

**Metropolitan Atlanta
HIV Health Services Planning Council**

FY 2002 - 2004

**Atlanta EMA
Comprehensive
HIV Services Plan**

September, 2002

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DRAFT

Contributors

Metropolitan Atlanta HIV Health Services Planning Council

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Evaluations
HOPWA Allocations
Membership
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Title IV Coordinating

Council Task Forces

African American Outreach Initiative
Case Management
CBC/MAI Initiative
Client Involvement
Comprehensive Planning
Housing
Mental Health
Medical Providers
Oral Health

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Letter of Concurrence

September 19, 2002

The shared vision and values set forth in the Comprehensive HIV Services Plan: 2002-2004 guide the Metropolitan Atlanta HIV Health Services Planning Council in its work to empower HIV infected individuals to achieve and to maintain physical, emotional, and spiritual health. Although these were not officially codified until 1998 when the Planning Council produced its first comprehensive services plan, this vision and these values have guided the Council since its inception in 1990.

From this vision has evolved a service delivery model that has responded to the changes in the Atlanta EMA's epidemic over the years. Proof of this model's success in responsiveness is evident in the improved health of persons served with MAI funds; over 65% of persons served with MAI funds experienced an increase in their CD4+ counts.

During the three-year life of this Plan, this service delivery model will be put to the test and subjected to evaluation and study. This is in an effort to refine, and even redefine, the model in order to respond to the future challenges presented by the epidemic.

We, the undersigned, attest that the Metropolitan Atlanta HIV Health Services Planning Council reviewed this Comprehensive HIV Services Plan during its meeting on September 19, 2002 and adopted the Plan to guide service delivery between 2002 and 2004.

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Chair

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Introduction

Comprehensive HIV services planning is a central focus of the Ryan White CARE Act legislation and an essential component of Title I programs. Comprehensive planning is necessary to achieve the goals of the Ryan White CARE Act: to develop, organize, coordinate, and implement more effective and cost-efficient systems of essential services to individuals and families with HIV disease.

Comprehensive planning guides decisions about services for people living with HIV disease and AIDS (PLWH/A). Planning activities undertaken by Planning Council members assist the decision making process of members in the development and maintenance of a system of care and support for PLWH/A. This is especially important in light of the changing and increasingly complex health care environment.

The comprehensive HIV services planning process undertaken by the Planning Council required members to ask four questions related to the Atlanta Eligible Metropolitan Area (EMA) HIV service delivery system and to engage in a planning process that resulted in this written Comprehensive HIV Services Plan. The four questions addressed in the Plan are:

- ▶ Where are we now?
- ▶ Where should we be going?
- ▶ How will we get there?
- ▶ How will we monitor our progress?

Critical Issues in the Atlanta EMA HIV Service Delivery System

A number of critical issues were identified by the Planning Council regarding the service delivery system. These included:

- the range of client needs to be met: HIV+ persons who are newly diagnosed and asymptomatic and essentially well, but who need access to expensive medications; Long-term survivors who may need medical care and several types of social and financial support; Persons in the end-stage of illness who have no resources and no access to care; Persons with multiple problems, such as dementia or other mental illness, substance abuse, other health problems, homelessness;
- the changing picture of clients to be served;
- people not in care;

- early intervention services; and
- the need for refinement of standards of care among local providers related to initial diagnostic tests and continuing care for PLWHA, within the limits of PHS guidelines.

Members considered the “povertization” of AIDS and the “feminization” of AIDS. More clients are coming to providers across the system with basic needs to be met – food, shelter, emergency financial assistance, transportation. Many clients are lacking any ongoing relationships with medical professionals and health care settings. Changing welfare policies are restricting access to Medicaid by women, families, and adolescents. Lack of family support and childcare further restricts access to care.

Members addressed the questions: “Who can we help? How can we balance needs of clients in different stages of illness and life circumstances with available resources? Do we provide intensive services to a few clients, or fewer services to all clients?”.

Increasing numbers of clients with complex, multiple needs are seeking case management services. Particularly pressing is the limited number of long-term treatment slots for clients with multiple diagnoses.

The Council noted that multiple demands on Title I dollars come from numerous directions and from other service systems — mental health, substance abuse, housing. At the same time, there is inadequate information about the capacity of these other service systems to make decisions about the use of Title I dollars to support these services. There is a need to “mainstream” HIV/AIDS clients into these service systems, but in most cases these systems are already overburdened and inaccessible.

Among the most critical current demands on the HIV service delivery system in the Atlanta EMA are:

1. Paying for anti-retroviral multiple drug regimens,
2. Clients’ restricted access to Medicaid,
3. Clients’ lacking private health insurance,
4. Assisting clients in making co-payments for medications, and
5. Assisting clients in retaining existing insurance coverage.

Executive Summary

[TO BE WRITTEN AFTER PUBLIC COMMENT PERIOD]

Section 1

Where Are We Now: What Is Our Current System of Care?

Description of the EMA

Based on U. S. Census (2000) data, 51% of the State of Georgia's population (4,112,198 persons), 51% percent of the State's African American population, 62% of Georgia's Latino population, and 38% of the State's poor reside within the boundaries of the 20-County Atlanta EMA. Within the Atlanta EMA, 65% of the total population resides in the four most urbanized counties of Fulton County (816,006 residents/20% of EMA population), DeKalb County (665,865 residents/16% of EMA population), Cobb County (607,751 residents/15% of EMA population) and Gwinnett County (588,448/14% of EMA population). The largest concentrations of minorities within the Atlanta EMA reside in the counties of Fulton (28%), DeKalb (28%) and Cobb (11%), respectively.

The Atlanta EMA has an extensive HIV care network. Ryan White care providers in the Atlanta EMA use an early intervention and advanced staging process in the design of the HIV clinical network, as well as a centralized case management system to help clients access these services. Modifications to this system have historically been made as needed based on changes in the epidemiology and input from HIV service providers and consumers.

Epidemiologic Profile

Current Local Epidemic

Seventy percent (70%) of AIDS cases in Georgia are within the Atlanta EMA, primarily in Fulton and DeKalb counties, but the number of new cases in counties outside of these larger metropolitan areas within the EMA is increasing annually. In the Atlanta EMA, between January 1, 2000 and December 31, 2001, there were 1,923 new cases (AIDS incidence), and as of December 31, 2001, there was a total of **8,292** current cases (AIDS prevalence). There were **10,700** estimated cases of HIV infection as of June 30, 2000, representing an increase of **2,300 cases (28% increase)** from the previous two years.

The African American population continues to exhibit the greatest impact from the HIV/AIDS epidemic in the Atlanta EMA. Although African Americans account for only 28% of the Atlanta EMA population, 76.76% of all new AIDS cases diagnosed between the period of January 1, 2000 – December 31, 2001 were reported for this population. African Americans also account for the largest number of people living with AIDS (5,540 persons/66.80% of EMA AIDS prevalence) and the largest number of people living with HIV/non-AIDS (7,319 persons/68.4% of EMA HIV prevalence) within the Atlanta EMA. The proportion of women newly diagnosed with AIDS decreased slightly, while the proportion of women living with AIDS has increased, and those living with non-AIDS HIV prevalence **has increased**. In a comparison of incidence and prevalence data for women within the Atlanta EMA for the previous reporting period of June 1, 1998 – June 30, 2000 and the most recent reporting period of January 1, 2000 –

December 31, 2001, AIDS incidence has decreased slightly from 24.33% to 23.13%, while AIDS prevalence has increased from 16.77% to 17.15% and HIV prevalence increased from 18% to 24.33%.

Future Trends

Between 1994 and 2001, the number of reported AIDS cases declined across the State and in the Atlanta EMA, while the number of persons living with HIV disease increased; this can be attributed to increased availability and successful use of new treatment options. However, Ryan White-funded primary care sites have observed over the last two years that people are presenting at later stages of the disease. These “observations” will not be seen in the State’s data reporting for another two years given data limitations, such as, under-reporting, delayed reporting, and the fact that the data do not account for migration.

In the Atlanta EMA, 25% of AIDS cases are among females. This compares to 1987 when only 3% of AIDS cases were female. This trend is expected to continue. Linked to the number of females represented is the rise in persons identifying heterosexual contact as their mode of transmission (10% between 1981 and 2001). In the future, men who have sex with men (MSM) is expected to continue as the number one mode of transmission; 53% identified their mode of transmission as MSM during the same reporting period. The State is currently developing a factor/model based on other rates of sexually-transmitted diseases among MSMs in order to get a more accurate picture of what is happening among the MSM population. Hepatitis A outbreaks/resurgences, increases in syphilis rates, and incidence of shigella are a part of this investigation.

Although the national trend has been to see more young persons becoming infected with AIDS, the Atlanta EMA has also seen a significant increase in the number AIDS cases among persons over the age of 40. Between 1990 and 2001, the percentage increased from 28% to 40% in the Atlanta EMA.

History of the Local, State, and/or Regional Response to the Epidemic

Georgia’s earliest response to the AIDS epidemic was the formation of the multi-disciplinary Georgia Task Force on AIDS in 1985. The Task Force was made up of local community-based organizations, and State and County public health entities including AID Atlanta, Grady Hospital, Visiting Nurses Association, Fulton County Board of Health, and DeKalb County Board of Health. The primary role of the Task Force was the development of strategies for combating AIDS and minimizing transmission. The Task Force also assumed an advisory role for the coordination and distribution of grant funds received through the Robert Wood Johnson Foundation.

The 1987 Georgia General Assembly directed the Department of Human Resources (DHR) to prepare a 5-year plan detailing the impact of the AIDS epidemic on the State’s human and fiscal resources. The plan was developed

for the period 1987 through 1991 by a multi-agency collaboration that defined the status of the AIDS epidemic, made projections and outlined plans for the system of care.

Currently, the Georgia Division of Public Health has 330 public health and publicly-funded HIV counseling and testing sites in the State. Eighty-one of these sites are located in the EMA, thus providing a linkage with efforts to facilitate early intervention. Two agencies within the EMA are funded by the State to locate persons who tested positive and have not returned for test results.

Following the initial enactment of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990, the Metropolitan Atlanta HIV Health Services Planning Council was established to set priorities for the allocation of Ryan White Title I funds in the EMA. In 2001, the Atlanta EMA administered Title I funds for outpatient/ambulatory care (including nutrition counseling and medical regimen adherence counseling), drug reimbursement, oral health services, substance abuse treatment/counseling, case management, support services, mental health services, home health, and hospice. There are 6 primary care sites in the EMA: Grady Infectious Disease Program, Fulton County Department of Health and Wellness, DeKalb County Board of Health, Cobb County Board of Health, St. Joseph's Mercy Care Clinic, and the AID Atlanta Clinic. Services provided at these sites include comprehensive primary medical treatment and care to medically indigent persons, HIV treatment services to TB patients, annual check-ups for "well-child care" to children of infected mothers, and infusion services to HIV/AIDS patients. Funds allocated for drug reimbursement allow primary care sites to provide medications to a greater number of clients who ordinarily would not have access to new and emerging therapies; these funds also support the State ADAP. The EMA also provides anti-retroviral medications to PLWH/A. Oral Health services are available at 5 primary care sites.

Assessment of Need (Including Individuals In & Out of Care)

HIV Care Needs

During 1999 and early 2000, the Center for Applied Research and Evaluation Studies at the Southeast AIDS Training and Education Center (SEATEC), Department of Family and Preventive Medicine in the Emory University School of Medicine, conducted the Statewide Georgia HIV Consumer Survey. This study was conducted on behalf of the Georgia Department of Human Resources Division of Public Health STD/HIV Section (DHR), Fulton County Government, and the Metropolitan Atlanta HIV Health Services Planning Council. Overall direction and study parameters were provided by DHR and Fulton County Government staff. This study is a companion study to the Statewide HIV/AIDS Prevention and Care Needs Assessment, conducted in 1998-99, the results of which are presented in a separate document.

Primary medical care, antiretroviral medications and information services to inform clients how to protect themselves and others from disease transmission were the most frequently used services in Georgia. This was consistent across regions, including the Atlanta EMA, although the order of frequency of use for these services did vary. Home nursing and hospice care had very low levels of use throughout the State, consistent with the change in the epidemic as people are living longer given the improved treatment options. Mental health and substance abuse services were not as commonly used, and financial help services were some of the least used services in the State.

In 2000 using the HRSA-supported Rapid Assessment, Response, and Evaluation (RARE) methodology, ethnographers and Outreach Teams identified HIV prevention and treatment interventions for minority populations. While many of the recommendations focused on prevention activities, one key recommendation of the study was to consider the feasibility of conducting after hours/on-site testing and counseling in an effort to identify, test, and counsel at-risk populations, particularly individuals who do not know their status. The Fulton County Health Department, a Ryan White funded public facility, has implemented after-hours/on-site testing and counseling in response to this recommendation and primary care.

Gaps in Care

Overall according to the Statewide Georgia HIV Consumer Survey , the Georgia HIV care system met the needs of consumers in most of the Ryan White designated service areas, with 20 out of 30 services showing a level of need less than 15%, defined as “unmet need” for the purposes of this Plan. However, receiving dental services continues to be a major problem within the EMA, as well as the State as a whole, and was the most frequently reported service needed but not received in every region of the State. This need has been reported throughout the past several years, as documented in other needs assessment studies.

Statewide dental capacity issues beyond the Ryan White system underscore the challenges facing Ryan White providers in addressing this need and necessitate both short and long term system-wide options to address this issue. Overall, Georgia has one of the lowest rankings for the number of dentists and dental professionals in the nation. Specifically, according to the Bureau of Health Professionals, in 1998, Georgia ranked 46th out of 50 states for the number of dentists per 100,000 population, 32nd for the number of dental hygienists, and 45th for the number of dental assistants. In addition, between 1991 and 1998, the number of dentists in Georgia declined by 4% while the State’s population grew by 15%,

resulting in a 17% decline in dentists per capita compared to a 12% decline nationwide. The impact of this limited capacity is magnified by the Surgeon General's Report on oral health, which noted that "the burden of oral diseases and conditions is disproportionately borne by individuals with low socioeconomic status at each life state and by those who are vulnerable because of poor general health," consistent descriptors of PLWH who are receiving services at Ryan White clinics in Georgia. Based on both of these issues, the need for dental care is not anticipated to decrease, but in fact may increase given that PLWH are living longer with current treatment options.

The Atlanta EMA reported basic needs-related services such as food and financial assistance as the other top services needed but not received. Also, analysis of the data showed that factors such as years since a person tested HIV positive, race, gender and income level may increase use of or need for specific services.

While case management was anticipated to impact service use and need, only isolated examples of this were found. Specifically, among Atlanta EMA participants having a case manager appeared to have little effect on survey participants who reported an unmet need for most service categories, with the exception of transportation assistance and free groceries. These findings may be due in part to data collection issues. Specifically, case management was a difficult concept to measure. It was evident during the survey that participants were more familiar with the individuals who provided them with assistance, rather than the individual's profession or job title. Given this limitation, as well as the fact that only the Atlanta EMA had a sufficient sample to examine this issue, additional research in this area would be suggested.

Level of functional health literacy, which research suggests may be lower among people who do not remember their t-cell counts, also appears to be directly related to levels of unmet need in some regions and may warrant further study. Specifically, Atlanta EMA survey participants who reported they couldn't remember their t-cell count had elevated levels of need for all medical services.

In response to a concern expressed by the community of an unmet need for substance abuse treatment among PLWH in the EMA, a study was conducted by SEATEC on behalf of Fulton County Government and the Planning Council; the report is entitled, the Substance Abuse Treatment Needs Assessment and Resource Inventory for People Living with HIV Disease in the Atlanta EMA. In July 2002, the final report revealed that clients who had major problems (problems that significantly interfere with a client's normal functioning) most frequently requested treatment services

(35%), but were unable to receive them more than one-third of the time (44%). The largest unmet need was among those clients who had major problems and needed detoxification services. While only 17% of these clients requested detoxification services, half were unable to receive the services they requested. In contrast, only 10% of clients who had minor problems (problems that occasionally interfered with a client's normal functioning) requested treatment services, and only 9% of them were unable to receive this service.

Description of the Current Continuum of Care

Testing and Counseling Sites: In 2000, there were 81 HIV Counseling and Testing System (HIV CTS) sites in the Atlanta EMA. Based on data submitted by public health and publicly funded HIV CTS programs to the Georgia Department of Human Resources STD/HIV Section, Prevention Services Branch and published in a document entitled "*2000 Georgia HIV Counseling and Testing Summary*", of the total 76,928 individuals receiving HIV testing and prevention counseling statewide, 35,734 (48%) were tested in the Atlanta EMA (59% in Fulton County and 17% in DeKalb County), with 1,174 (3.29%) in the EMA testing positive compared to 1,728 (2.27%) statewide. The summary also indicates that MSM and IDU represent the highest risk behavior categories for HIV infection, but an STD diagnosis also appears to be a significant risk exposure for HIV infection, regardless of any other population characteristic or risk behavior. Also, more females than males are being tested for HIV, but men represent almost twice the number of positives identified.

Specific activities include:

The African American population continues to exhibit the greatest impact from the HIV/AIDS epidemic in the Atlanta EMA. In response to the epidemiology, the African-American Outreach Ad Hoc Committee of the Planning Council sponsored a testing and counseling event targeting underserved populations. On National HIV Testing Day, June 27, 2001, a collaboration of local HIV/AIDS community based organizations, a local radio station, and pharmaceutical and HIV testing product companies sponsored a community HIV testing event. Of those tested, 370 (93.34%) were African Americans, 19 (4.80%) White, 6 (1.52%) Hispanic, and 1 (0.25%) Native American. A total of 398 tests were given with 388 (97.49%) negative results, 5 (1.26%) positive results, and 3 (0.76%) inconclusive results. The most significant outcome of this event is that 86.37% of those tested returned for their test results. Post-test counseling sessions were provided to 334 (86%) who tested negative, 5 (100%) who tested positive, and 3 (100%) with inconclusive results. The five individuals who tested positive were immediately referred to primary care providers during the counseling process. Several initiatives, such as after hours testing and off site testing, have been implemented.

Early Intervention Services - Linkage(s) of Early Intervention Services to Primary Medical Care Services: The 81 HIV Counseling and Testing System (HIV CTS) sites listed above include county health departments and their satellite programs, as well as publicly funded CTS sites such as drug treatment programs, community-based organizations, jails and detention centers, hospitals, university student health clinics, and various outreach projects. All clients receive pretest prevention counseling and give informed consent for testing. All positive clients who return for their test results are referred to Ryan White clinics for medical assessment and case management, and all identified partners of positive clients are offered counseling and referral services as well.

The CBC/MAI funded efforts in FY 2001 to continue a client tracking and follow-up system for individuals “lost to care” initiated in FY 2000. Additionally, substance abuse providers added personnel or “case finders” who go into the community and seek individuals with HIV disease who have begun treatment, but have subsequently discontinued therapy. Once the individual is located, he/she is quickly referred to a Case Manager or other social service provider who assists the client with reentry into the primary care system.

In FY 2001, the EMA allocated funds to hire pre-release discharge planning case managers to ensure the continuity of care and case management services for individuals soon to be released from local correctional facilities. Discharge planners conduct education sessions with correctional facilities staff and assist in identifying resources in the continuum of care that will enable individuals to seek and remain in care upon release with follow-up to assure that clinic appointments are met. These pre-release efforts were instituted to ensure that individuals are released with a 30-day supply of medications and with an individualized service plan.

Using funds allocated to Program Support, the African American Task Force conducted a Ryan White-funded African American Outreach Initiative on March 10, 2001. This forum, entitled "African Americans Living Positive", targeted newly infected individuals, those who had not yet committed to primary care treatment, and “treatment drop-outs” who had discontinued medical care services. In a follow-up evaluation of the event, eighty-six (86%) of the participants reported that the event motivated or encouraged them to seek treatment (16.7%) or adhere to their treatment (69.2%). Of 116 participants responding to the question “Are you now in treatment?,” 82 (71%) indicated they were in treatment. Responses for not being in treatment varied, from “not yet finding a provider because they just moved”, “just been released from jail”, “experiencing adverse side effects from medications”, “medical treatment was not for them”, and “prayer removes all things”.

The Atlanta EMA has a coordinated service delivery system which encompasses a comprehensive range of healthcare and psychosocial services for individuals and families infected and affected by HIV disease. Included in this delivery system are mechanisms for linking available services to respond to changing service needs of individuals and families. These coordinated efforts, which encourage early enrollment in HIV primary medical care and support services, work to provide treatment and care to patients in a timely manner, thus enabling access to a variety of services. By addressing barriers that prevent early access to health services, the EMA strives to delay progression from HIV infection to AIDS as well as premature death from HIV-related diseases.

Primary Medical Care for the Treatment of HIV Infection That Is Consistent with Public Health Service Guidelines: Ryan White clinics use the Southeast AIDS Training and Education Center (SEATEC), protocols as prescribed in the guideline publication entitled *“Clinical Management of the HIV-Infected Adult: A Manual for Mid-Level Clinicians”*, (revised August, 2000). These protocols are designed for use by mid-level clinicians, physician assistants, and nurse practitioners and recommend treatments of HIV infection which are consistent with Public Health Service (PHS) guidelines which establish the standard of care for HIV therapy. The guidelines lay the foundation for determining when to begin therapy, when to change a failing regimen, and how to choose alternative combinations. Primary care providers are informed of changes to PHS guidelines by SEATEC and the Medical Providers Task Force.

The needs of newly affected and underserved populations are being met through the provision of treatment and care that is consistent with the most current protocols recommended by the medical community. It affords the patient the opportunity to seek alternative and flexible therapies which best meet his or her needs.

Access to Drug Therapies: Clients have access to prophylactic medications for the prevention and treatment of opportunistic infections through their primary care providers and Patient Assistance Programs. Ryan White primary care providers can request funds for opportunistic infection medications from the Drug Reimbursement priority category. Currently the local drug reimbursement program and the ADAP expanded formulary include 50 HIV/AIDS drugs for treatment and prophylaxis of opportunistic infections. Additional Title I funding may be used for other HIV-related medications not on the ADAP formulary, mental health medications, and oral health medications.

For the past six years, a portion of the Title I award has been set aside to support Georgia’s ADAP. In turn, funds targeted to ADAP have furthered client access to treatment. Efforts to increase access to medications are partnered with strategies to remove barriers to adherence which vary from fear of side effects to the disruption of normal schedules. Because adherence is crucial to the

effectiveness of HIV medications, the implementation of effective medication adherence protocols and policies which encompass education, counseling and follow-up have been established in the EMA's primary care sites. These protocols and policies ensure patients receive maximum benefits from antiretroviral and protease inhibiting drugs and foster the belief that the educated patient is the patient who remains active in care.

A new pilot program was initiated with FY 2001 carryover funding to address two emerging issues related to access to drug therapies. First, many individuals have improved health outcomes and have returned to work. These individuals now exceed the income guidelines for ADAP and are to be taken off the program. The costs for their medications must be assumed immediately by the client, and many do not have the resources for their medications. Second, some clients who have insurance coverage for medication cannot afford to pay the required deductible or co-payment. An evaluation of this pilot program is scheduled to be conducted prior to the award of funds during Phase II of FY 2003. This will assist the Planning Council in making a decision regarding continuation of funding for this initiative under the Drug Reimbursement category.

Substance Abuse Treatment: Epidemiologic data indicate an increase in the proportion of AIDS cases associated with injection drug use in AIDS incidence (an increase from 21.1% through December, 1998, 23.4% through September, 1999, and 23.8% through June, 2000) and in AIDS prevalence (an increase from 19.9% through December, 1998, 21.5% through September, 1999, and 21.5% through June, 2000). The HIV Prevalence rate among IDU increased from 18.2% through September, 1999 to 20.0% through June, 2000. To help address the needs of these increased numbers of newly infected and underserved substance users, the current continuum of care provides access to substance abuse treatment through referrals from primary care clinics, AIDS service organizations, case managers, and substance abuse service providers. Agencies also work closely with the criminal justice system by receiving referrals of substance abusers and low income probationers/parolees for substance abuse services. Once the client is referred to a provider, agencies strive to provide "treatment on demand" and enroll the client in programs specifically designed for HIV positive clients with substance abuse histories. Referrals link clients with medical services, housing, drug treatment services, legal services, and emergency assistance. Other services include basic information on HIV/AIDS such as risk reduction, early intervention, disclosure, and discussions on sexual behavior, role playing, and prevention methods that promote personal responsibility.

Experience has shown that the most effective method of encouraging clients with histories of substance abuse to remain in care is through the use of "peer-to-peer" service delivery by staff members indigenous to the population served. In these instances, services are performed by peer counselors who are recovering substance users and/or living with HIV disease. To promote compliance among

substance abusers, staff work with clients to negotiate treatment plans which require the client to understand the importance of adherence and his/her responsibilities in managing their therapies. The acceptance of the plan between the provider and the client includes the understanding that compliance becomes a condition of continued medication therapy.

In FY 2001, based on the recommendations of a needs assessment developed by the CBC Task Force, CBC/MAI funding was used to expand and to increase treatment and counseling services to meet the changing needs of the Substance Use/Abuser. Funding was allocated to:

- provide substance abuse treatment slots, specifically detoxification beds.
- develop and implement systems for client tracking and follow-up for individuals “lost to care”.
- provide substance abuse treatment services by Certified Addiction Counselors, Nationally Certified Addiction Counselors, or trainees that are eligible for certification.
- provide higher level interventions, i.e., ASAM levels 2 or above.

In July 2002, the study entitled, Substance Abuse Treatment Needs Assessment and Resource Inventory for People Living with HIV Disease in the Atlanta, reinforced the need for outpatient services. Over the past ten years, the study noted that the majority of potential treatment need was for outpatient services. Moreover, the proportion of participants potentially needing outpatient services has increased over time, from 67% of all participants needing treatment in 1991 to 78% in 1999.

Mental Health Treatment: The current continuum of care includes provisions for no-cost, comprehensive mental health services to individuals, groups and families affected by HIV disease. Clients access services through referrals by primary care providers, case managers, AIDS service organizations, and other social service providers. The initial contact with mental health providers may begin with a screening process that enables the provider to assess the nature of the client’s mental health issues, after which the client is then scheduled for a mental health intake and assessment. During the intake interview, the client is broadly assessed for substance abuse, depression, risk of suicide, and addiction. If the client is determined to be experiencing any of these difficulties, a more extensive evaluation is conducted and he or she may be assessed for cognitive functioning related to HIV-related dementia. Clients who appear to be in crisis are referred to a medical facility for emergency services and treatment. In addition to the psychological assessments, clients are educated about the services available to them and their rights and responsibilities as a client. Services are linked to medical care, case management, treatment education and advocacy, and social support services. In addition to providing on-site services,

patients may be referred to other psychiatric facilities for intensive therapy, depending upon the mental health needs of the patient.

Counseling services are provided by trained, certified mental health professionals, many of whom are volunteers that have been recruited from academic institutions, private hospitals, social service organizations, private practice settings, and professional organizations. Some mental health providers enhance capacity to provide services to clients dealing with trauma (i.e., schizophrenia, Axis II disorders, multiple personality disorder) by recruiting additional volunteer providers with expertise in these areas and by providing community training on these issues. The scope of mental health treatment and counseling services in the EMA include:

- psychotherapy and counseling to HIV infected/affected individuals, couples, families, and groups.
- counseling services to women, adolescents, and HIV-infected and affected children.
- mental health outreach to homeless persons and persons living in AIDS housing facilities.
- advanced training to community mental health professionals and other social service providers regarding HIV-related mental health issues.

State surveillance data for the EMA indicate increasing numbers of consumers of HIV-related services with dual diagnoses of mental illness and substance abuse (e.g., major depression and alcohol dependence; schizophrenia and crack cocaine use). In recognition that mental illness and substance abuse are closely connected, and that treatment for many clients should be integrated, funds were allocated to the Primary Care category in FY 2001 to continue to employ dual diagnosis clinicians who are trained and licensed in both fields to meet the changing needs of newly affected and underserved populations with dual diagnoses.

In FY 2001, the CBC Task Force recommended that CBC/MAI funds should be used to expand and initiate mental health services in order to:

- Increase access to psychiatric medications and psychiatric treatment.
- Expand group and individual therapy for persons and families affected by HIV.
- Provide cross-training for mental health and substance abuse professionals.

Care providers know that mental health treatment not only improves quality of life, but also the overall comprehensive health of the patient; therefore, intensive efforts are made to ensure that patients with mental health issues enter and remain in care by linking services to primary care, case management, treatment education and advocacy, and support services.

Oral Health: A report from the Dental Providers Task Force indicated that dental care was the most frequently reported service needed in the EMA but not received. Many patients have not accessed dental care services prior to their initial visit to a health department or community clinic; in most instances an average of 6.6 years have passed since the patient's last dental visit. Therefore, the oral health needs of the typical patient are very extensive and require a full range of services and multiple visits.

Patients receive an Oral Health assessment as part of the medical assessment received at primary care sites such as the Clarke County Board of Health, Cobb County Board of Health, Grady Infectious Disease Program, Fulton County Department of Health and Wellness, DeKalb County Board of Health, and St. Joseph's Mercy Care. Oral health services in the continuum of care emphasize the provision of comprehensive, high quality dental services for HIV-infected persons, with the average number of visits for each patient to complete required treatment being 14 visits. These services include:

- Preventive dental care which encompasses dental exams, cleanings, diagnostic x-rays, and fluoride therapies.
- Periodontal (gum) care.
- Restorative dental care which includes amalgam (silver) fillings and composites.
- Endodontic therapy (root canals) for severely decayed and/or painful teeth which can be restored.
- Surgical procedures including extraction of severely decayed teeth or periodontally involved teeth (very loose teeth that easily bleed and hurt) and biopsies of suspect lesions. (When the difficulty or extent of the surgery is beyond the scope of general dentists, patients are referred to the Oral surgery Department of the Grady Infectious Disease Clinic for specialty care).
- Prosthetic care (partial and complete dentures) which involves replacing multiple missing teeth and enables clients to maintain proper nutrition, function, and esthetics.

Disproportionate levels of oral health problems continue to be a major issue for the indigent, minority population with complex medical needs. Without the comprehensive dental treatments provided by care personnel in the Atlanta EMA, clients would be limited to emergency room visits for the extraction of painful and potentially abscessed teeth. Additionally, adherence to the difficult drug regimens now recommended for the treatment of HIV disease would be almost impossible under these circumstances. Local dental care providers have observed that with increased life expectancies comes a greater demand for dental care.

Hospice Services: The goal of hospice providers in the EMA is to support the rights of people living with AIDS to have the highest quality of life through the end stages of AIDS. This support is accomplished through the hospice philosophy of care - coordinating an interdisciplinary program of support services with pain and symptom control for the terminally ill person, and support services for patients, their families and significant others. Constant contact with physicians at the primary care sites supports patients remaining in the primary care medical model. An interdisciplinary team consisting of physicians, nurses, families, social workers, counselors, specialized therapists, nutritionists, clergy, and volunteers address the four areas of patients' needs: physical, mental, social, and spiritual. Care is offered in both the home and home-like settings, concentrating on the patient and the family as a unit.

Integration of Other Public Health Programs: Title I-funded programs integrate with the following public health programs:

WIC Programs: At the largest Ryan White primary care provider site, staff enroll individuals in the WIC program while, at the same time, the patient is linked to other services in the clinic, including counseling and testing, primary care, medications, substance abuse treatment, mental health treatment, and support services.

Enhanced Perinatal Case Management Program: The Georgia Department of Human Resources developed a program which provides intensive case management to at-risk mothers during pregnancy and 18 months postpartum to eliminate perinatal transmission in infants. All case managers are located at local health departments in the EMA and each patient is assigned a case manager upon entry into the clinic for medical care. The case manager assesses the clients' level of understanding of risk factors, provides counseling, and links clients promptly with available resources according to need, including automatic referrals to Ryan White programs.

Hemophilia of Georgia: This program provides services to persons who have hemophilia and HIV disease, many of whom receive primary care at Ryan White clinics in the EMA. As further coordination, a representative from this program is a voting member of the Planning Council.

HIV Counseling and Testing Programs: HIV counseling and testing programs refer persons with HIV disease for treatment. Most of the primary care sites in the EMA provide counseling and testing and are able to assure immediate entry into care and treatment after diagnosis of HIV infection. Prevention programs target the same high risk populations to encourage counseling and testing and to refer persons with HIV disease to the EMA's continuum of care.

Substance Abuse Prevention and Treatment Programs: The Fulton County Alcohol and Drug Treatment Center and the DeKalb County Treatment Program continue to receive funding from the State Division of Mental Health/Mental Retardation/Substance Abuse to support early intervention and treatment for dually diagnosed clients.

Support Services That Enhance Access To and Retention in Care or Improved Quality of Life: The Atlanta EMA is committed to provide care that addresses the needs of the individual as a whole, while realizing limitations to providing for all of a person's needs. The inclusion of support services in the continuum of care is a strategy used to relieve barriers, both physical and mental, that can complicate an already compromised circumstance and can impede an individual's ability to seek, enter, and remain in care: Support services provided in the EMA include:

- transportation assistance;
- case management;
- day care/foster care for children;
- emergency assistance;
- bi-lingual health promotion targeting Latinos;
- legal counseling services;
- meals;
- culturally sensitive client education regarding HIV care and treatment;
- sign-language interpretation services;
- culturally sensitive community outreach efforts targeting women, African Americans, and Latinos;
- language translation services;
- peer-driven Counseling/Support Group Services; and,
- in-home practical support and respite care.

In FY 2001, the CBC Task Force recommended that CBC/MAI funds be used to continue the following support services:

- follow-up system for drop-outs/peer education;
- respite care or daycare/childcare;
- language translation with treatment and outreach; and,
- homeless day services.

Resource Inventory & Profile of Provider Capacity and Capability **(By Service Category)**

During 2000-2001, the Center for Applied Research and Evaluation Studies at the Southeast AIDS Training and Education Center (SEATEC), Department of Family and Preventative Medicine in the Emory School of Medicine conducted a Statewide Georgia HIV/AIDS Resource Inventory. The study was conducted on behalf of the Georgia Department of Human Resources, Division of Public Health STD/HIV Section. The Resource Inventory listings are divided into four regions:

Atlanta EMA, Middle Georgia, North Georgia, and South Georgia. The inventory is divided into two sections: the first section lists the HIV prevention programs and care services, and the second section lists specific populations that are served. A total of 128 organizations responded to the mailed survey, including 70 based in the Atlanta EMA. Respondents were asked to provide information about their organization, including the type of organization, their budget, the composition of their board of directors and organizational use of computer technology.

Statewide, a majority of the organizations were established within the past two decades, with 28% established during the 1980s and 46% between 1990 and the present. Respondents often reported that their organization's response to the HIV/AIDS epidemic came later, with the majority of HIV prevention programs and care services beginning since 1990 (67% of prevention and 57% of care). Over half of the organizations in the Atlanta EMA (54%) reported federal grants as a source of funding.

Respondents were also asked a series of questions regarding organizational capacity and provision of services in the past year, including number and HIV status of clients. Not all respondents answered these questions; therefore, results could only be reported on a statewide level. When asked about maximum capacity, two-thirds of individual organizations that provide HIV prevention programs reported they could serve at least 1,000 people. Two-thirds of individual organizations that provide HIV care services reported they could serve up to 500 individuals.

A Resource Inventory of Georgia HIV Prevention Programs and Care Services (2000-2001) is included in this Plan by reference. Inventory and population grids illustrate the collective capacity and capability of organizations in the Atlanta EMA to respond to the challenges presented by the HIV epidemic.

Barriers to Care

Capacity and information issues were the most frequently reported barriers for the top services needed but not received. "Information barriers" were defined as not knowing where to go or who to ask for the service. "Capacity barriers" were defined as needing more of a specific service to meet HIV care needs. In the State, the persons in the Atlanta EMA reported information barriers most frequently. Methods such as case management, peer counseling and marketing campaigns to increase the awareness among PLWH about available services may be necessary to help clients access the services that they need. Given the literacy issues found in this study, marketing campaigns should not be predominantly based upon print media. Capacity issues are most frequently tied to a need for increased fiscal resources or refocusing of existing resources.

Factors such as years since a person tested HIV positive, race, gender and

income level may also influence the type of barriers reported. For example, individuals who tested positive for HIV more than 11 years ago reported the highest percentage of information barriers while those who tested positive less than three years ago reported the highest percentage of personal barriers. Blacks/African Americans reported a lower percentage of capacity barriers and a higher percentage of information barriers than did other participants. Females reported fewer personal barriers than males and more frequently reported they had begun the process to get a specific service. Finally, individuals who had lower annual incomes (<\$8,053) reported a higher percentage of system barriers than those with higher annual incomes.

In 2000/2001, further insight was provided into barriers to care in the Atlanta EMA during the EMA's participation in the HRSA-sponsored Rapid Assessment, Rapid Response, Rapid Evaluation (RARE) Study. The absence of evening HIV testing/counseling and after hours outreach were seen as barriers to bringing persons "not in care" into care.

In 2002, the Minority AIDS Initiative Task Force started its collaborative effort with SEATEC to hold a series of focus groups to evaluate in more detail the needs of African American PLWH. The first focus group revealed several barriers to care, which were revealed in the EMA-wide needs assessment, such as, lack of information. One that was unique to African American PLWH was lack of African American doctors/personnel. This information alone should not impact service delivery, but help guide the steps for the next studies and give insight into what other questions need to be asked.

Section 2

Where Do We Need To Go: What System of Care Do We Want?

Ideal Continuum of Care

The Planning Council developed a series of strategic goals and objectives that address four components of the HIV care system: **Services, System Capacity, Planning, and Evaluation**. The values that guided the Planning Council's process to identify and select strategic service, systems and planning goals are derived from Shared Vision and Shared Values of the Council.

Shared Vision

The Planning Council's vision is a compassionate and caring community where HIV affected individuals achieve and maintain physical, emotional, and spiritual health.

The Council shall plan, build, and set allocations for funding that will encourage community partnerships to deliver HIV services effectively and efficiently. This will be accomplished through:

- ◆ Increasing public awareness
- ◆ Increasing the level of community involvement in the needs assessment and planning process.
- ◆ Setting clear priorities.
- ◆ Facilitating collaborative projects.
- ◆ Collaborating with other Ryan White programs, such as Title II, Title III, Title IV, SPNS, AETCs, Dental Reimbursement Program, and other Local and State HIV planning institutions.
- ◆ Maintaining an evaluation process.
- ◆ Encouraging the identification of additional funding resources.

Shared Values

The Planning Council values:

- ◆ The quality and dignity of human life.
- ◆ Cultural competency/appropriateness in service delivery.
- ◆ Respect for diversity and cultural differences.
- ◆ Effective and timely support for basic needs.
- ◆ The involvement of HIV infected individuals in decision-making.
- ◆ The involvement and support of each affected individual's personal support system, as well as the greater community, in caring for persons with HIV.
- ◆ An individual's right to self-determination.
- ◆ The health of the community
- ◆ Service delivery systems that promote independence and self-sufficiency.
- ◆ The efficient use of resources.
- ◆ Prevention, education and early intervention.

Section 3

How Will We Get There:

- ***What Steps Can We Take to Develop This Ideal System?***
 - ***What Strategies are Needed to Assure Access to the System?***
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GOALS & OBJECTIVES

LONG-TERM & SHORT-TERM Goals, Objectives, and Activities

The Comprehensive HIV Services Plan provides the framework for the development and implementation of activities by the Planning Council and the Ryan White program office that will enhance the delivery and effectiveness of services to PLWH/A. Following the development of Strategic Service, System, Planning, and Evaluation Goals, specific activities were identified to make the Plan an “action-oriented” document and to guide the development of annual work plans. Specific activities to be conducted through the work of the Planning Council that are directly related to stated goals and objectives are presented in this section.

Implementation and Impact

Existing linkages will be enhanced between the Planning Council, the Ryan White program office, public health and social service agencies, the affected and infected community, service providers and others involved in the HIV continuum of care as a result of the implementation of these activities. It is anticipated that new opportunities will emerge as well for the creation of additional community and organizational linkages that will improve the delivery of effective and comprehensive HIV services throughout the EMA.

The long-term and short-term goals, objectives, and activities detailed here will serve as the foundation for the goals and priorities to be implemented by the grantee, as a part of its Annual Implementation Plan, in its efforts to enhance the delivery and effectiveness of the continuum of care. These include:

Ambulatory/Outpatient Care

To ensure accessible HOV/AIDS primary medical care that is consistent with the U. S. Public Health Service guidelines for all eligible PLWH in the EMA.

Drug Reimbursement

To provide medications and viral load tests that are consistent with the U. S. Public Health Service guidelines for all eligible PLWH in the EMA.

Case Management

To provide comprehensive, community-based case management services that will identify and assess the needs of PLWH and increase access to primary care and support services.

Support Services

To provide support services that enhance access to and retention in care and improve clients' quality of life.

Mental Health

To provide comprehensive mental health care services for all PLWH in the EMA.

Substance Abuse

To provide comprehensive substance abuse treatment and counseling services for all PLWH in the EMA.

Home Health Care

To provide home care to HIV/AIDS patients.

THREE YEAR ACTION PLAN

STRATEGIC SERVICE GOAL

To ensure that services meet the needs of People Living With HIV/AIDS (PLWH/A), including new and emergent populations.

Strategic Service Objective

To set service priorities based on epidemiologic data, needs assessments, service utilization data, and available resources.

HIV/AIDS service goals, objectives and priorities are determined by the Priorities Committee of the Planning Council on an annual basis. The Planning Council recommends the continued implementation of an outcome-based evaluation system that will require contracted service providers to develop measures and performance indicators related to the delivery of services as proposed in annual funding proposals.

It is anticipated that Year One activities will focus on the continuation of the collaborative effort between the Council and the grantee to evaluate the process for including criteria in the RFP process. The process for developing and implementing an outcome-based performance and evaluation system to be applied to service priorities is expected to take place over a one to three-year period.

THREE YEAR ACTION PLAN

<p>STRATEGIC SYSTEM GOAL 1 To ensure high quality care and services across the continuum.</p>
<p>Strategic System Objective To develop standards of care with measurable outcomes.</p> <p>System Priority 1. Standards of Care <i>System Objectives:</i></p> <ul style="list-style-type: none"> • To develop standards of care with measurable outcomes for all service categories. • To educate clinic providers on standards of care. • To develop uniform guidelines of compliance for the Atlanta EMA.

Year One Activities	Year Two Activities	Year Three Activities
<ol style="list-style-type: none"> 1. Develop agency-based standards of care as a requirement of the application process; agency-based outcome measures will assist in monitoring Continuous Quality Improvement (CQI). 2. Outcomes should adhere to community standards. 3. Ryan White site visits should include evaluation and monitoring of performance 4. The Atlanta EMA will participate in the Institute of Health Improvement (IHI) Study focusing on the quality of care in the primary care and case management categories. 	<ol style="list-style-type: none"> 1. Written accounting of CQI performance by agencies based on contracted outcome measurements from previous year's application. 2. Continued refinement of standards of care. 3. Repeat steps 2, 3, and 4 from Year One. 3. First effort at reporting Community-wide assessment of agency service provision and outcome measurement. 4. Conduct analysis of Strengths and weaknesses in the system, as well as an assessment of opportunities to address additional or unmet needs in the EMA. 5. First of an on-going Effort to assess special Needs in the EMA, i.e., Adherence 	<ol style="list-style-type: none"> 1. Two years of data available on standards of care. 2. Review and revise system-wide indicators that cross agencies. 3. EMA guidelines in place that detail adherence to medical protocols. 4. Annual assessment of community wide goals established. 5. Replicate IHI study methodology in other service categories.

THREE YEAR ACTION PLAN

STRATEGIC SYSTEM GOAL 2

To increase the capacity of communities in the twenty-county EMA to provide medical and support services.

Strategic System Objective

To identify ways to enhance the integration of services for PLWH/A.

System Priority

2. Service Integration

System Objectives:

- To provide opportunities for inter-agency cooperation and information sharing to improve service integration.
- To increase the involvement of mental health, substance abuse, housing, and other service systems within the HIV/AIDS system of care.
- To encourage service providers to incorporate comprehensive education/secondary prevention activities into existing programs.

Year One Activities

1. Identify agencies within the EMA that are involved, and others that should be involved, in the HIV/AIDS service delivery system.
2. Develop a plan to be used to engage dialogue among agencies outside of HIV/AIDS service system.

Year Two Activities

1. Define objectives for inter-agency cooperation and service integration. Make recommendations to the Planning Council for service integration activities.
2. Increase cooperation and inter-agency information sharing within the HIV/AIDS system of care by the following activities:
 - a. Two HIV/AIDS agencies will have five minutes to describe their services at each Planning Council meeting.
 - b. Bi-annual HIV/AIDS information exchange fairs to be held by HIV/AIDS organizations.

THREE YEAR ACTION PLAN

STRATEGIC PLANNING GOAL 1

To improve the ability of Planning Council members to make effective decisions about HIV/AIDS service delivery.

Strategic Planning Objective

To provide information and support to Planning Council members to help them identify and resolve service delivery problems.

Planning Priority

1. Data Collection

Planning Objectives:

- To improve methods of obtaining information on client needs, client service utilization, service costs and cost effectiveness of services.
- To make data useful to individual agencies and the Planning Council.

2. Long-term Planning

Planning Objectives

- To develop long-term goals for services in the EMA and document goals in a Three-Year Plan

3. Multi-agency Planning

Planning Objective:

- To develop a mechanism for joint planning to reduce inefficiencies in the delivery of services.

4. Planning Council Response to Client Identified Service Delivery Problems.

Planning Objective:

- To assign client identified problems to standing committees and task forces for resolution.

Year One Activities

1. Complete EMA Resource Guide to Ryan White funded and other HIV services to be widely distributed.
2. Hire and work with Information Technology consultant to implement CAREWARE data collection program; train all data staff and investigate feasibility of importing current data from Epilinfo program; and evaluate first year after implementation.
3. Facilitate service planning forum for all funded agencies to identify new service goals, evaluate current services, and develop long-term planning objectives.
4. Develop standardized client satisfaction form to obtain client input during evaluation process.

Year Two Activities

1. Evaluate changes in data management.
2. Implement resource guide utilization plan to assist in allocation process and service delivery analysis to increase efficiency.
3. Implement use of client input form in evaluation process.

Year Three Activities

1. Update resource guide.
2. Evaluate client input evaluation process.

THREE YEAR ACTION PLAN

STRATEGIC PLANNING GOAL 2

To enhance the involvement of PLWH/A in the decision making process at all levels.

Strategic Planning Objective

To recruit and sustain the participation of PLWH/A in Planning Council leadership, standing committees, and task forces.

Planning Priority

1. PLWA/A Involvement

Planning Objectives:

- To assess the existing Planning Council structure to determine ways to encourage meaningful participation of PLWH/A.
- To assess the Planning Council orientation process and support/ mentoring systems for PLWH/A.

Year One Activities

1. Continue mentoring structure.
 - a. Council Member responsibilities:
 - Each voting member is responsible for mentoring or co-mentoring a PLWH/A member.
 - Each non-voting member is encouraged to mentor or co-mentor a PLWH/A.
 - b. Agency responsibilities:
 - Each Ryan White funded agency's designated representative is required to identify their agency's mentor(s).
 - Agencies required to find and support the participation of at least one PLWH/A in the Planning Council's activities.
2. Begin Caucus Structure Modifications
 - a. Meet annually with all PLWH/A Planning Council members to explain how they can assist in bringing the voice of clients to the Council.
 - b. Make the Caucus structure more of an identified outreach arm of the Planning Council.

Year Two Activities

1. Evaluate effectiveness of mentoring structure and modify as needed.
2. Complete Caucus structure modifications.
3. Develop a Speakers Bureau from Caucus Structure modifications
 - a. Raise awareness about what the Planning Council does, how it does it, and how to participate in it.
 - b. Speakers will bring back feedback from the community/clients regarding services and the Planning Council's work.

Year Three Activities

1. Final mentoring structure in place.
2. Final Caucus Structure in place.
3. Evaluate effectiveness of the Caucus Speakers Bureau.

Section 4

How Will We Monitor Our Progress:

How Will We Evaluate Progress in Meeting Our Short- & Long-Term Goals?

The grantee and the Planning Council will set aside funds for quality management activities. Grantee staff will initiate programs to implement quality assurance programs to implement quality management activities and to report progress to the Planning Council. The grantee will also require a written Quality Management Plan from each of the contractors and a report indicating the results of the quality management activities for monitoring by the grantee.

There are **mechanisms** to address progress made toward meeting short- and long-term goals. Through the Atlanta EMA's participation in the Institute for Healthcare Improvement (IHI) Quality Management Collaborative, these mechanisms will be coordinated into one system. The integration and coordination of quality management mechanisms into one system is a focus of the IHI Collaborative.

Clinical Evaluation of Care Sites

Evaluation and quality assurance specialists will visit Ryan White clinics to meet with staff and assess personal and professional interaction with clients. This evaluation/quality assurance team will also examine issues such as protocols for care, patient flow clinic hours, and staffing patterns. This study will update the previous assessment which was conducted in 1998.

Quality Assurance

The Atlanta EMA will participate in the Institute of Health Improvement (IHI) Study focusing on the quality of care in the primary care and case management categories.

Treatment Protocol Updates

The Medical Providers Task Force will continue to review and provide recommendations regarding treatment protocols to ensure compliance with PHS guidelines and access to medical care. Additionally, the Task Force will continue to make recommendations for revisions to the ADAP formulary, as needed. Recommendations from the Task Force will be presented to the Planning Council for review and adoption.

There will be continued collaboration with the Southeast AIDS Treatments and Education Center (local AETC) to ensure that the latest treatment information is disseminated with direct Internet access for updates and that requested training is conducted.

Standards of Care

- a. **Substance Abuse Treatment:** The consultant will produce a Substance Abuse Needs Assessment and Inventory final report and provide training to Planning Council members regarding the incorporation of results and recommendations from the Inventory into HIV/AIDS care services planning, delivery, and evaluation.
- b. **Outreach/Peer Education:** A training curriculum/manual for outreach workers and peer educators will be developed for use consistently throughout the EMA.
- c. **Case Management:** A study will be implemented to assess the current centralized case management system's cost effectiveness and its effectiveness in providing client access to information for treatment and support services.

Unit of Cost Evaluation

Currently, unit cost reimbursements have been implemented for several services, including residential hospice and home-delivered meals in the EMA, as well as medical care visits in the outlying areas. This study will determine the feasibility of assigning units of cost to other service areas, and how this information can be used during the priority setting and allocation process, the Outside Review process, and the Grantee's fiscal and programmatic reviews of subcontractors.

Assessment of Medical Triage System

In an effort to make more efficient use of its resources, the Atlanta EMA uses a medical triage system that sends people with T-cell counts below 200 to the Grady Infectious Disease Program; people with T-cell counts over 200 are treated at one of the remaining five primary care sites. In the next year, SEATEC will facilitate discussions among medical providers in the EAM to assess this triage system and to make recommendations for the future. This effort will examine the capacity of Ryan White-funded primary care providers in the Atlanta EMA, reviewing the current triage system and examining the current client loads at each provider.

Collection of Client-Level Data

The Atlanta EMA will use the collection of client-level data, through its CADR process required of all subcontractors, to assess the effectiveness of the EMA's service delivery model in improving clients' health outcomes.

