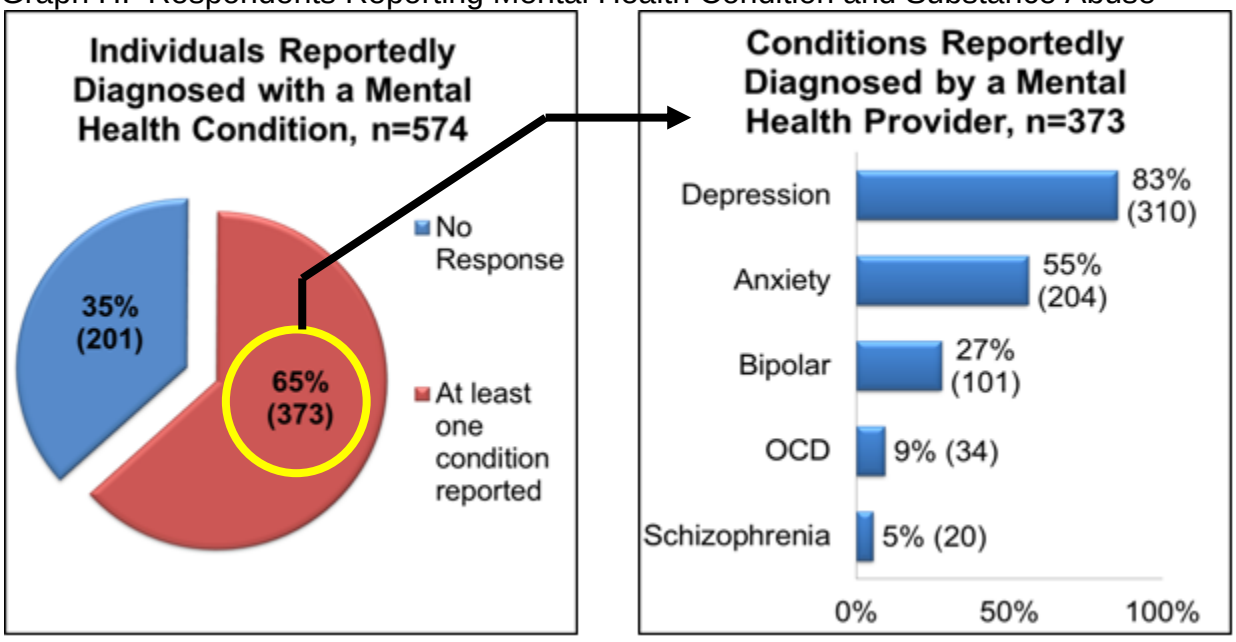
Table M: Common Barriers – Out-of-Care Respondents

Individual Barriers	(N=129) %	n
Did not think that I needed care because I wasn't sick	20.9%	27
Did not want anyone to find out I had HIV	18.6%	24
Did not think medical care would do me any good	14.7%	19
Did not know where to go for medical care	10.1%	13
There was no one to help me figure how to access care	10.1%	13
Poor personal treatment by a provider	7.8%	10
Did not want services	7.0%	9
No one told me that I needed to get medical care for HIV	3.1%	4

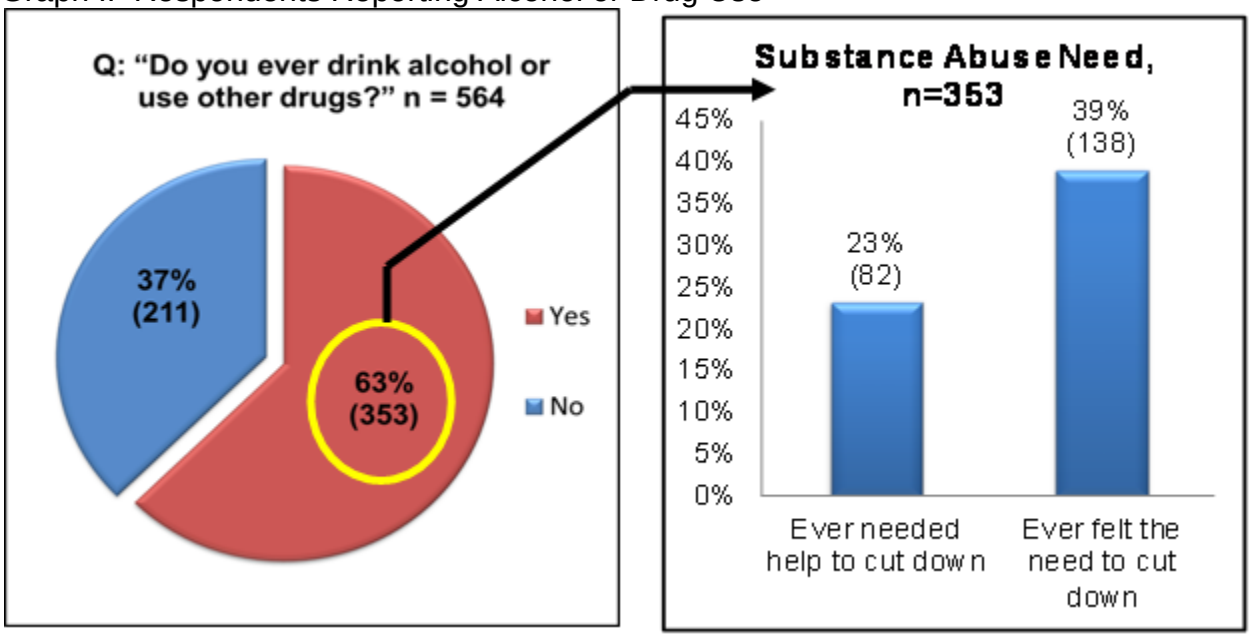
Other barriers to care include:

- Homelessness, particularly as it affects medication adherence
- Recent incarceration – PLWHA who are recently released from incarceration face hurdles around seeking employment and housing, among other things
- Mental health and substance abuse issues – graph H outlines the high prevalence of these issues among PLWHA.

Graph H: Respondents Reporting Mental Health Condition and Substance Abuse

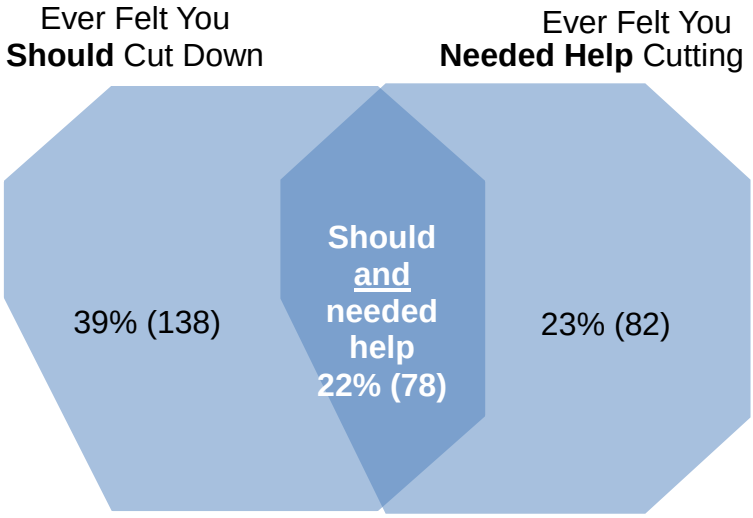


Graph I: Respondents Reporting Alcohol or Drug Use



Among those individuals in Graph I, Diagram1 below depicts how many PLWHA indicated *both* the need to cut down and the need for help to cut down alcohol or drug use.

Diagram 1: Respondents Reporting A Need To Cut Down and Help Cutting Down, Among Those Who Drink Alcohol Or Use Drugs



Both consumer and key informant interviews provide additional qualitative context to these issues. From the consumer perspective, mental health and substance abuse issues are highly correlated. Depression was commonly cited as a factor resulting from

an HIV diagnosis. Depression often led to substance abuse problems, which in turn interfered with the individual's ability to manage HIV. Support groups were commonly cited as integral to ensuring that substance abuse issues were addressed.

Combating the Barriers (Structural/Individual Factors)
Table N summarizes the factors listed by out-of-care survey respondents that would have helped them stay in care. These have clear implications for care.

Table N: Factors That Would Have Helped Out-of-Care Respondents Stay In Care

Q: What would have helped you stay in care? (n=126)	%	(n)
Support Systems/Counseling	19.8%	25
Health Insurance Access	15.9%	20
Financial/Affordability	19.0%	24
Don't Know/Nothing	11.9%	15
Information/Knowledge	8.7%	11
Transportation	7.1%	9
Streamlined Systems	4.0%	5
Case Management	4.0%	5
Being sober	4.0%	5
Seeing the 'right' Provider	3.2%	4
Side Effect Management	2.4%	3
Housing	1.6%	2
Dental	1.6%	2

H. Evaluation of 2009 Comprehensive Plan

The 2009-2011 Comprehensive Plan established a set of long-term system goals to help the Denver TGA develop and maintain a system of care responsive to the needs of PLWHA over time. The following table outlines the accomplishments and challenges in implementing the goals and activities laid out in the 2009-2011 Comprehensive Plan and describes how the plan has impacted the continuum of care within the TGA.

Denver TGA 2009-2011 Comprehensive Plan Progress Report

Goal 1: Implement a quality improvement and project management structure to address critical issues within the TGA.			
Activity	**Responsible Parties/Due Date**	**Accomplishments**	**Challenges**
Finalize/review Quality Improvement Plan (QIP) for TGA, utilize new workgroup infrastructure to assure broad involvement of stakeholders and consumers.	DHRPC Staff, Leadership Committee, DOHR December 31, 2009	The transition to a workgroup structure has had a measurable impact on the TGA. Utilizing workgroups has given DHRPC the ability to react quickly to identified issues and engaged a wide variety of community members, established a sense of ownership among members, and brought diverse perspectives to the table	A QIP has not been collaboratively established in the Denver TGA. Without a collaborative plan, it has been difficult to establish system-wide quality priorities and processes.
Finalize QI performance measures, utilize new workgroup infrastructure to assure broad involvement of stakeholders and consumers.	DHRPC Staff, Leadership Committee, DOHR June 30, 2010	New QI performance measures established for case management, substance abuse, mental health, oral health, and home and community health services in line with HRSA's quality measures.	None identified.
Create a process where	DHRPC Staff, Leadership	Workgroups were or are currently	While the workgroup

the Leadership Committee identifies and prioritizes emerging issues and establishes workgroups to develop solutions.	Committee February 28, 2009	established around emerging issues including: substance abuse and mental health, housing for newly released incarcerated PLWHA; general housing issues; improving standards of care in Outpatient/Ambulatory Care; medical case management; early intervention services; oral health; and HIV and aging. Workgroups have held numerous community/provider forums around emerging issues, established a housing program for the recently released/formerly incarcerated population, and made changes to the Standards of Care.	structure has been successful in taking on many key issues, the sheer volume of groups at times taxed the capacity of DHRPC staff. Moving forward, workgroups will be limited in number, time specific and goal driven.
Establish a structure for the Leadership Committee to determine timelines, chair person(s), and reporting mechanisms between the workgroups, Leadership Committee and DHRPC.	DHRPC Staff, Leadership Committee February 28, 2009	A process has been established by the DHRPC for workgroup establishment and monitoring by the Leadership Committee. When implemented this format has shown success in giving workgroups purpose and focus. Additionally, an online leadership training has been developed and is mandatory for anyone taking on a leadership position within the Council. These efforts have helped improve	There was a delay in full implementation of this activity while the DHRPC figured out the best way for the simultaneous operations of committees as well as workgroups so as to reduce duplication of efforts. A "hybrid" structure of standing committees and time-limited workgroups was established as the most effective.

		both committee and workgroup efficiency and effectiveness.	
Evaluate the quality improvement and project management structure at the end of each year, utilizing direct feedback from workgroups and the NQC Part A Quality Management Program Assessment Tool.	DHRPC Staff, Leadership Committee, DOHR December 31, 2009, 2010, 2011	The CP workgroup convened at the DHRPC retreat, consented that the full workgroup structure as called for in the CP was not realistic and that the hybrid structure of standing committees and time-limited workgroups was the most effective format for DHRPC operations.	Since full implementation of the structure as outlined in the CP did not occur and was in fact revised, a formal evaluation process could not take place. Moving forward, DHRPC will continue to assess the impact of the adapted hybrid model.
Goal 2: Establish workgroups to take on critical TGA initiatives.			
Activity	**Responsible Parties/Due Date**	**Accomplishments**	**Challenges**
Create workgroups to address current PC processes: needs assessment; priorities/resource allocation process; home health care standards.	Leadership Committee July 31, 2009	For the last three years, the DHRPC has established workgroups to plan and execute a new approach to the priorities process driven by the CP. While a specific workgroup was not established, the needs assessments strategy was undertaken by a breakout group at the 2010 DHRPC, with the process being managed by the Evaluation & Assessment Committee. Workgroup established to create Standards of Care for two newly funded services; Home Health Care	None identified.

		and Early Intervention Services. Assessment.	
Plan and prioritize future workgroups (based on main focus areas) to address emerging needs and identified quality improvement initiatives.	DHRPC Staff, Leadership Committee June 30, 2009	DHRPC has utilized multiple data sources to create and prioritize workgroups including changes in HRSA standards and policies; findings in needs assessment and other data sources; and issues identified by providers, community members, grantees, and Council members. The workgroups have allowed DHRPC to be responsive to needs as they arise.	Limitations of CAREWare data in the decision making process was identified.
Goal 3: Strategically improve the functioning of the DHRPC.			
Activity	**Responsible Parties/Due Date**	**Accomplishments**	**Challenges**
Create a Development Committee whose sole purpose is to ensure efficient and effective operations of the DHRPC.	Development Committee March 31, 2009	A Membership Development Committee was established and has since accomplished the following tasks: revised DHRPC's bylaws and grievance procedures; updated the DHRPC's organizational chart; developed standards and assessments for reapplying members; revised confidentiality policy for members; and revised confidentiality policies for Leadership and MDC committee members.	None identified.
Create protocol to strategically recruit	DHRPC Staff, Development	This was a key area of focus for the Membership Development Committee	Maintaining a representative The annual ebb and flow of

membership with a focus on the development of future leaders.	Committee June 30, 2009	and created a fresh approach to recruitment which yielded some innovative results including: updated and revised new member orientation manual; interview process for potential members; new online leadership training; and new online orientation training – presented at HRSA's All Parts Conference in August 2010 as a best practice model.	newly appointed members continues to be a challenge for annual recruitment and leadership development but focal point for DHRPC.
Goal 4: Ensure that strong communication exists between DOHR, DHRPC and providers.			
Activity	**Responsible Parties/Due Date**	**Accomplishments**	**Challenges**
Turn present MDASC format into an information sharing and gathering forum led by Leadership Committee and DOHR.	DHRPC Staff, MDASC Leadership, DOHR April 21, 2009	MDASC has launched several initiatives that have impacted overall services in the TGA. These include: development and revision of EIS SOC; revision of SOC based on recommendations from site visits; development of new QI performance measures; and development of SOC to incorporate HRSA universal, fiscal and programmatic standards.	Balancing discussion of specific issues and information sharing within the context of MDASC.
Develop a networking component to MDASC to ensure strong communication across TGA providers.	DHRPC Staff, MDASC Leadership, DOHR April 21, 2009	Networking and information sharing are priorities and continue to happen within MDASC.	Not all providers are present at MDASC meetings, making TGA-wide communication and networking difficult.

II. Where Do We Need to Go?

The purpose of this section is to discuss the Denver TGA's vision for an ideal high quality continuum of care, and the elements that shape this ideal system.

A. Plan to Meet Challenges Identified in 2009 Comprehensive Plan

Although the Denver TGA was mostly successful in addressing the objectives and strategies outlined in the 2009-2011 Comprehensive Plan, there were some challenges. The main challenge has been the lack of quantitative measures for identified objectives, resulting in a lack of outcomes measures for evaluation purposes.

Addressing some of the specific challenges identified under the various goals and activies, moving forward these are the focus areas for the TGA:

- DHRPC and DOHR will revisit the QI plan for the TGA outlined in Goal 1, Activity 1, utilizing a new workgroup to assure broad involvement of stakeholders and consumers.
- DHRPC will consider utilizing the NQC tool to implement the QI Plan.
- Continual reassessment of the "hybrid" committee and workgroup structure that has been established to evaluate effectiveness and avoid duplication of efforts.
- Even with the limitations of CAREWare data, DHRPC continues to strive towards a fully data driven decision making process.
- Continued focus on recruitment and training in order to maintain a representative Council.
- Continue to utilize MDASC as an information venue to ensure that strong communication exists between providers, DHRPC, and DOHR. Towards this end, MDASC will consider hosting resource fairs and other networking events.

B. 2012 Proposed Goals

The overall mission of the Denver HIV Resources Planning Council is to assist in the coordination of high quality, culturally proficient delivery of HIV/AIDS services in the Denver TGA. We envision a system that is integrated, accessible, and affordable. Through our continuum of care, we strive for a system that links, engages, and retains PLWHA in care.

To assist in accomplishing our mission and vision, the comprehensive planning process has identified six goals to assure a coordinated continuum of care for PLWHA. Goals are outlined below along with the problem statement, supporting data, and NHAS and/or Healthy People 2020 correlation. All goals will also be further outlined in Section III by strategies, responsible parties, timeline, and evaluation components.

Goal 1: Ensure that HIV-positive individuals who are unaware of their status are identified, informed of their status, referred to medical treatment, and linked into care.

Problem statement: As of June 30, 2011, there were an estimated 2,312 HIV-positive individuals in the Denver TGA who were unaware of their status.

NHAS, Healthy People 2020 correlation: increasing access to care and improving health outcomes for people living with HIV (NHAS); increase the proportion of persons living with HIV who know their serostatus (Healthy People 2020).

Supporting data: The unaware estimate of 2,312 was calculated using the Estimated Back Calculation (EBC) methodology.

Goal 2: Identify individuals who know their HIV status but are not in care, and inform and link these individuals to HIV-related services.

Problem statement: Once diagnosed there is a delay to link to care for a large percentage of PLWHA in the TGA.

NHAS, Healthy People 2020 correlation: Increasing access to care and improving health outcomes for people living with HIV (NHAS); increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards. (Healthy People 2020).

Supporting data: In the 2011 Needs Assessment, 10% of PLWHA said there was no one to help them figure out how to access the system (system issues); 19% did not want anyone to find out they had HIV (stigma); 26% did not access medical services for 7 months after diagnosis; and 19% did not access medical services within a year (linkage issues).Upon diagnosis, PLWHA expressed the following needs: 55% needed emotional support, 51% help finding a doctor or provider, and 44% information about HIV. Note a large number of survey respondents had been out of care at some point since the time of their original diagnosis, very few respondents indicated being currently out of care (e.g., out of care in the 12 months prior to responding to the survey).

Goal 3: Increase the proportion of PLWHA who are retained and/or re-engaged in care.

Problem statement: Data indicates that there is a large proportion of PLWHA that have not been in care in the last 12 months.

NHAS, Healthy People 2020 correlation: NHAS goal: Increasing access to care and improving health outcomes for people living with HIV (NHAS); increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards. (Healthy People 2020).

Supporting data: Both unmet need estimates (CDPHE 53% and DOHR 36%) show a large number of PLWHA out of care. 2011 Needs Assessment data showed the following system literacy issues for why PLWHA are out of care: 36% couldn't afford it,

27% had insufficient insurance, 10% did not qualify for services, 16% thought there were too many requirements/too much paperwork, and 11% lacked transportation. In regards to health literacy, 21% of PLWHA did not feel that they needed care because they were not sick and 15% did not think medical care would do them any good.

Goal 4: Monitor and evaluate the impact of the Affordable Care Act on HIV services in the TGA.

Problem statement: HIV services in the TGA must adapt to changes that occur with the implementation of the ACA.

NHAS, Healthy People 2020 correlation: Increasing access to care and improving health outcomes for people living with HIV (NHAS).

Supporting data: Approximately 84% of Part A clients are below 133% of FPL, making them eligible for Medicaid under the ACA.

Goal 5: Increase access to affordable dental care.

Problem statement: The capacity of the Denver TGA oral health services does not meet the need.

NHAS, Healthy People 2020 correlation: Increasing access to care and improving health outcomes for people living with HIV (NHAS).

Supporting data: In the 2011 Needs Assessment, dental care was listed as the top service needed but not received by women, monolingual Spanish speakers, formerly incarcerated, white MSM, MSM over 40, foreign born, MSM of color, and the newly diagnosed.

Goal 6: Reduce disparities in accessing care for the following special populations: adolescents, injection drug users, homeless, transgender, PLWH aging with HIV, African Americans, foreign born, undocumented, and African immigrants/refugees.

Problem statement: increase in PLWHA over 50 with corresponding acuity. Over representation of African Americans in PLWHA population but underutilization of core and support services. Increase in foreign born population who are testing and thus linking into care with higher medical needs. Adolescents, IDUs, homeless and transgender PLWHA have increased likelihood for delayed or dropping out of care.

NHAS, Healthy People 2020 correlation: reducing HIV-related Disparities and health inequities (NHAS).

Supporting data: Individuals 50+ are the largest PLWHA population by age breakdown at 41%. There has been a 26% increase in ages 50-59 population in the last three years and an 80% increase in 60+ age group in last three years. African Americans represent 15% of PLWHA population versus 11% utilizating services. They are also

disproportionately impacted by HIV (15% of PLWHA population versus 5% of overall TGA population. There has been a 15% increase in foreign born population in the past three years. There will be unique needs and possible challenges for undocumented PLWHA if not covered in health care reform.

C. Goals Regarding Individuals Aware of Their HIV Status, But Not in Care (Unmeet Need)

In the comprehensive plan, the following goals address the needs of individuals aware of their HIV status, but who are not in care:

- Goal 2: Identify individuals who know their HIV status but are not in care and inform and link these individuals to HIV-related services.
- Goal 3: Increase the proportion of PLWHA who are retained and/or reengaged in care.

For newly diagnosed PLWHA, one overarching component that helps ensure access to care is the fact that all EIS service providers in the TGA are co-located with case managers, primary medical care providers, and other HIV support service providers. Having all services offered from a single facility or campus makes it easier for diagnosed individuals to maintain a seamless network of support as they navigate the new system and adjust to the change in their lives.

Although EIS services are designed to last only three months while the PLWHA is integrated into primary care and Medical Case Management, the standards of care require that the EIS staff follow up six months after discharge to ensure that the individual has been retained in primary care. If the participant has fallen out of care, the EIS staff are required to provide outreach in an attempt to re-engage the PLWHA. Through the EIS Standards of Care, EIS is well positioned to increase engagement and retention for the newly diagnosed and those who have dropped out of care.

The Denver TGA has embraced participation in the in+care Campaign as a way of improving outcomes around key retention measures in order to address linkage and retention in care issues.

D. Goals Regarding Individuals Unaware of their HIV status (EIIHA)

In the Denver TGA, the specific goal addressing the EIIHA initiative are Goal 1: ensure that HIV positive individuals who are unaware of their status are identified, informed of their status, referred to medical treatment, and linked into care.

1. Increase the number of individuals who are aware of their HIV status.
2. Increase the number of HIV positive individuals in medical care. By increasing awareness and increasing the number of HIV+ persons in care, the strategy directly supports the second National HIV/AIDS Strategy goal of optimizing health outcomes for people living with HIV. Increasing awareness and treatment

will also help reduce infection rates (NHAS goal #1) and health disparities (NHAS goal #3).

The EIHHA strategies will be carried out by agencies funded through EIS. EIS is a separate funded category for the Denver TGA, prioritized as #7 out of 14. To implement the EIIHA strategy, the TGA will fund three public hospitals and one private hospital affiliate, so coordination with hospitals will be seamless. In addition, two of the hospitals maintain operating agreements with two clinics serving undocumented immigrants and the formerly incarcerated. These operating agreements help close the gaps that once existed in the safety net of the continuum of care by enabling disenfranchised populations to obtain equal access to primary care. The operating agreements have been in place for several years, so Denver CBOs are aware of the clinic resources. Additionally, all EIS funded providers are required to have collaborative agreements with testing sites in the TGA. Two of these providers conduct 80% of the HIV Testing in the TGA. This integrated EIS model provides a seamless link between testing and care.

Within the system of care as a whole, the Denver TGA has an effective record of reducing disparities in access and service provision. The same is expected to be true of EIS services, particularly because of the populations served. Three of the funded hospitals are public health organizations, and the two smaller clinics with which they are affiliated focus on care to monolingual Spanish speakers, undocumented immigrants, and the formerly incarcerated. Service utilization data is expected to confirm that the EIIHA network is well utilized by underrepresented groups including Hispanics, African Americans, and WICY populations.

In terms of identifying HIV+ unaware individuals, both DHRPC and CDPHE are involved with the Colorado Coalition for HIV Care & Prevention, which is overseen by Part B. The Part B representative is also on the Planning Council. In order to address the new EIIHA requirements, a workgroup was developed and meetings were conducted in FY 2010 with the Part A and B grantees to develop consistent strategies throughout the state regarding testing and post-test counseling.

The State of Colorado HIV Prevention program is overseen by the CDPHE STI/HIV Section, the same division that administers Part B funds. Similar protocols are in place for prevention collaboration as for Part B coordination. The staff members involved in community-wide meetings to address the EIIHA strategy are the same for both Prevention and Part B. Coordination has always existed between the programs and will continue to exist. This relationship applies for all four categories: identifying, informing, referring, and linking.

The main challenge associated with making individuals aware of their HIV status is the stigma of getting tested for HIV. While the TGA is always working with its partners in prevention, the stigma against testing is the biggest obstacle faced, particularly within communities of color and certain cultural groups. At this point, testing is still voluntary within the TGA. Even within the confines of the incarceration setting and an emergency room visit, an individual can opt out of testing if he or she chooses.

E. Proposed Goals for Closing Gaps in Care

Closings gaps in HIV care is critical to advancing the goals of the National HIV/AIDS Strategy. As stated in the SCSN, affordability of services, particularly health care services, is often linked to gaps in care. Accordingly, the Comprehensive Plan has identified the following goals for closing gaps in the HIV continuum of care in the TGA:

- Goal 5: Increase access to affordable dental care
- Goal 6: Reduce disparities in accessing care for the following special populations: adolescents, injection drug users, homeless, transgender, PLWH aging with HIV, African Americans, foreign born, undocumented and African immigrants/refugees

By increasing access to care, improving health outcomes for PLWHA, and reducing HIV-related health disparities, the identified goals directly support the NHAS.

F. Proposed Solutions for Addressing Overlaps in Care

Collaboration and coordination are essential for avoiding duplication of efforts, overlaps in care, fragmented service delivery, and for maintaining the most efficient continuum of care in the TGA. Several solutions are in place within the Denver TGA to avoid overlaps in care:

- To increase communication, both DHRPC and CDPHE are involved with the Colorado Coalition for HIV Care & Prevention, which is overseen by Part B. The Part B representative is also on the Planning Council.
- Providers within the EMA tend to serve unique populations, thus minimizing overlaps in care.
- Continual provider communication about services happens on an ongoing basis within the MDASC forum.

G. Description of Proposed Coordinating Efforts with the Following Programs

Part A services in the Denver TGA coordinate with the following programs to ensure integrated access to care for PLWHA, as well as to minimize duplication of efforts.

Part B Services: The Part B grantee is the Colorado Department of Public Health and Environment. There has been significant coordination between Parts A and B in coordinating the EIIHA initiative.

There have also been coordinated needs assessment activities between Parts A and B, with a first-ever joint needs assessment conducted in 2011 to determine the service needs and barriers to care of PLWHA in the TGA as well as statewide. Additionally,

DHRPC and CDPHE have collaborated on the Statewide Coordinated Statement of Need, as well as respective comprehensive plans.

Additionally, there is joint participation across planning bodies. The Part B Care and Treatment Program Manager serves as a full member of the Council and sits on the Executive Committee, which provides leadership and direction for the Planning Council, committees and workgroups.The Part A grantee Division Director is an appointed member of the Colorado HIV/AIDS Care and Prevention Coalition, which advises CDPHE on issues and needs pertaining to HIV/AIDS in the promotion of effective HIV care and prevention programs, including the AIDS Drug Assistance Program. Additionally the contracts administrator for the Part A grantee is an ADAP committee member. This has increased communication and has resulted in an increased understanding of deficits the ADAP program has faced.

All Part A clients receiving primary care are screened for ADAP eligibility. In regards to ADAP, the TGA has worked with Part B to fund the Health Insurance Continuation Program so a waiting list could be avoided for ADAP.

Part C Services: There are four medical providers supported with Part C funding in Colorado, one of which is located within the Denver TGA.This clinic is also home to the largest HIV testing program in Colorado – in 2010 there were over 20,000 tests performed. In 2005, the clinic instituted a linkage-to-care program, utilizing case managers to link PLWHA to Part A primary care clinics. The Part A ID clinic at the University of Colorado Hospital also provides onsite consultation services to the Part C clinic is Western Colorado.

In regards to planning, Part C is also a partner in the SCSN, and the medical director of the Part C Primary Care Clinic currently serves as a member of the Planning Council and the Evaluation and Assessment Committee, which is responsible for developing the Needs Assessment and Comprehensive Plan.

Part D Services: One of the Part A EIS funded hospitals is also a Part D recipient. Ryan White Part D funds care for women, infant, children , and youth (WICY) through the Children's Hospital Immunodefiency Program (CHIP). CHIP offers specialized services for HIV-positive women, infants, children and youth within the TGA. Care for WICY is provided at several sites, including Part A funded clinics.

Currently the Part D Program Manager is a member of the Planning Council, as well as serving on the Metro Denver AIDS Services Coalition. Comprised of service providers and consumers, this group establishes standards of care for Ryan White funded services, and reviews issues of concern for service providers in the Denver TGA.

Part F Services: The Part F Community-Based Dental Partnership Program (CBDPP) is housed at the University of Colorado School of Dental Medicine. One of the greatest national healthcare workforce shortage areas is oral health, which holds true for Colorado as well. The 2011 Needs Assessment identified oral health as a high service

need, but one that is more difficult to access than many other services. This is generally understood to be a provider shortage issue. The goal of the CBDPP is to increase access to oral health care services for PLWHA, while providing education and clinical training for dental care providers, especially those located in community based settings. To achieve its goals, the CBDPP works through multi-partner collaborations between dental and dental hygienist programs and community based-based dentists and dental clinics, including a Part A funded clinic

In addition to serving as an education and training resource for Part A providers, the Colorado AIDS Education and Training Center has collaborated with Part A on the Needs Assessment and Comprehensive Plan, with the program coordinator currently a member of the Evaluation and Assessment Committee.

Providers (Non-Ryan White Funded, Including Private Providers): PLWHA receiving primary care from private providers within the TGA are eligible for other Part A services. Part A primary care providers also routinely provide consultation to private providers around the care of PLWHA.

The coordinating case manager from Kaiser Permanente's Infectious Disease Clinic is a member of the Planning Council who coordinates closely with Part A funded Medical Case Management providers. Additionally, one of the Veterans Affairs' (VA) regional facilities is in the Denver TGA.The full-service VA hospital houses an HIV-specific clinic that serves about 300 participants, all of whom are former military personnel. Approximately 80% of the VA's total PLWHA client population reside in the Denver TGA. Staffing for the clinic includes a full-time nurse practitioner and three part-time physicians who provide primary medical care, laboratory work, and medications to their participants. Veterans who are HIV-positive, regardless of stage of disease, are eligible for these services. Working with the VA to identify unmet need is a high priority for the Denver TGA.

Prevention Programs Including Partner Notification Initiatives and Prevention with Positives Initiative: The state of Colorado HIV Prevention Program is overseen by the CDPHE STI/HIV Section, the same division that administers Part B funds. The staff members involved in community-wide meetings to address the EIIHA strategy are the same for both prevention and Part B. Coordination has always existed between the programs and will continue to exist. This relationship applies to identifying, informing, referring and linking PLWHA to services, as well as to partner notification and prevention with positives.

In terms of informing HIV-positive unaware individuals of their status, the Part B/Prevention office employs a dedicated staff member whose role is to conduct follow up with individuals who have tested positive but have not come back for a confirmatory test. Coordination is being developed between the CDPHE office (Part B/Prevention) and DOHR (Part A) so that the Part B/Prevention staff member may be utilized to conduct follow ups for Part A clients. Each Part A testing provider is contractually obligated to conduct this type of follow up as part of its service provision, but the addition of a cooperative agreement with Part B may ease the burden on Part A staff.

Substance Abuse Treatment Programs/Facilities: Colorado Medicaid does not cover substance abuse treatment, except for pregnant women through its Special Connections Program offered at multiple sites throughout the Denver TGA. This treatment is available during pregnancy and for 60 days postpartum. The Special Connections Program is affiliated with the Part A-funded Addiction Research and Treatment Services (ARTS) program, run through the University of Colorado Denver School of Medicine, which offers van transportation for treatment groups three times weekly. Medicaid also covers limited residential treatment for substance abusers that qualify for two three-day detoxification and assessments. Additionally, the State of Colorado receives a block grant from the Substance Abuse Mental Health Services Administration. This block grant is administered through the Signal Program, and it provides funds for HIV early intervention primary care services for substance-abusing participants who are receiving mental health and substance abuse treatment. Within the Denver TGA there are two recipients of this funding who also receive Part A funds.

STD Programs: Two Part A funded clinics in the Denver TGA are also funded by Part B to provide comprehensive STD testing on site. Both are also Part A funded EIS service providers with on-site linkage to care programs for newly identified PLWHA. The Medical Directors of both clinics are also current members of the Planning Council.

Medicare: In 2008, Part B began a new program, Bridging the Gap Colorado (BTGC), to assist Medicare Part D eligible PLWHA to acquire and pay for medications through a Medicare Prescription Drug Plan (PDP). BTGC "wraps around" Medicare Part D coverage, by paying for participants' premiums, co-pays, deductibles, and co-insurance, including fees in the so-called "coverage gap." This allows participants to access the entire formulary of their prescription drug plan at significant cost savings.

Medicaid: An expansion of Colorado Medicaid is currently underway. For Part A clients who can qualify and enroll, Colorado Medicaid covers a substantial portion of their medical needs . A representative from the Health Care Policy and Financing Department (HCPF), which administers Colorado Medicaid, sits on the Planning Council to provide information regarding Medicaid implementation in the state.

Children's Health Insurance Program: The Colorado Child Health Plan Plus (CHP+) is the Children's Health Insurance Program for Colorado. It is a low-cost health insurance program for uninsured Colorado children aged 18 and under and pregnant women, whose families earn too much to qualify for Medicaid, but cannot afford private insurance. Some Part A funded sites are also CHP+ providers. Both the HCPF and Part D representative inform the Council of issues regarding CHP+ as they arise.

Community Health Centers: The Colorado Community Health Network (CCHN) represents Colorado's fifteen Community Health Centers (CHCs) that together are the backbone of the primary health care safety-net in Colorado. CHCs ensure that Colorado's low income residents have access to affordable, high quality primary health care. Part A funds two community health centers to provide primary care for underserved and foreign born PLWHA among others, as well as EIS services at two CHC sites at Denver Public Health.

III. How Will We Get There?

The purpose of this section is to describe the Denver TGA strategies, plans, activities and timelines associated with achieving specified goals and with meeting identified challenges. Table O below outlines the overall goals of the Denver TGA. The following subsections A-D will further outline the same goals by specific areas gaps and/or needs.

Table O: Denver TGA Goals

Goal 1: Ensure that HIV positive individuals who are unaware of their status are identified, informed of their status, referred to medical treatment, and linked into care.			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Partner with Colorado Comprehensive HIV Testing Plan to facilitate earlier testing, particularly among foreign born population	POCLC	Ongoing	• Document action plan
Explore testing initiative in Denver County Jail	DHRPC	April 2012-Ongoing	• Record of meetings
Goal 2: Identify individuals who know their HIV status but are not in care and inform and link these individuals to HIV-related services (Linkage to Care).			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Evaluate data for any opportunities for improvement and create and update linkage strategies when opportunities are identified.	EAC, MDASC, EIS Workgroup	June 2012-Ongoing	• Needs assessment reports • CAREWare data reports
Present cumulative site visit quality indicator data on linkage measures to EAC, Leadership Committee, MDASC and POCLC on an annual basis.	DHRPC, DOHR	March 2013-Ongoing	• Meeting minutes • SOC measures Appendix 1
Goal 3: Increase proportion of PLWHA retained and/or reengaged in care (retention/reengagement in care).			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Collect and review data and develop strategy for addressing In+Care campaign objectives.	EAC, MDASC, EIS Workgroup	June 2012-Ongoing	• Document review

Establish baselines and system goals for In+Care objectives.	EAC, MDASC, EIS Workgroup	October 2012-Ongoing	• List of goals • Document baseline measures
Present cumulative site visit data on retention/reengagement measures to EAC, Leadership Committee, MDASC, and POCLC on an annual basis.	EAC, MDASC, EIS Workgroup	March 2013-Ongoing	• Site visit reports • SOC measures Appdendix 1
Goal 4: Monitor and evaluate the impact of the Affordable Care Act on HIV services in the TGA.			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Review data on PLWHA 133% of FPL to better understand impact of Medicaid expansion on the TGA.	Leadership Committee	July 2012-August 2012	• Data reports • List of recommendations
Identify service gaps between current RW services in the TGA and those covered under Medicaid/Medicare.	DHRPC, DOHR	July 2012-Ongoing	• List of service gaps
Monitor ACA legislation and develop strategies to address its possible impact in RW funding.	DHRPC, Leadership Committee	Ongoing	• Description of strategies • List of recommendations
Include updates on ACA as standing agenda item at monthly Planning Council meetings.	Leadership Committee	Ongoing	• Planning Council meeting notes
Oversee strategies to maintain undocumented PLWHS in care if ACA and RW services present barriers to accessing care in the future.	Leadership Committee	Ongoing	• List of strategies
Goal 5: Increase access to affordable dental care.			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Conduct an oral health focused needs assessment to determine the dental needs of PLWHA in the TGA.	Oral Health Workgroup	June 2012-August 2012	• Needs assessment report

Develop a Denver TGA strategy to address dental capacity issues.	Oral Health Workgroup	August 2012-September 2012	• List of recommendations
Continue to assess oral health capacity issues as part of needs assessment, priorities and allocation processes.	Oral Health Workgroup	September 2012-Ongoing	• Allocations report • Needs assessment report
Goal 6: Reduce disparities in accessing care for the following special populations: adolescents, injection drug users, homeless, transgender, PLWH aging with HIV, African Americans, foreign born, undocumented and African immigrants/refugees.			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Collect and analyze data to identify needs of adolescents, IDU, homeless, and transgender PLWHA in the TGA.	EAC	By July 2013	• Needs assessment and other data
Conduct awareness campaign to educate PLWHA and providers on issues surrounding aging with HIV.			• Campaign schedule
Position the Denver TGA to best meet the needs of PLWHA aged 50+.	Rebuilt+/POCLC	October 2012-March 2013	• Resource inventory review
Assess the reasons that African Americans are underutilizing RW core and support services.	Rebuilt+/POCLC	March 2013-July 2013	• Need assessment review and follow-up
Develop strategy and establish specific goals to remove barriers to care that lead to underutilization of services by and addresses unmet need of African Americans.	Rebuilt+/POCLC	March 2013-July 2013	• Description of strategies • List of recommendations
Continue to evaluate the impact of ACA on undocumented population.	Rebuilt+/POCLC	Ongoing	• Assessment/progress report
Develop strategies to maintain undocumented PLWHA in care if ACA and RW services present barriers to accessing care in the future.	Rebuilt+/POCLC	Ongoing	• List of strategies

Collaborate with Colorado Comprehensive HIV Testing Plan to prioritize linkage needs of PLWHA who are foreign born.	Rebuilt+/POCLC	Ongoing	• Linkage plan
Increase provider knowledge about specific PLWHA populations from Africa.	Rebuilt+/POCLC	Ongoing	• Workshop/training agenda
Increase PLWHA knowledge of resources and services across systems of care.	Rebuilt+/POCLC	Ongoing	• List of resources
Identify opportunities to increase the TGA's ability to link and retain African immigrants in culturally competent primary care and support services.	Rebuilt+/POCLC	Ongoing	• List of strategies

A. Strategy, Plan, Activities, Timeline to Close Gaps in Care

The specific goal that will address gaps in care is goal 5.

Goal 5: Increase access to affordable dental care.			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Conduct an oral health focused needs assessment to determine the dental needs of PLWHA in the TGA.	Oral Health Workgroup	June 2012-August 2012	• Needs assessment report
Develop a Denver TGA strategy to address dental capacity issues.	Oral Health Workgroup	August 2012-September 2012	• List of recommendations
Continue to assess oral health capacity issues as part of needs assessment, priorities and allocation processes.	Oral Health Workgroup	September 2012-Ongoing	• Allocations report • Needs assessment report

B. Strategy, Plan, Activities, Timeline to Address the Needs of Individuals Aware of Their HIV Status But Not in Care

The specific goals that will address the needs of individuals who are aware of their HIV status but are not in care are goals 2 and 3.

Goal 2: Identify individuals who know their HIV status but are not in care and inform and link these individuals to HIV-related services (Linkage to Care).			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Evaluate data for any opportunities for improvement and create and update linkage strategies when opportunities are identified.	EAC, MDASC, EIS Workgroup	June 2012-Ongoing	• Needs assessment reports • CAREWare data reports
Present cumulative site visit quality indicator data on linkage measures to EAC, Leadership Committee, MDASC and POCLC on an annual basis.	DHRPC, DOHR	March 2013-Ongoing	• Meeting minutes • SOC measures Appendix 1
Goal 3: Increase proportion of PLWHA retained and/or reengaged in care (retention/reengagement in care).			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Collect and review data and develop strategy for addressing In+Care campaign objectives.	EAC, MDASC, EIS Workgroup	June 2012-Ongoing	• Document review
Establish baselines and system goals for In+Care objectives.	EAC, MDASC, EIS Workgroup	October 2012-Ongoing	• List of goals • Document baseline measures
Present cumulative site visit data on retention/reengagement measures to EAC, Leadership Committee, MDASC, and POCLC on an annual basis.	EAC, MDASC, EIS Workgroup	March 2013-Ongoing	• Site visit reports • SOC measures Appdendix 1

C. Strategy, Plan, Activities, Timelines to Address the Needs of Individuals Unaware of their HIV Status

The specific goal that will address the needs of individuals who are unaware of their HIV status is goal 1.

Goal 1: Ensure that HIV positive individuals who are unaware of their status are identified, informed of their status, referred to medical treatment, and linked into care.			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Partner with Colorado Comprehensive HIV Testing Plan to facilitate earlier testing, particularly among foreign born population	POCLC	Ongoing	• Document action plan
Explore testing initiative in Denver County Jail	DHRPC	April 2012-Ongoing	• Record of meetings

D. Strategy, Plan, Activities, Timelines to Address the Needs of Special Populations

The specific goal that will address the needs of special populations in the TGA is goal 6.

Goal 6: Reduce disparities in accessing care for the following special populations: adolescents, injection drug users, homeless, transgender, PLWH aging with HIV, African Americans, foreign born, undocumented and African immigrants/refugees.			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Collect and analyze data to identify needs of adolescents, IDU, homeless, and transgender PLWHA in the TGA.	EAC	By July 2013	• Needs assessment and other data
Conduct awareness campaign to educate PLWHA and providers on issues surrounding aging with HIV.			• Campaign schedule

Position the Denver TGA to best meet the needs of PLWHA aged 50+.	Rebuilt+/POCLC	October 2012-March 2013	• Resource inventory review
Assess the reasons that African Americans are underutilizing RW core and support services.	Rebuilt+/POCLC	March 2013-July 2013	• Need assessment review and follow-up
Develop strategy and establish specific goals to remove barriers to care that lead to underutilization of services by and addresses unmet need of African Americans.	Rebuilt+/POCLC	March 2013-July 2013	• Description of strategies • List of recommendations
Continue to evaluate the impact of ACA on undocumented population.	Rebuilt+/POCLC	Ongoing	• Assessment/progress report
Develop strategies to maintain undocumented PLWHA in care if ACA and RW services present barriers to accessing care in the future.	Rebuilt+/POCLC	Ongoing	• List of strategies
Collaborate with Colorado Comprehensive HIV Testing Plan to prioritize linkage needs of PLWHA who are foreign born.	Rebuilt+/POCLC	Ongoing	• Linkage plan
Increase provider knowledge about specific PLWHA populations from Africa.	Rebuilt+/POCLC	Ongoing	• Workshop/training agenda
Increase PLWHA knowledge of resources and services across systems of care.	Rebuilt+/POCLC	Ongoing	• List of resources
Identify opportunities to increase the TGA's ability to link and retain African immigrants in culturally competent primary care and support services.	Rebuilt+/POCLC	Ongoing	• List of strategies

E. Description of Activities to Implement Coordinating Efforts To Ensure Access to Care

Part B Services – Part A will coordinate with Part B around the EIIHA initiative. In the Denver TGA, routine HIV testing is funded by Part B and CDC prevention dollars, both administered by CDPHE. Part A EIS agencies will help facilitate routine testing efforts by informing clients, referring them, and linking them to care. Coordinated activities around the SCSN, comprehensive planning, needs assessments, development of an HIV services resource inventory, the statewide quality improvement plan, and meetings will continue.

Part C Services: In the Denver TGA, the Part C clinic funds a part-time Linkage to Care Coordinator, which helps facilitate rapid and seamless enrollment of new clients into primary care. Part A providers will continue to provide both phone and onsite consultations to Part C clinics throughout Colorado.

Part D Services: Part A funded clinics routinely refer HIV-positive youth and pregnant women to CHIP for specialized care. The Part D clinics also work with Part A primary care clinics to transition HIV-positive youth to adult care.

Part F Services:. The Part F Community Dental Partnership (CBDPP) is intended to expand the oral health care workforce, and thus access to care for patients, through enhancing the HIV oral health skills of their staff as well as participating in student and resident training. With growing attention to the number of individuals who are living with HIV infection but are unaware of their status, CBDPP dental programs are strengthening linkages to local HIV testing programs and, in some cases, assessing the feasibility of implementing HIV testing in dental settings. There will likely be diagnostic testing recommended when oral signs and symptoms are consistent with HIV infection.

The Colorado AIDS Education and Training Center will continue to provide HIV training and educational resources to Ryan White Part A funded providers.

Providers (Non-Ryan White Funded, Including Private Providers): Part A primary care providers will continue to provide individual consultations with providers in the TGA about the care needs of PLWHA. DHRPC and DOHR will also work closely with the VA to more accurately estimate unmet need in the TGA.

Prevention Providers, Including Partner Notification Initiatives and Prevention with Positives: Part A will collaborate with the Colorado STI/HIV Prevention Program to support current prevention activities around partner counseling and referral. Part A providers also continue to screen patients for risk behaviors, communicating prevention messages, discussing sexual and substance use behaviors, and identifying and treating STIs.

Substance Abuse Treatment Programs/Facilities: Part A will continue to explore substance abuse treatment options for PLWHA at non-Ryan White funded programs

such as the Special Connections and Signal programs as applicable. Part A will also continue to fund substance abuse treatment services for PLWHA in the TGA.

STD Programs: Part A will continue to coordinate with STD testing sites to provide linkage to care and early intervention services for newly identified PLWHA.

Medicare: Part A will continue to enroll clients in Bridging the Gap Colorado to assist Medicare Part D eligible PLWHA to acquire and pay for medications through a Medicare Prescription Drug Plan.

Medicaid: Part A will continue to be involved the Colorado Medicaid expansion that is underway by supporting PLWHA enrollment in the program.

Children's Health Insurance Program: Part A will continue to refer and assist with enrollment of uninsured Colorado children and pregnant women in the Colorado Child Health Plan Plus (CHP+), particularly through the Children's Hospital Immunodeficiency Program.

Community Health Centers: Part A will continue its partnership in this area through the continued funding of efforts with community health centers to provide primary care and EIS services for underserved PLWHA. Part A clinicians will also continue to provide individual and group consultations around HIV care of PLWHA to CHCs across the state, including CHCs in Pueblo and Colorado Springs.

F. Description of How the Comprehensive Plan Addresses Healthy People 2020 Objectives

Healthy People 2020 is a national initiative led by Department of Health and Human Services which establishes 10-year objectives for improving the health of Americans through health promotion and disease prevention. Healthy People 2020 consists of 4 overarching goals and 42 topic areas, one of which is HIV.

In general, the Comprehensive Plan as a whole addresses the following goals of Healthy People 2020:

- Achieve health equity, eliminate disparities, and improve the health of all groups
- Promote quality of life, healthy development, and healthy behaviors across all life stages

More specifically, the goals 1, 2 and 3 in the Comprehensive Plan addresses the following Healthy People 2020 objectives:

HIV-10: Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards (Goal 2, 3).

HIV-13: Increase the proportion of people living with HIV who know their serostatus (Goal 1).

HIV-14: Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months. (Goal 1).

G. Coordination with the Statewide Coordinated Statement of Need

Part A is an integral partner in the development of the SCSN. Additionally, needs identified for PLWHA statewide as well as in the Denver TGA were obtained through a joint Part A and B needs assessment process. As such the Comprehensive Plan is fully compatible with the SCSN. The following cross cutting issues and goals jointly identified in the SCSN helped inform the Comprehensive Plan:

- Bringing into care those who know their status but are not receiving primary care or treatment
- Increased testing and subsequent linkage to care for PLWHA.
- Increase the proportion of PLWHA that become eligible for Medicare, Medicaid, or private health insurance
- Improve retention in medical care and adherence to medication regimens
- Screen clients for mental health and substance abuse issues and provide or actively link clients to appropriate, client centered behavioral health services
- Improve access to support services for people living with HIV or AIDS
- Increase access to affordable dental care, integrated as part of comprehensive medical care
- Assist and support PLWHA to enhance quality of life
- Address stigma through enhanced peer-based services and outreach
- Promote quality improvement
- Promote cultural competence among service providers
- Address disparities in HIV care through outreach and education
- Prepare for the impact of health care reform and ease the transition of clients to alternate sources of third-party payment as they become available.

H. Coordination with the Affordable Care Act

The intent of the ACA is to expand health insurance coverage and reform the US health delivery system. The ACA will undoubtedly impact Ryan White funding and alter the delivery of HIV/AIDS care within the Denver TGA. Much of this change is uncertain however, as the law's constitutionality is currently being challenged in front of the US Supreme Court. Traditionally, PLWHA have had difficulty in accessing Medicaid.However, the ACA will expand Medicaid coverage to individuals with incomes below 133% of the Federal Poverty Level. Currently, it is estimated that 84% (1936 out of 2314) of PLWHA served under Part A are under 133% of FPL, thus making them eligible for Medicaid under the ACA. Due to be reauthorized in 2013, there are concerns about the role of Ryan White funding in the ACA era.

Accordingly, the Denver TGA has developed a specific goal around the ACA in order to adapt to changes in the implementation of the ACA: Monitor and evaluate the impact of the Affordable Care Act on HIV services in the TGA. Specifically, the outlines the following strategies for accomplishing this:

- Review data on PLWHA at 133% of FPL to better understand impact of Medicaid expansion on the TGA
- Identify service gaps between current RW services in the TGA and those covered under Medicaid/Medicare
- Monitor ACA legislation and develop strategies to address its possible impact in RW funding
- Include updates on ACA as standing agenda item at monthly Planning Council meetings
- Develop strategies to maintain undocumented PLWHS in care if ACA and RW services present barriers to accessing care in the future

In keeping with the ACA, the SCSN also identified the following cross cutting issue and goal: increase the proportion of PLWHA that become eligible for Medicare, Medicaid, or private health insurance.

I. Description of How the Comprehensive Plan Addresses the Goals of the National HIV/AIDS Strategy

Through its various goals and strategies (refer to Section II, Part B to see how each goal in the CP is linked to the NHAS), the Comprehensive Plan addresses all three primary goals of the NHAS:

1. Reducing new HIV infections
2. Increasing access to care and improving health outcomes for people living with HIV
3. Reducing HIV-related disparities and health inequities

J. Strategy to Respond to Unanticipated Changes in the Continuum of Care as a Result of State or Local Budget Cuts

In times of uncertain funding and with concerns about the future of Ryan White funding in the ACA era, the Denver TGA is continually reviewing Needs Assessment as well as client utilization data in order to be able to respond to any potential changes in funding in a timely manner. In such cases, the Leadership/Priorities Committee will reconvene to discuss the impact of cuts on services and develop a plan for the potential reallocation of resources.

IV. How Will We Monitor Our Progress

A. Describe Plan to Monitor and Evaluate Progress in Achieving Proposed and Identified Challenges

Progress on the Comprehensive Plan will be reviewed on a quarterly basis, using quality indicators where indicated. The EAC will coordinate this activity. Individual performance measures will be assessed to determine if current efforts are generating the desired outcome and if additional action is necessary. Quality measures will be evaluated based on several data sources including:

- CAREWare data reports
- Site visit reports
- Needs Assessment data

DHRPC is also part of the Quality Improvement Committee, formed to centralize and coordinate QI efforts across RW contractors statewide. The QI committee is responsible for reviewing the state's QI plan, establishing shared quality measures, promoting collaboration among contractors, ensuring consumer involvement in the QI plan, and supporting the development and implementation of the PDSA/improvement change activities.

The QI program is designed to address quality assessment and improvement in the following key focus areas: access to care, retention in care, adherence to treatment, evidence-based care. These efforts will include monitoring system level measures as well as process and outcome measures on the provider/service level.

Describe How Impact of EIIHA Initiative Will Be Assessed

As explained before, the EIIHA strategies will be carried out by agencies funded through Early Intervention Services and assessed through the EIS Standards of Care.

The EIS Standard of Care that relates to informing unaware individuals of their HIV status is as follows:

Requirement	Indicator	Data Source
Provider will perform a confirmatory HIV test to newly diagnosed participants, including CD4 enumeration and accurate medical interpretation of such labs.	Laboratory screening performed upon referral.	Participant's file will document the date when laboratory tests were completed and specific lab values.

The EIS Standards of Care with respect to referring unaware individuals into care are as follows:

Requirement	Indicator	Data Source
EIS is utilized to connect those not in care to the services they need to manage their HIV/AIDS	EIS is designed to connect the participant with primary care and other needed services and follow up to ensure these services are implemented. EIS should not last longer than three months unless a barrier is identified and documented that shows services continue past the three month period.	Participant's file will demonstrate that referrals are made in a timely manner or documentation exists to explain why services continue past three months.
	Appointment will be set with a primary care provider within 90 days of entry into EIS. However, providers should recognize that expedited entry into primary care is best practice.	Participant's file will document an appointment date and referral to primary care within 90 days of entering EIS.
	If appropriate, a referral to a medical case management provider will occur within 45 days of entering EIS.	Participant's file will document linkage referral to medical case management within 45 days. If not appropriate for referral, this reason is documented.
Every participant shall have an intake interview and needs assessment to collect data important for proper referrals.	Provider shall schedule an intake interview within two business days of a positive diagnosis or within one week of an identified need.	Participant's file will demonstrate an intake interview was scheduled within two days of a positive diagnosis or within one week of an identified need.
	During the intake interview the staff will work with the participant to gather all eligibility data (income, residency, HIV status, and legal name).	Participant's file contains copies of the necessary eligibility data.
	Initial assessment of a participant's functional capacity, health (including oral health), mental health, substance abuse, health literacy, resources, insurance eligibility and needs will be completed within the first two meetings. Mental health and substance abuse must be assessed with a standardized assessment tool.	Participant's file has initial assessment with all necessary information completed within the first two meetings.
Every participant shall have a	The Referral Plan will demonstrate how the participant's needs (identified in	Participant's file contains a Referral Plan which

Requirement	Indicator	Data Source
Referral Plan which guides their EIS services.	their assessment), will be met through Part A and other service providers.	demonstrates connections to proper services.
	The plan will be completed within one week of the assessment.	Participant's file contains a Referral Plan that is completed within the required timeframe.
	The Referral Plan contains goals for referrals and care adherence and should be time limited to three months of EIS services.	Participant's file contains a Referral Plan with appropriate goals.
EIS Quality Measures	85% of participants determined eligible for EIS services will have a primary medical appointment within a 90 days of becoming a participant of an EIS program.	Participant's file documents a medical appointment within 90 days.
	90% of participants will have a Referral Plan.	Participant's file contains a Referral Plan.

The EIS Standards of Care regarding linking unaware individuals to care are as follows:

Requirement	Indicator	Data Source
Every participant shall have a Referral Plan which guides their EIS services.	At the end of three months of EIS services, the Referral Plan should be updated to show that goals have been accomplished. If services are continued, new goals should be established for existing needs.	Participant's file contains a Referral Plan with documented progress and new goals if necessary.
Progress notes shall be completed after every significant contact with participant. (Significant contact is defined as contact over 15 minutes or that is significant to care)	Progress notes demonstrate that the Referral Plan is being implemented and followed or revised to meet the participant's changing needs.	Participant's file contains progress notes related to the Referral Plan.
Discharge shall be documented and proper referrals made if applicable.	Discharge from EIS will be completed at the request of the participant, a provider, after allotted EIS timeline or at death, using pre-established provider guidelines and criteria. A summary of services provided should be documented in the	Participant's file states the reason for discharge and summary of services.

Requirement	Indicator	Data Source
	discharge summary.	
EIS will ensure that participant has initiated services with primary care six months after discharge from EIS services.	EIS staff will follow-up with medical provider six months after EIS discharge to ensure participant has initiated services in primary care.	Participant's file demonstrates participant is initiated in primary care six months after EIS discharge.
	If participant has not initiated primary care, EIS staff will outreach to participant to reengage in EIS services.	Participant's file documents outreach efforts and demonstrates that participant is initiated in EIS if they have fallen out of primary care. If participant refuses to reengage, the file documents the participant's reason.
Caseload	Caseload size will be determined by individual provider organizations. Caseload sizes shall be routinely assessed by supervisor.	Provider's policies and procedures and Report from Provider on Caseloads.
EIS Quality Measures	90% of participants will be referred out of EIS within the three month service period.	Participant's file will document discharge within the service period.

Timeline for Implementing the Monitoring and Evaluation Process

Improved Use of Ryan White Client Level Data

The Evaluation and Assessment Committee will review Comprehensive Plan progress at least on a quarterly basis. Client level data provided through CAREWare is one of the main data sources that will assist the TGA is arriving at fully data driven priorities and decision making processes.

Use of Data in Monitoring Service Utilization

The DHRPC will compile data from various sources on a quarterly basis and compile year to date progress reports for evaluation purposes.

Measurement of Clinical Outcomes

The TGAs SOC include standards for clinical services, which are monitored through onsite monitoring and analysis of data.

Colorado’s statewide QI committee also takes a leadership role in identifying clinical measures regarding clinical services and measuring progress toward quality improvement.

Appendix 1: Standards of Care Measures

Goal 2: Identify individuals who know their HIV status but are not in care and inform and link these individuals to HIV-related services (Linkage to Care).			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Assure EIS clients are assigned a MCM within 90 days of becoming an EIS client if appropriate.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 85% of EIS clients assigned MCM within 90 days
Assure that EIS eligible clients have a primary medical care appointment within 90 days of enrolling in program.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 85% of EIS eligible clients have primary medical appointment within 90 days of enrollment
Assure that EIS clients engaged in care 6 months after their EIS close date.	EAC, MDASC, EIS Workgroup	End FY 2014	• Provider chart review notes • 75% of EIS clients engaged in care 6 months after close date
Goal 3: Increase the proportion of PLWHA retained and/or reengaged in care (retention/reengagement in care).			
Strategies	**Responsibility**	**Timeline**	**Evaluation**
Assure that clients eligible for EIS reengagement services are successfully contacted.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 65% of clients eligible for reengagement services are successfully contacted.
Assure that clients eligible for EIS reengagement services who were successfully contacted will have attended a medical appointment within 90 days.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 75% of clients eligible for EIS reengagement services who were successfully contacted will have attended

			a medical appointment within 90 days.
Assure that clients eligible for EIS reengagement services who were successfully contacted and reconnected to care will still be engaged in medical care 6 months after their EIS close date.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 75% of clients eligible for EIS reengagement services who were successfully contacted and reconnected to care will still be engaged in medical care 6 months after their EIS close date.
Assure that outpatient ambulatory clients determined to be out of care received outreach to reestablish care.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 80% of outpatient ambulatory clients determined to be out of care received outreach to reestablish care.
Assure that outpatient ambulatory participants with HIV infection had 2 or more medical visits in an HIC care setting at least 3 months apart in the measurement year.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 75% of outpatient OA participants with HIV had 2 or more medical visits in an HIC care setting at least 3 months apart in the measurement year.
Assure that medical case management clients have at least 1 primary medical care appointment within the last 6 months.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 85% of MCM clients have at least 1 primary medical care appointment within the last 6 months.

			• 75% of MCM clients will submit their lab results to their case manager
Assure that medical case management clients have at least 1 annual assessment of their level of self-management.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 85% of MCM clients have at least 1 annual assessment of their level of self-management.
Mental health clients self-reports that they are accessing primary care every 6 months.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 75% of mental health clients self-reports that they are accessing primary care every 6 months.
Substance abuse clients self-reports that they are accessing primary care every 6 months.	EAC, MDASC, EIS Workgroup	By end FY 2014	• Provider chart review notes • 75% of substance abuse clients self-reports that they are accessing primary care every 6 months.