

Alabama State Plan

Implementation of the National HIV/AIDS Strategy



know.
manage.
live.

“The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination”

*President Barack Obama
July, 2010*

NATIONAL AIDS STRATEGY // ALABAMA QUOTES

“A tremendous amount of work is being done throughout Alabama in the area of HIV/AIDS Prevention. A long-term, statewide effort is underway to reduce infections, to increase access to care, to improve outcomes for people living with HIV/AIDS, and to reduce inequities among those battling HIV/AIDS. The credit goes to many people, including physicians, nurses, hospital and clinic staffs, education advocates, and employees of the Alabama Department of Public Health. This is a coordinated, comprehensive effort, and it’s helping people throughout Alabama live longer, healthier lives.”

Robert Bentley, Governor

“I am a 54 year old white female who has been living with HIV (that I know of) since October of 1985, and I have allowed AIDS to live with me since April of 2002. I say it in this way because I do not allow HIV /AIDS to define who I am. I finally know my purpose for living. I go out into the community and educate others about the disease, and about the Peer Mentor Program, I truly believe this is why God has spared my life. I hope I have touched one person in my journey. I know this journey has not been in vain.”

Janet Johnson, Peer Mentor
HIV/AIDS Division of Prevention & Control

“A quote from Vince Lombardi, I believe, sums up Alabama’s plan and commitment for addressing HIV/AIDS in Alabama. “People who work together will win, whether it be in complex football defenses, or the problems of modern society.” This is what the AIDS Community has done from the first days of AIDS in Alabama. I have been privileged to be part of this group.”

Jane B. Cheeks
State AIDS Director

“The continued expansion of screening throughout the state will play a significant role in further reducing the burden of HIV infection in Alabama. Though State Statutes of Alabama are supportive and in accordance with the CDC’s recommendation for non-targeted screening, many healthcare providers still face institutional barriers to providing this service. The ADPH and local health departments will play a pivotal role in overcoming these barriers and providing technical support in hospitals and primary care clinics.”

Jim Galbraith, MD FACEP
Assistant Professor
Assistant Residency Director
Department of Emergency Medicine
University of Alabama at Birmingham

“People in the HIV/AIDS field in Alabama are committed to providing the best treatment and services that we can for the state’s HIV-positive population and for persons at high risk of contracting the virus. As care for those impacted moves further into the mainstream medical systems, all of us in the field along with persons living with HIV disease must fight to ensure that critical supportive services, such as transportation and non-medical case management, along with safe, decent, affordable housing, are maintained. “

Kathie M. Hiers
CEO, AIDS Alabama

"So many of our citizens are in poor health and suffer from chronic medical conditions. They do not have access to the medical care that they need. Telemedicine would profoundly impact patient care and outcomes, as well as healthcare providers, and the communities they serve. Telemedicine saves lives! It is our responsibility to use the technology available to reach those most in need."

Ron Sparks, Director
Alabama Rural Development Office

“Over the past 30 years Alabama has made tremendous strides in establishing a Comprehensive HIV/AIDS program through the Division of HIV/AIDS Prevention and Control of the Alabama Department of Public Health. President Barack Obama’s National AIDS Strategy framework further encourages the need for state and local leadership to strengthen systems of prevention and care services for all Alabamians. Partnerships and adequate funding can significantly help to leverage this access and availability of HIV/AIDS resources. It is my belief that even more communication, collaboration, coordination and commitment by providers and community stakeholders can elevate the level of programs and community engagement necessary to effectively serve Alabama residents. This sense of unfettered support reminds me of an African proverb wisdom, *“When Spider Webs Unite, We Can Tie Up a Lion”*. We all have a responsibility to encourage someone to **KNOW** their HIV status, **MANAGE** their Health and **LIVE** their Best Life.”

Sharon V. Jordan, B.S., M.P.H., Director
Planning and Development
Division of HIV/AIDS Prevention and Control
Alabama Department of Public Health

Presented January 2012 to:
Governor Bentley’s 2011 Alabama HIV/AIDS Prevention Task Force

Alabama State Plan - 2012
Plan for Implementation of President Obama’s National HIV/AIDS Strategy

Members of the Alabama HIV/AIDS Community who worked together and wrote or had input into the development of this document wish to recognize Jane B. Cheeks, J.D., M.P.H., State AIDS Director for her leadership of the HIV/AIDS prevention, control, and service provision efforts in Alabama and dedicate this document to her.

Jane Cheeks has been the standard-bearer for Alabama HIV/AIDS programs and services for over 23 years. Her commitment has been steadfast to ensure that Alabama receives its fair share of federal allocations to meet the needs of individuals and communities impacted by HIV/AIDS.

Ms. Cheeks has spent countless hours on boards and committees at all levels of government to educate and collaborate through partnerships to fulfill the mission of the Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control. Ms. Cheeks has demonstrated through her work and life that above all else people living with HIV infection deserve equitable treatment and support services. Ms. Cheeks has been a positive force for Alabama and the AIDS services community has grown and evolved under her leadership.

Message from the Alabama State AIDS Director

Working in the HIV/AIDS arena in Alabama for the past 32 years has been an incredible journey both professionally and personally. The first diagnosed case of AIDS in Alabama was discovered in the Jefferson County Health Department’s Sexually Transmitted Disease (STD) clinic in 1982. At that time, clinic physicians thought it was a new kind of STD – AIDS had not been defined or named. You can read the history of those first days in the attached document “AIDS in Alabama: The First 1000 Days).

From those first days when AIDS was an unknown syndrome attacking primarily young homosexual men with no known cause or treatment which ended in death within months, amazing progress, in a relatively short time, has been made in defining, diagnosing, testing, treatment and management of HIV/AIDS in Alabama, nationally and around the World.

A quote from Vince Lombardi, I believe, sums up Alabama’s plan and commitment for addressing HIV/AIDS in Alabama. “People who work together will win, whether it be in complex football defenses, or the problems of modern society.” This is what the AIDS Community has done from the first days of AIDS in Alabama. I have been privileged to be part of this group.

Respectfully,

Jane B. Cheeks



Prelude

On July 13, 2010 President Barack Obama signed the National HIV/AIDS Strategy, the Nation's first ever-comprehensive plan for HIV/AIDS. This new strategy calls for renewed efforts in both prevention and care of HIV and AIDS. In September 2011, the Director of HIV/AIDS for Alabama Department of Public Health, Jane Cheeks called for Alabama to be one of the lead states in the response to meeting the goals of the National HIV/AIDS Strategy. This statewide epidemic requires new commitments in meeting the three primary goals of the National HIV/AIDS Strategy: 1) reducing the number of people who become infected with HIV; 2) increasing access to care and improving health outcomes for people living with HIV; and, 3) reducing HIV-related health disparities. To accomplish these goals, we must achieve a more coordinated national and state response to the HIV epidemic.

In September 2011, the HIV/AIDS Division of the Alabama Department of Public Health embarked on an effort to develop this State plan. This year long process has guided us toward greater collaboration among all HIV/AIDS service and lead agencies; a merging of prevention and care as one entity; and a strengthening of the commitment and unity of the HIV/AIDS community in Alabama.

Integral to success of this plan, on December 1, 2011, Governor Bentley created, by Executive Order Number 26, the Alabama HIV/AIDS Prevention Task Force. The charge of this body is to research and develop options to encourage statewide efforts to reduce cases of HIV/AIDS and to improve the overall health of Alabamians by adopting and promoting a statewide comprehensive HIV/AIDS Prevention and Direct Services Plan for the general public, state and local elected officials, various public and private organizations and associations, businesses and industries, agencies, potential funders and other community resources.

Special Thanks

Alabama AIDS Service and Community Based Organizations & Clinics
Anne Jordan Reynolds, Ph.D.

Division of HIV/AIDS Prevention & Control

Janet Johnson, Peer Mentor, HIV/AIDS Division of Prevention & Control

Jim Galbraith, MD. FACEP, UAB Department of Emergency Medicine

Kathie Hiers, CEO, AIDS Alabama Inc.

Nic Carlisle, J.D., Director, AIDS Action Coalition Inc.

Ron Sparks, Director, State of Alabama Rural Development Office

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Executive Summary

Alabama reported the first case of what later became known to be HIV infection in 1981. At that time, no one had any idea what the medical community and public health were facing.

Nationally and internationally, research was being conducted at an accelerated pace to understand more about this new syndrome. People who were infected (mostly young gay males) were dying within months of diagnosis.

Thirty years later between 1982 and 2011, a total of 17,839 cases of HIV infection were reported to the Alabama Department of Public Health (ADPH). At the end of 2011, 64% (11,342) were known to be living. An additional 2,000 to 4,000 Alabama residents are likely infected and unaware of their positive HIV status. One point two million (1,200,000) people in the United States are living with HIV infection.

The Centers for Disease Control and Prevention (CDC) estimate that 20% of these people are unaware of their infection.

Alabama has responded to the HIV/AIDS epidemic at many levels of government to ensure that citizens living with HIV infection are able to receive medical treatment, medications and support services. Alabama leaders and HIV/AIDS Advocates accepted President Obama's National AIDS Strategy goals for the nation and responded with action. This document lists Alabama's comprehensive approaches to respond to the HIV/AIDS epidemic.

Governor Robert Bentley's HIV/AIDS Prevention Task Force was created December 1, 2011, by Executive Order Number 26:

“BE IT FURTHER ORDERED that the Task Force is charged with researching and developing options to encourage statewide efforts to reduce cases of HIV/AIDS and to improve the overall health of Alabamians by adopting and promoting a statewide comprehensive HIV/AIDS Prevention and Direct Services Plan to the general public, state and local elected officials, various public and private organizations and associations, businesses and industries, agencies, potential funders and other community resources.”

The ADPH, Division of HIV/AIDS Prevention and Control (DHPC) has been working tirelessly since 1987 to reduce the spread of HIV infection, increase survival time and improve the quality of life for persons already infected. The charge of the HIV/AIDS Division is to monitor the epidemic, improve the public understanding of HIV, prevent or reduce behaviors that transmit HIV, increase individual knowledge of HIV serostatus and strengthen systems of care and prevention.

The DHPC could not have taken on this task without collaborating with the Alabama's AIDS Service Organizations. During the 1980s, ordinary people concerned about the HIV infection rates and subsequent deaths of our citizens began to come together and talk about what they could do to help. These ordinary people began to create extraordinary support systems that

became beacons of light for people who were infected and afraid, were living without medical care, and with little or no family or community support. Most uninfected people were afraid, but these few courageous people came together in spite of the fear. Alabama owes them a debt of gratitude. The first AIDS Service Organizations became incorporated in the early 1980s. Today, Alabama has eleven AIDS Service Organizations dedicated to providing HIV prevention and treatment services to people infected and affected by HIV/AIDS. In this document there will be additional organizations listed that also provide services for Alabama's HIV infected citizens.

Throughout this document you will read personal quotes from people living with HIV infection. At the beginning of this summary, there were a few statistics mentioned. Each statistic represents a person's life. People living with HIV and AIDS have dreams and hopes like other people. They have families, attend churches, schools, and go to work every day. Most important is that they have feelings that can be hurt or uplifted like other people. Through the words of people living with HIV, this document will remind the reader that the services are not for someone in another country or state but the citizens in Alabama. People living with HIV are our neighbors, sons, daughters, mothers and fathers. They like everyone else deserve our respect and compassion.

"I KNOW THIS JOURNEY HAS NOT BEEN IN VAIN" HIV + Advocate

Part 1: INTRODUCTION

HIV+ Advocate: “We have met so many wonderful people through this virus. Dorothy, Robin, Michael, and his partner David (who is now gone) Glenda, and the list goes on and on. Julie however, made the biggest impact on me as far as teaching me that I and Gary had rights, that we were and should be part of the Medical Team that we could say no if we wanted to and it would be alright. What an inspiration. Then along came Dr. David, oh what a Blessing he is.”

The National HIV/AIDS Strategy (NHAS) is the nation’s first ever-comprehensive coordinated HIV/AIDS plan for the United States with measurable targets to be achieved by 2015. The Strategy is a renewed commitment to increase existing efforts and to deliver better results within current funding levels, as well as to highlight the need for new investments. The NHAS requires a coordinated, comprehensive and systematic response in reaching the goals, which will include a significant increase in coordination among HIV programs across Alabama. Governor Robert Bentley created the Alabama Governor’s Task Force on HIV/AIDS Prevention to help Alabama achieve the goals of the National Strategy, and to improve measurable results. The Task Force will ensure collaboration among agencies, streamline HIV efforts and increase coordination among programs in Alabama.

The following document represents a network of HIV/AIDS prevention, treatment, planning and advisory organizations across Alabama. The documentation and program inclusions support the goals of the National HIV/AIDS Strategy.

Statewide onsite visits, meetings, discussions, and email communications were implemented to ensure that groups and organizations were represented in the Alabama response to the NHAS. The programs represented in this document are focused on prevention, reducing HIV infections and provision of treatment for all citizens living with HIV/AIDS in Alabama.

The Division staff is grateful to all the organizations across Alabama who participated in creating this document. The collective plan is to help ensure Alabama continues to offer the best HIV/AIDS treatment and prevention services as the population continues to grow, the epidemic changes, and the State moves forward in implementation of new and innovative health solutions to fully support the National HIV/AIDS Strategy.

Part 2: Statistical Overview

HIV+ Advocate: “I am a 54 year old white female who has been living with HIV (that I know of) since October of 1985, and I have allowed AIDS to live with me since April of 2002. I say it in this way because I do not allow HIV/AIDS to define who I am”.

Following the 2010 decennial census, the United States Census Bureau reported 4,779,736 persons reside in Alabama. The majority of residents (62%) were between the ages of 18 and 54 years, 24% were younger than 18 years, and 14% were 65 or older (median age = 37.8).

The incidence and prevalence of HIV infection in Alabama is highest among individuals aged 13 to 44 years, with 76% of newly diagnosed HIV infections and 81% of prevalent cases occurring in this age group during 2011. Males accounted for three-quarters (76%) of newly diagnosed cases in 2011, with African American males representing one-half (50%) of all new HIV infections. White males represented another 21% of 2011 newly diagnosed HIV infections. African American females followed closely representing 19%.

New infections are disproportionately occurring in Alabama’s African American population. Although African Americans comprised only 26% of the state’s population in 2011, they represented 68.35% of newly diagnosed HIV infections. The rate of HIV diagnosed among African Americans (38.4 per 100,000) was more than seven times higher than among Whites (5.3 per 100,000). The rate of newly diagnosed HIV infections in African American males (60.2 per 100,000) was more than six times higher than White males (9.1 per 100,000). Sixty-six percent of males diagnosed with HIV in 2011 were African American. A similar trend was seen among females, with 78% (131) of new diagnoses in females occurring in African Americans. The rate of newly diagnosed HIV infections in African American females (19.4 per 100,000) was eight times higher than White females (1.6 per 100,000) and two times higher than White males (9.1 per 100,000).

Alabama’s population can be divided into three geographical groupings: major urban centers (>200,000 population), minor urban centers (100,000-200,000 population), and rural areas (<100,000 population). Major urban centers include Jefferson, Madison, Mobile, and Montgomery Counties. In 2010, these major urban centers represented 34% (1,635,632) of the State’s total population and 61% (10,597) of cumulative HIV cases reported to ADPH. Minor urban centers include eight counties and comprised 24% (1,156,292) of the State’s population and 14% (2437) of cumulative HIV cases. Rural areas accounted for 25% (4256) of cumulative HIV cases. Alabama is considered primarily rural with 55 of the 67 counties located outside of the state’s major and minor urban population centers.

The proportion of persons living with HIV/AIDS (PLWHA) increased 32% from 2007 to 2011 (Figure 1). A total of 11,342 persons were known to be living with HIV infection in Alabama at

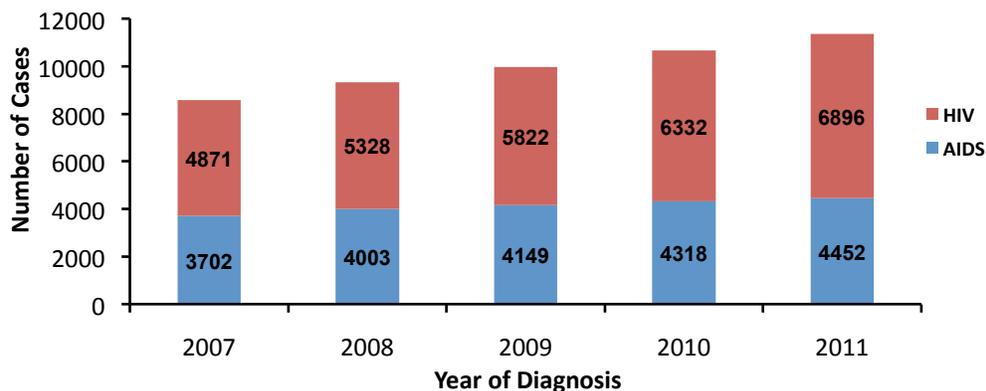
the end of 2011, and 4,452 (39%) of these individuals have progressed to AIDS. An additional 2,000 to 4,000 Alabama residents are likely infected and unaware of their positive HIV status.

The increase in PLWHA is in part due to the introduction of effective drug treatments and therapies capable of delaying the progression of HIV. Currently 62% of prevalent PLWHA are between the ages of 25 to 44 although 57% of newly diagnosed infections occur in 13 to 34 year olds. As a result of the increased PLWHA population, ADPH is becoming stressed to provide adequate medical and social services (e.g., Ryan White and Medicare) to HIV infected individuals. This is a major concern not only in Alabama, but for all states, especially in the Southern United States.

For Alabama to achieve the primary goals of the NHAS, prevention and testing efforts must be aimed at populations at greatest risk for HIV infection. Alabama ranks 12th among the 50 states for cumulative AIDS cases in the United States. The number of persons who are living with HIV in Alabama continues to increase each year. In 2011, there were 719 cases of HIV newly reported in Alabama.

Figure 1

Persons Living with HIV/AIDS, Alabama 2007-2011



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

Rural Areas

Alabama is a rural state where 55 of the 67 counties are located outside of the State’s major population centers. Alabama’s agricultural counties (referred to as the “Black Belt”) located in the western and southwestern part of the State encounter some of the highest HIV incidence rates, as well as, the highest poverty and unemployment rates in the state. Alabama’s rural populations represent 23.8 % of all HIV cases and 41% of the State’s total population.

As of December 31, 2011, counties with the highest rates of HIV/AIDS are:

- 1) Lowndes (53.10)
- 2) Montgomery (38.37)
- 3) Hale (38.07)
- 4) Conecuh (30.24)
- 4) Chambers (35.07)
- 5) Jefferson (31.44)
- 6) Conecuh (30.24)

*Rates per 100,000 persons residing in county.

Rural areas present with a broad range of systemic problems. Two major barriers to care in Alabama are lack of transportation services and a severe shortage of primary care physicians. Transportation challenges create obstacles in linking patients to treatment services and to other interrelated services such as substance abuse programs, nutritional programs, and mental health facilities. Alabama currently lacks almost 500 primary care physicians that are needed to serve the population. The lack of physicians combined with a lack of transportation to what limited care that is available has created a serious health care crisis in Alabama.

African Americans

African Americans continue to be disproportionately affected by HIV/AIDS. While 26.2% of the State's population is African American, 68.35% of the persons diagnosed with HIV in 2011 were African American. Recent trends in Alabama indicate increasing rates of HIV among both males and females, with a rate that currently is seven times higher than among Caucasians.

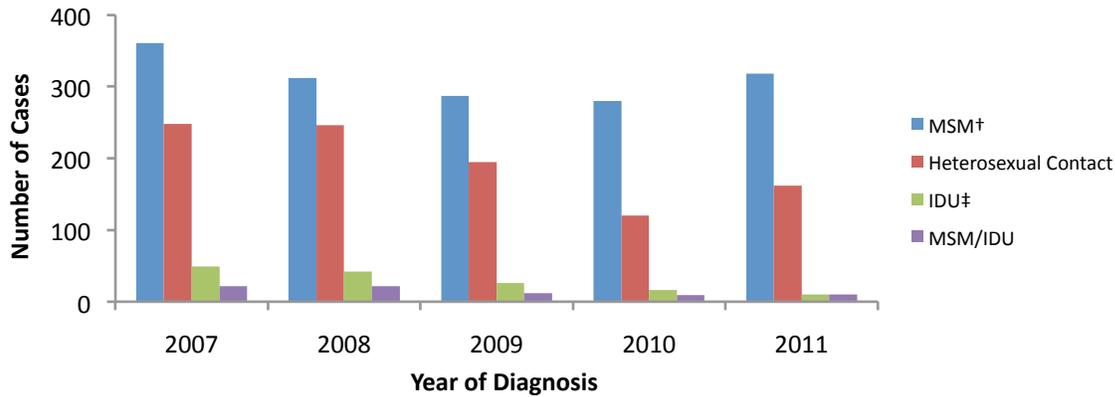
With Centers for Disease Control and Prevention (CDC) funding, ADPH began an expanded HIV testing initiative and included the State's Historically Black Colleges and Universities (HBCUs). This expanded HIV testing initiative is an excellent example of how Alabama is addressing the goals of the NHAS. The expanded testing initiative in Alabama follows closely with step one of the recommended efforts of the NHAS to "*intensify HIV prevention efforts in the community where HIV is most heavily concentrated.*"

MSM

Men who have sex with men (MSM) represent the "hardest hit" populations in the State. MSM accounted for 26.1% of the newly diagnosed cases for 2011, and 26.9% of persons living with HIV. Of the reported risk behaviors, 1.8% of new cases of MSM reported injection drug use. In order to achieve the goal of reducing the number of new cases of HIV, specific prevention programs need to be targeted for the MSM population. Both prevention and linkage to care strategies need to identify and target the MSM population for increased prevention education, testing, and treatment. Priority should be given to this population which represents unique challenges given the combined risks of MSM and Intravenous Drug Use (IDU).

Figure 2

HIV Cases by Year of Diagnosis & Exposure Category, Alabama 2007-2011



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.
 †MSM - Men who Have Sex with Men, ‡IDU - Injection Drug Use

Heterosexual

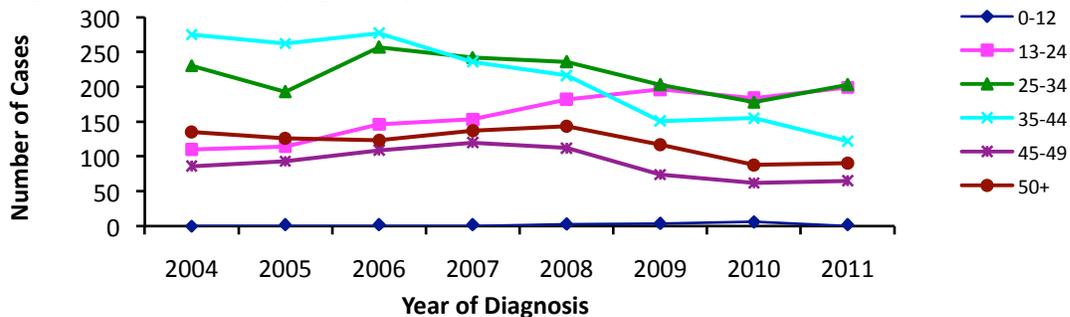
In 2011, 87.5% of new cases of HIV infection in females were attributed to heterosexual contact. Among these cases, African American females constituted 80.7% compared to 14.3% among Caucasians. Additional risk behaviors included 4.8% of HIV infected females who reported intravenous drug use (IDU). These HIV infected females represent a significant population for whom treatment and prevention services need to be developed and should become easily accessible.

Overall, heterosexual contact was the sole reported risk factor for 26.1% of newly reported HIV infections in 2011, and for 26.9% of all PLWHAs in Alabama.

Youth

The highest incidence of newly diagnosed HIV infections shifted from persons aged 25 to 44 years in 2004 to persons aged 13 to 34 years in 2011 (Figure 3). During 2011, 13 to 34 year olds accounted for 59% of newly diagnosed cases. While new infections increased 10% among 13 to 25 year olds in 2011, infections among 35 to 44 year olds decreased 21%.

Figure 3. Trends in HIV by Age Group, Alabama 2004-2011



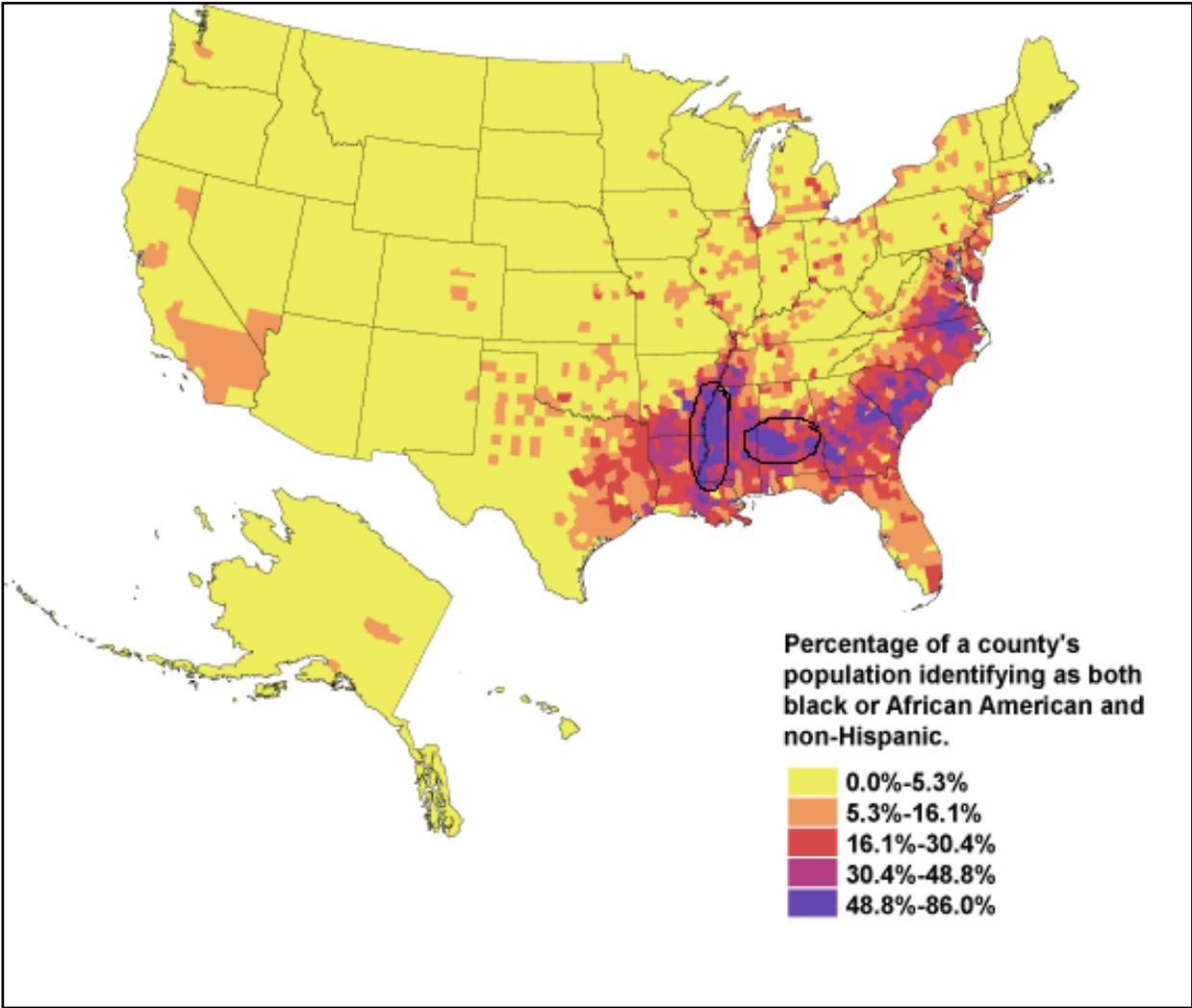
The Alabama Youth Risk Behavior Survey, 2009, indicates that among high school students in grades 9-12, 57% had engaged in sexual intercourse, and 41% reported they did not use a condom. The 2008 *Alabama School Health Profiles* states that 68% of high schools in Alabama had policies for students and teachers with HIV to protect them from discrimination. With recent upward trends in HIV and STD among Alabama's youth ages 13-25, increased HIV prevention education and advocacy for Alabama's youth must be a priority.

Socioeconomic and Social Factors Affecting Health in Alabama

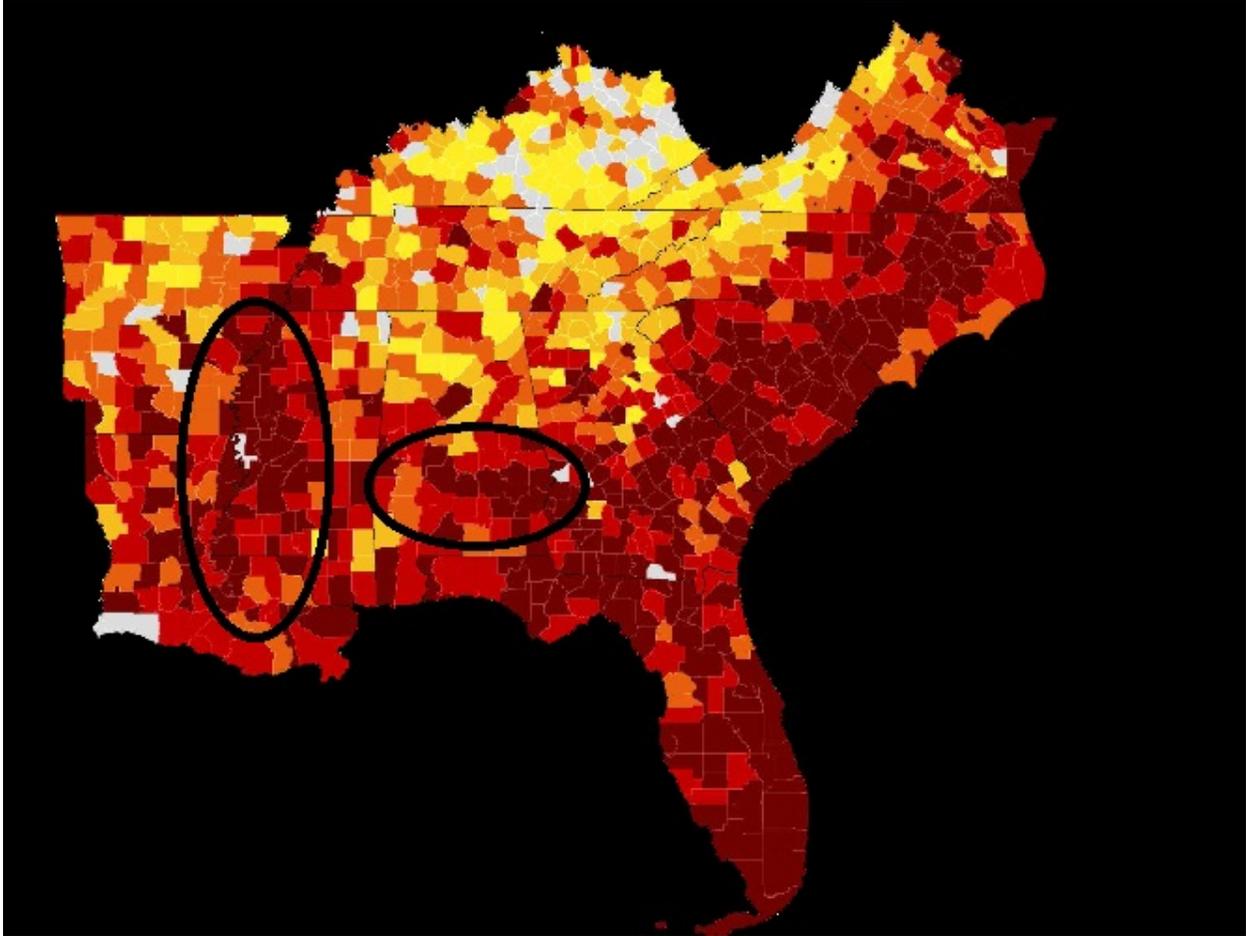
The median per capita income in the state of Alabama for 2011 was \$22,984 ranking Alabama 46th in the nation. As noted by Americas HealthRankings.org 2011, people with lower incomes tend to experience higher incidence of illness and death. Thirty-two percent of Alabama's children <18 were living below the federal poverty level. The combination of poverty and rural geography creates complex barriers for HIV prevention and care. These factors also influence educational opportunities, housing, nutrition, youth outreach, senior services, substance abuse, mental health and other complex social factors that contribute to a higher risk of HIV infection.

Between 2006-2010, 81.4% of persons > 25 graduated from high school in Alabama. Many of the areas "hardest hit" for HIV are in rural Alabama. These factors contribute to disparities in health care. Lack of transportation and lack of health care providers create barriers to healthcare that urgently need to be addressed. In order to reduce the disparities in health care and access to care, and assist in reaching the goals of the NHAS, the community must be involved. These social determinants which involve education, poverty, behavior and economics must be addressed to decrease HIV in these hard hit areas. This requires a coordinated effort between both the State and local level for targeted community-based interventions to address these issues.

Alabama – 2010 Census – Circle indicates area of highest population of African Americans.



Alabama 2011 – Circle indicates highest rates of HIV in rural areas.



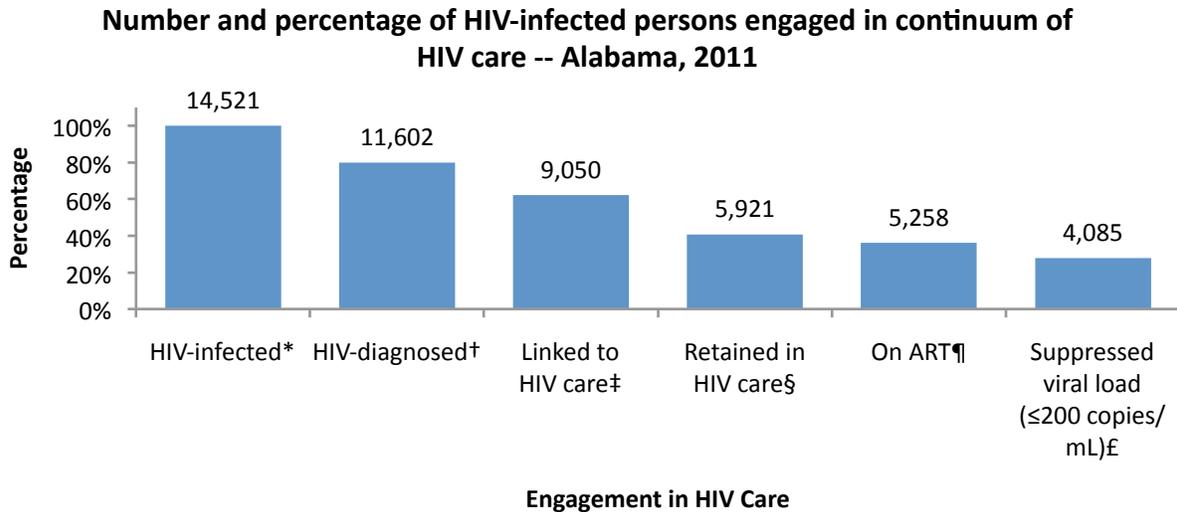
A 23-page publication entitled "Southern Exposure: HIV and Human Rights in the Southern United States," was released in advance of World AIDS Day 2010. In that document, the Human Rights Watch reported their study on Southern states and HIV. According to Human Rights Watch, the HIV/AIDS epidemic has hit hardest in minority populations, particularly African-Americans who bear a disproportionate burden of infection. "Nowhere are racial disparities in HIV/AIDS rates more visible than in southern states," McLemore said.

The maps above clearly indicate that the severe HIV/AIDS crisis Alabama faces is centered in the rural area of the State which has had the highest population of African Americans since 1860, well over 150 years. (See Map – Attachment 1) This area of the State suffers a shortage of health providers, no public transportation system, and a high number of families living in poverty. All of these factors contribute to disparities in health care among African-Americans in rural Alabama.

As stated in Southern Exposure, lack of access to health care is a more serious problem for people in the South than in any other region of the US. Residents of southern states are less likely to have health insurance than those in other regions. The South has fewer medical

providers with more people living in federally designated “health professional shortage areas” than any other area of the country. Nearly two in five southern residents are considered “medically disenfranchised,” meaning they lack access to a primary health care provider. The shortage of health professionals specializing in HIV care, particularly in rural areas that dominate the South, is a major contributor to the failure of people who test positive for HIV to access medical care.

Figure 5



Source of data: HIV Surveillance Branch, Division of HIV/AIDS Prevention and Control

HIV-infected*	100%	14,521
HIV-diagnosed†	80%	11,602
Linked to HIV care‡	62%	9,050
Retained in HIV care§	41%	5,921
On ART¶ Anti-retroviral therapy	36%	5,258
Suppressed viral load (≤200 copies/mL)£	28%	4,085

The HIV/AIDS “Treatment Cascade” for Alabama, developed by the HIV Surveillance Branch Director, is a way to show in visual form, the numbers of individuals living with HIV who are actually receiving the full benefits of the medical care and treatment they need.

The treatment cascade provides a way to examine critical questions, including: How many individuals living with HIV are getting tested and diagnosed? Of those, how many are linked to medical care? Of those, how many are retained in care? Of those, how many receive anti-retroviral therapy? Of those, how many are able to adhere to their treatment plan and achieve viral suppression? By examining these separate steps, policymakers and service providers are able to pinpoint where gaps may exist in connecting individuals living with HIV/AIDS to sustained quality care. Determining where drop-offs occur can help state and local

policymakers and service providers to implement system and service improvements that better support individuals as they move from one step in the continuum to the next.

Data show that for every 100 individuals living with HIV in Alabama, it is estimated that: 80 are aware of their HIV status; 62 have been linked to care; 41 stay in care; 36 get anti-retroviral therapy; and 28 are able to adhere to their treatment and sustain undetectable viral loads.

Alabama estimated numbers match with CDC's estimates for 2011. In short, only 28% of the more than 1 million individuals in the U.S. who are living with HIV/AIDS are getting the full benefits of the treatment they need to manage their disease and keep the virus under control. Put another way, nearly 3 out of 4 people living with HIV have failed to successfully navigate the treatment cascade. Alabama has to do better!

Other Considerations for “Hard Hit” Communities

Service needs and gaps in services consistently identified across all regions in Alabama include funding for and access to dental care, transportation, mental health services, including substance abuse treatment, support groups, follow-up counseling; and referral to services. Other needs include access to clinical drug and vaccine trials, dentists and physicians willing and knowledgeable to care for clients with HIV disease, nutritional counseling and supplements, nursing home and long-term care, and primary and secondary prevention education and information. Because Alabama is a predominantly rural state, transportation is a constant barrier identified to accessing medical care and services for residents in rural areas statewide.

Access to quality treatment of HIV disease presents more of a challenge for those who live in rural areas of the state and must access resource poor and compromised health care systems. HIV care and services occur primarily outside of the State's private medical sector, so clients often rely on local health departments or Ryan White** funded care or service agencies. Most county health departments are not equipped to handle complex diseases like HIV, and if a rural area is fortunate to have a clinician, he or she often lacks the experience to treat HIV disease.

**The Ryan White Emergency Care Act was enacted in 1990 to fund medical and social service needs of person living with HIV/AIDS. All states, territories and highly impacted cities are funded by a Federal formula based on numbers of persons living in an area

Limited financial resources and inadequate health insurance or third party coverage are serious challenges for both urban and rural residents to accessing HIV care and services.

Uninsured individuals reported decreased access to routine and preventive care, decreased health information and advice and decreased use of private doctors and outpatient clinics.

Individuals who are eligible for Medicaid reported difficulty in locating a medical provider who accepts care for new Medicaid patients. This creates a significant barrier to equal access to medical care across the state for a large number of Alabama residents who rely on Medicaid to pay for medical care.

Medicaid is not health insurance for people living with HIV, but rather disability insurance,

covering a person with HIV only when it advances to full-blown AIDS and becomes disabling. In the South, states have established the most restrictive Medicaid income eligibility and offer the most limited benefits of any region in the country. Alabama sets the lowest income threshold for Medicaid eligibility in the nation at 11 percent of the Federal Poverty Level or US\$194 a month for jobless parents in a family of four. These rules put Medicaid out of reach for many people living with HIV/AIDS.

Stigma

Perhaps no other region in the United States faces the degree of stigma associated with HIV than the South. Deep-rooted social and religious views affect efforts in both education and health care. In order to prevent new infections and encourage infected persons to seek medical care, issues that affect stigma and discrimination for persons living with HIV/AIDS must be addressed. This requires education, enforcing policy, engaging the community, and increased advocacy from those living with HIV. Many people living with HIV in the South still face serious discrimination in many aspects of their life. Stigma creates barriers to housing, employment, access to care and community engagement. In order to decrease stigma, it is imperative to increase collaboration among faith-based and community-based organizations in Alabama. The HIV/AIDS community must also increase our efforts to enforce laws and policies to ensure protection for those living with HIV.

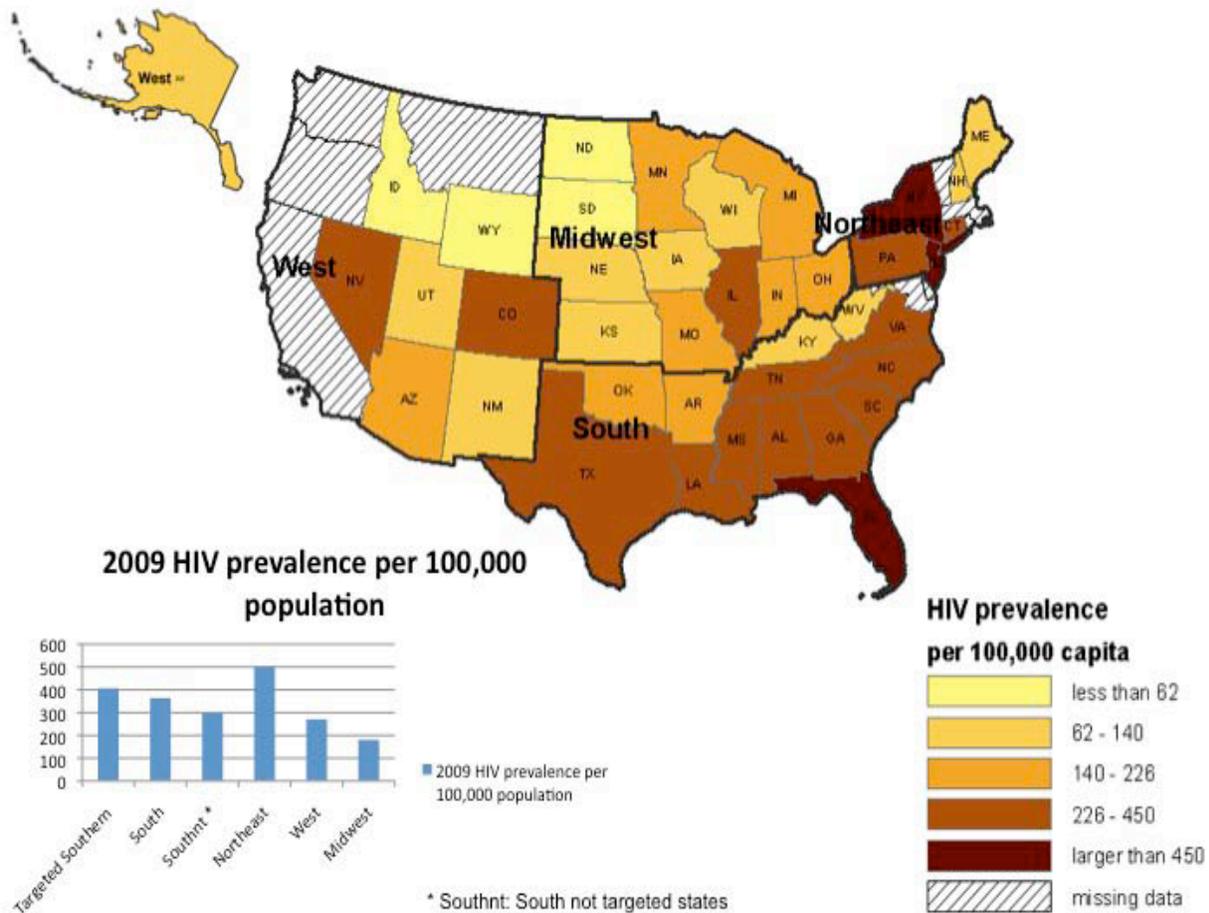
The University of Alabama recently announced a multiyear grant that will examine the role that African American faith-based congregations play in reducing HIV/AIDS stigma in rural Alabama. The overall goal of the project, "Faith-Based Anti-Stigma Intervention toward Healing HIV/AIDS" or "Project FAITHH", is to decrease both individual stigma and community-wide stigma in the targeted churches. This new initiative clearly addresses the goals of the NHAS in reducing stigma. According to Dr. Pamela Foster, principal investigator of the grant, "We know from previous research that HIV-positive persons value spirituality in their overall healing process. However, they have often not become active members of rural congregations because of the stigma. We hope to turn that around with the study."

The DHPC in collaboration with the University of Alabama at Birmingham Department of Health Care Organization and Policy proposes to disseminate a survey to healthcare employees titled "The Finding Respect and Ending Stigma around HIV (FRESH) Study." The survey is currently in review by ADPH Administration and will be distributed pending approval. Survey results will provide the basis for continuing education workshops and training opportunities. Working to end discrimination and stigma experienced by HIV positive persons is a vital component of reducing the HIV epidemic.

The South

“The Deep South – Alabama, Georgia, Louisiana, Mississippi, Florida, North Carolina, South Carolina, Tennessee, and East Texas – is facing a devastating HIV crisis. As indicated in Figure 4 below, the Deep South has the highest rates of new HIV and AIDS diagnoses in the United States and persons living with HIV in the Deep South die at much higher rates than in other parts of the country. This crisis is particularly acute in certain populations in the South: 54% of new HIV cases among African Americans in the United States were in the Deep South; 1 in 5 African American MSM (men who have sex with men) in the South are estimated to be living with HIV; eight of the Deep South states report a higher proportion of women among new HIV infections than the US average; and, one-half of the new HIV diagnoses among Hispanics/Latinos occur in the Southern US”. *SASI. the Southern HIV/AIDS Strategy*

Figure 2: HIV Prevalence in 2009



For an interactive view of the state of Alabama’s HIV/AIDS infection rates see, aidsvu.org

Part 3: Governor’s Task Force 2011 - Governor Bentley, Executive Order Number 26

HIV + Advocate: “I am now a State Peer Mentor. We find people newly diagnosed and link them to care, we find people who were in care and have fallen through the cracks. We find out what happened to them, and we work with people who are struggling to stay into care. I am part of the State’s HIV Prevention Planning Group, (working on the National Strategy, Alabama’s part). I am on the State Consumer Advisory Board, and last but certainly not least I am part of Governor Bentley’s HIV Prevention Task Force. I am so humbled and honored just to have been asked.”

Released by the Governor’s Office on December 1, 2011 – World AIDS Day!

Office of the Governor

ROBERT BENTLEY

Governor



STATE OF ALABAMA

Press Office

December 1, 2011

Governor Bentley Creates Alabama’s HIV/AIDS Prevention Task Force

MONTGOMERY— Governor Robert Bentley today announced the creation of Alabama’s HIV/AIDS Prevention Task Force. From 1982 through December 2010, there have been a total of 17,800 people infected with HIV/AIDS in Alabama. The 19-member Task Force will consist of people who are living with HIV/AIDS, representatives of the faith and health care communities, as well as other state agencies.

The HIV/AIDS Task Force will be charged with researching and developing options to encourage statewide efforts to reduce new cases of HIV/AIDS and to improve the overall health of Alabamians. The Task Force will adopt and promote a statewide comprehensive HIV/AIDS Prevention and Direct Services Plan that will address efforts to reduce cases.

"We must do all we can to prevent the spread of HIV/AIDS. This Task Force will work to reduce new HIV/AIDS infections, increase access to care, and improve the health outcomes for Alabamians living with the disease," said Governor Robert Bentley.

The Governor signed the Executive Order creating the HIV/AIDS Prevention Task Force on World AIDS Day today. Click [here](#) to view the Executive Order creating Alabama's HIV/AIDS Prevention Task Force.

Office of the Governor

ROBERT BENTLEY



December 1, 2011

EXECUTIVE ORDER NUMBER 26

WHEREAS, the Executive Branch of the State of Alabama, is charged with protecting, promoting, maintaining and overseeing the health, safety and welfare of Alabama citizens;

WHEREAS, the promotion of the health, safety and welfare of Alabama citizens includes preventing unnecessary mortality, morbidity and costs from the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);

WHEREAS, the people living in all areas of Alabama are in tremendous need of improved HIV/AIDS education, healthcare, and economic relief;

WHEREAS, from 1982 to October 2011, there have been a cumulative total of 17,799 persons infected with HIV/AIDS in Alabama;

WHEREAS, since 1982, there have been a cumulative total of 159 pediatric HIV/AIDS cases in Alabama;

WHEREAS, from 1982 to December 2010, 6358 individuals in Alabama have died due to complications related to HIV/AIDS;

WHEREAS, from 1985 to 2010, the number of persons living with HIV infection and in need of direct care and support services increased from 186 to 10,875;

WHEREAS, persons are living with HIV/AIDS in every county of Alabama;

WHEREAS, more US citizens have died from HIV/AIDS than were killed in World War II and the Korean, Vietnam and Persian Gulf war's;

WHEREAS, a coordinated, comprehensive, planned public and private effort is needed to prevent unnecessary deaths and suffering due to HIV/AIDS in Alabama; and,

WHEREAS, a coordinated, comprehensive, long-term, statewide effort is needed to reduce new HIV/AIDS infections, increase access to care and improve the health outcomes for persons living with HIV/AIDS, and reduce HIV/AIDS-related health inequities.

NOW, THEREFORE, based upon these considerations, and to achieve a more coordinated statewide response to the HIV/AIDS epidemic, I, Robert Bentley, Governor of the State of Alabama, by virtue of the authority vested in me by the Constitution and laws of the State of Alabama, do hereby establish **Alabama's HIV/AIDS Prevention Task Force** (Task Force) which shall be comprised of the following members:

- The Governor or his designee to serve as Chair;
- The Director/Commissioner or their designee of the: Department of Public Health
Department of Mental Health Department of Education Medicaid Agency
Office of Rural Development
Primary Health Care Association
- Two people living with HIV/AIDS to be appointed by the Alabama State AIDS Director;
- Two members of the Alabama House of Representatives to be appointed by the Speaker of the House of Representatives;
- Two members of the Alabama State Senate to be appointed by the President Pro Tem of the State Senate;
- One member of the faith community with experience in HIV/AIDS education to be appointed by the Governor;
- Two providers with experience treating people with HIV/AIDS to be appointed by the Governor;
- Two persons living with HIV/AIDS in Alabama to be appointed by the Governor; and,
- Any other individuals that the Governor may choose to appoint.

BE IT ORDERED that all members shall serve at the pleasure of the appointing authority.

BE IT FURTHER ORDERED that Executive Order Number 34, issued on August 31, 2000, is hereby rescinded.

BE IT FURTHER ORDERED that the Task Force is charged with researching and developing options to encourage statewide efforts to reduce cases of HIV/AIDS and to improve the overall health of Alabamians by

adopting and promoting a statewide comprehensive HIV/AIDS Prevention and Direct Services Plan to the general public, state and local elected officials, various public and private organizations and associations, businesses and industries, agencies, potential funders and other community resources.

BE IT FURTHER ORDERED that the Task Force, under the leadership of the Governor shall work with existing department heads, commissioners and directors to coordinate the efforts of their State agencies, departments, and commissions that support, aid, or assist, or have the capacity to support, aid, or assist in the HIV/AIDS Comprehensive Plan of Alabama.

BE IT FURTHER ORDERED that this Executive Order shall become effective immediately upon its execution and shall remain in effect until amended or modified by the Governor.

DONE AND ORDERED this 1st day of December, World AIDS Day, 2011.

Robert Bentley
Governor
Beth Chapman
Secretary of State

Task Force Meeting

The first called meeting of the Task Force was held at 1:30 in Room 410 of the Alabama State House on Friday, November 30, 2012. The meeting was called to order by Representative Laura Hall, appointed chair of the Governor. Fifteen of the nineteen appointed members, or their designees, were in attendance. After welcome and introductions, Representative Hall recognized Ron Sparks who was instrumental in working with the Governor to create the Task Force.

The agenda included Jane Cheeks, State AIDS Director, who presented the history, recommendations and progress made by the 2001 HIV/AIDS Commission; Anne Reynolds, Consultant for State Plan development, who presented the process for gathering data and information from multiple groups and individuals to build consensus and prepare the draft plan; Jane Cheeks presenting a summary of the draft plan, and Nic Carlisle, Director of Advocacy and Policy for AIDS Alabama who presented the work of the Alabama HIV/AIDS Policy Partnership on policies for consideration to be included in the draft plan.

Next steps for the Task Force are: The draft plan will be emailed to all members for consideration and proposed recommendations during the week of December 3 with deadline of December 15 for return comments. The next meeting of Task Force will be January 8, 2012. At that time, the final plan will be presented to members for consideration of adoption.

Part 4: ADPH - Division of HIV/AIDS Prevention and Control

The mission of the HIV/AIDS Division of Prevention and Control in collaboration with community partners is to reduce the incidence of HIV infections, to increase life expectancy for those infected, and to improve the quality of life for persons living with or affected by HIV. The state of Alabama (67 counties) continues to experience an HIV/AIDS epidemic of moderate magnitude, when contrasted with the experience of other states. HIV has infected/affected persons of all gender, age, race, ethnicity and all socioeconomic groups in every county in Alabama. However, the effect has not been the same for all groups.

Activities that are considered essential for identifying HIV positive individuals who are unaware of their status include using the latest incidence and prevalence data, priorities set through the prevention planning process, consulting with the community networks for grass root observations and ideas, and identifying where HIV testing sites are currently operating in order to expand HIV testing in areas that are underserved.

Recent trends suggest a shift in the HIV/AIDS epidemic toward African American males and females, heterosexual activity, and people under the age of 34. It is extremely important to identify those populations most affected and most at risk for HIV infection. This information helps health care providers create short and long term plans and allocate limited resources for HIV prevention, testing and treatment services. As the epidemic continues to change and the number of persons living with HIV/AIDS continues to increase, providers can continue to adapt services to address the changes.

Between 1982 and 2011, a total of 17,839 cases of HIV infection were reported to the ADPH. At the end of 2011, 64% (11,342) were known to be living. An additional 2,000 to 4,000 Alabama residents are likely infected and unaware of their positive HIV status. During 2011, 719 newly diagnosed HIV infections were reported in Alabama.

Since the early years in the HIV epidemic, the Division of HIV/AIDS Prevention and Control (DHPC) has nurtured it's relationships with State and community partners to gain acceptance as a recognized leader and partner in reducing the spread of HIV disease. The system of HIV/AIDS programs in Alabama is supported through a network of services statewide. ADPH, through the DHPC sets program policy and provides guidance, technical assistance and financial support to numerous public and private partnerships, and the eleven Public Health Area offices.

DHPC supports the following programs and initiatives:

1. PREVENTION

The Centers for Disease Control and Prevention mandated HIV Prevention Planning process, under the direction of the DHPC, has provided a solid foundation for the State's prevention efforts since 1992. Participation is inclusive of the "community" representing a wide range of those infected and affected, AIDS Service Organization and community-based agency staff and other interested lay individuals along with the state health department representatives. One statewide HIV Prevention Planning Group (HPPG) has evolved and continues to evolve into the recognized infrastructure for the direction of prevention program activities. The DHPC not only involves HIV+ persons through the HPPG process, but continues to support the Alabama Consumer Advisory Board (ACAB) which sponsors an annual conference targeting HIV+

individuals and other participants statewide. Prevention services managed by the DHPC are listed below.

A. Statewide Peer Mentoring Program

The program consists of peer mentors (PLWHAs) representing Public Health areas throughout the State of Alabama. The program goal is to identify HIV positive persons in the community who are not receiving prevention and/or direct care services. The peer mentors provide education and outreach services to infected persons, and offer referrals and linkages to medical/dental care, consumer advocacy groups, inpatient/outpatient substance abuse treatment, emergency and transitional housing, case management and secondary prevention counseling services where available. The peer mentors work with local HIV medical clinics, AIDS Service Organizations (ASOs) and community-based organizations (CBOs) that provide HIV specific services to infected persons and high-risk negative individuals.

B. Alabama Consumer Advisory Board (ACAB)

The CAB consists of persons living with HIV (consumers) throughout the state and represents various Public Health Areas. Each consumer participates in her or his local consumer group to discuss community needs, advocate for medical/dental and social services, and offer support to newly diagnosed persons. The CAB participates in its local prevention network meetings, consortia meetings, patient advisory board meetings, and consumer advocacy meetings. The CAB provides a voice for consumer issues to be expressed at the state level Public Health and ASOs /CBOs. This creates an opportunity for consumer participation and input in state and community planning, primary and secondary prevention activities and direct care services.

C. Alabama Prison Initiative

The goal of the Alabama Prison Initiative is to provide primary and secondary education services to HIV positive inmates in the Alabama Department of Corrections (ADOC). The Initiative is a collaborative partnership between the DHPC, ADOC, NaphCare Pharmacy, ASOs and CBOs. DHPC has collaborated with the National Minority AIDS Council (NMAC), and ADOC to provide in-service training such as the Prison Rape Elimination Act (PREA) and Discharge Planning. ASOs and CBOs also provide agency and AIDS prevention and treatment information to inmates on a routine basis.

D. Funded Projects

The DHPC provides HIV prevention funding to support primary and secondary education and outreach activities. Since 1997, the Division has funded projects in agencies that responded to a competitive Request for Proposals. Funded agencies were those that presented unique and innovative strategies for responding to the prioritized risk populations in the eleven public health areas. Currently, five CBOs throughout the State receive CDC federal funding for effective and scientifically proven prevention interventions.

In 2013, the emphasis will be placed on CDC defined high-impact prevention interventions targeted toward areas of highest HIV morbidity in the State.

E. Enhanced Referral Tracking System (ERTS)

ERTS was designed by staff of DHPC to respond to several needs and requirements of both CDC and the Health Services Resources Agency (HRSA) who provide funding for prevention and direct care services in Alabama. ERTS has nine HIV Program Coordinators located in Public Health Areas. Their charge is to track and link newly reported/diagnosed HIV cases into care. The program was fully implemented in January 2005, and has been presented at several national conferences as a model for other states to track, report, and link newly reported/diagnosed HIV cases into care. For the past three consecutive years, Alabama has reported over 70% of newly reported/diagnosed HIV cases have been linked into care. The ERTS program will continue follow-up and verify client's entry into care. In addition, the Quality Assurance component of the program continues to gather data and evaluate the information reported by Coordinators. In order to handle the continued increase in new HIV cases, the Coordinators maintain their strong collaborations with Disease Intervention Specialists, ASOs, and peer mentors.

F. FOCUS Program – implemented in early 1990s.

The purpose of the FOCUS Program is to promote school and community partnerships for the prevention of HIV/AIDS and other adolescent risk behaviors. In order to support ongoing prevention education, school systems are asked to offer the FOCUS Program as a class elective. At this time ten school systems have adopted the program in central and north Alabama. The intention is to expand this successful prevention program to additional areas and schools in the State in 2013, pending available funding.

G. Expanded HIV Testing Initiative

In October 2011, DPHC, under the CDC *Expanded HIV Testing Initiative*, was funded to expand HIV testing to hospital emergency departments, primary care clinics and colleges and universities. The Division's Data and Quality Management staff estimates the expanded testing initiative will increase testing in Alabama by 30%.

H. Pregnancy Improvement Project

The DHPC and the University of Alabama at Birmingham, Family Clinic will collaborate through a new strategy called *The Pregnancy Improvement Project (PIP)*. A web page has been created that provides perinatal updates, statistics, CDC recommendations, and treatment guidelines. A 1-800 number has been placed on the web page with HIV perinatal experts

answering the calls five days per week. Private providers will have access to web resources and professional consultations.

I. Bureau of Clinical Laboratory (BCL)

Since 1987, when the State Health Office declared HIV as a Sexually Transmitted Disease and therefore a notifiable disease, the ADPH Bureau of Clinical Laboratory (BCL) had provided HIV testing including confirmatory tests at no cost to the clients. For the last five years, the BCL has also performed CD4, viral load and drug resistance testing for the HIV clinics and other selected providers supported by CDC and/or HRSA funding. This laboratory, located in Montgomery, Alabama, provides reliable and cost efficient services.

Effective June 30, 2011 a public health law was implemented mandating laboratory reporting of CD4 counts and viral loads. The CD4 and viral load results will be used to estimate linkage and retention in care, community viral load, quality of care, and to provide feedback of results to providers and patients, as requested. Patients identified with CD4 counts who have no documented HIV medical care will be tracked, by ERTS staff, the same as clients with a positive Western Blot.

2. TREATMENT AS PREVENTION

HIV + Advocate: “I am now the State Peer Mentor for Jefferson county (we find people newly diagnosed and link them to care, we find people who were in care and have fallen through the cracks, we find out what happened to them and we work with people who are struggling to stay into care)...”

A. Direct Care Services

Increased longevity due primarily to positive HIV/AIDS treatment outcomes and better drug therapies has significantly impacted the State’s public and private health care systems and HIV care and service resources. Service providers have to work longer and creatively to keep up with the care and service needs of Alabama’s population living with HIV disease and their family members. This has impacted Alabama’s ability to provide adequate medical and social services (i.e., Ryan White and Medicaid) for the State’s increasing and aging HIV/AIDS population. Increased testing efforts to identify HIV positive persons and refer them into care has resulted in increased care and service needs in the State’s HIV/AIDS population presenting major challenges in the current economic climate and as funding resources are decreasing.

The cost for the Alabama Drug Reimbursement Program (ADAP) to provide life saving medications in FY 2010 was approximately \$10,000 to \$11,000 per client (National Average is \$11,500). ADAP does not collect specific data from applicants regarding their HIV rapid testing history making it difficult to determine an exact correlation between HIV rapid testing and CDC’s prevention initiative with the steady increase in ADAP enrollment. However, program utilization data confirms an increase in ADAP enrollment during the same time-period that the

ERTS program reports an increase in newly diagnosed HIV positive individuals referred into care. This would suggest a correlation in the increase in new HIV positives with the increase in ADAP enrollment to access life saving HIV medications.

Service needs and gaps in services consistently identified across all regions in the State include funding for and access to dental care; transportation; mental health services; including substance abuse treatment, support groups, follow-up counseling; and, referral to services. Other needs include access to clinical drug and vaccine trials, dentists, and physicians willing and knowledgeable to care for clients with HIV disease, nutritional counseling and supplements, nursing home and long-term care, and primary and secondary prevention education and information.

Alabama uses a collaborative strategy to identify residents with HIV/AIDS who do not know their status, to make them aware of their status and to link them to care and services that includes State and non-State programs as well as special projects. Extensive coordination of HIV Prevention and Direct Care strategies are discussed in detail in Alabama's HIV Prevention and Direct Care Comprehensive Plans (See adph.org/hiv aids website for Plans) and include the following goals:

Goal 1) to increase the number of persons seeking HIV Counseling Testing and Referral Services (CTRS);

Goal 2) to increase the number of persons who return or stay for Post Test Counseling and Referral Services to 85%;

Goal 3) to strengthen the quality of Partner Counseling Referral Services (PCRS) offered to be able to identify high-risk partners of HIV positive clients;

Goal 4) to improve linkages between health departments, physicians, ASOs and other providers for early PCRS;

Goal 5) to improve public understanding of, involvement in and support for HIV testing and screening, secondary and primary HIV prevention services;

Goal 6) to continue to monitor and evaluate linkages to new HIV positives into care through the Enhanced Referral Tracking System (ERTS); and

Goal 7) to improve activities to link Minority AIDS Initiative-Funded Education/Outreach to Part B ADAP, other Prescription Drug Programs and/or other RW HIV/AIDS Program Services through the State's Peer Mentor program.

B. Statewide Coordinated Statement of Need (SCSN)

Proposed Ryan White (RW) allocations in FY 2012 will fund care and service agencies to meet HIV core care and service needs identified in the State's most recent SCSN. Updating the SCSN in FY 2012 provided an opportunity for representatives from HIV care and prevention and other State and local agencies in Alabama to address cross program care and prevention issues and gaps in services identified across all regions of the state.

Alabama's Comprehensive Direct Care Plan and SCSN guides and supports resource allocation decisions made by the HIV/AIDS Division for the State's RW Part B program. It is anticipated that the same clinics and ASOs will reapply for and receive RW funding in FY 2013 to continue to provide core HIV care and services to meet the needs of persons living with and affected family members identified in the State's most recent SCSN and Comprehensive Direct Care Plan. (The 2012 SCSN and Comprehensive Plan can be viewed at www.adph.org/aids).

The DHCP has established partnerships with all of the Ryan White Part B & C clinics. The Division provides rapid test kits to seven of the eleven clinics. Clinic staff is trained to provide HIV test results at the point of care. Individuals who require additional follow-up are contacted by staff at the clinics or county health department STD Disease Intervention Specialists. All testing data is reported to the DHPC.

C. Alabama Drug Reimbursement Assistance Program

DHPC (ADAP), in collaboration with community health care providers, is committed to providing HIV medications to low income and uninsured residents living with HIV disease in an effort to increase life expectancy and to improve quality of life. Case management services continue to play a major role in Alabama's efforts to increase access to care and provide ADAP medications with a focus on the underserved minority and hard-to-reach populations. Alabama's HIV+ residents access ADAP through an application process initiated by their social worker/case manager or clinician.

Many Ryan White funded care and service agencies receive support to provide transportation services for clients who live in rural areas to ensure access to HIV clinic appointments and ADAP medications. Because of increased utilization of ADAP, the program implemented an enrollment cap in FY2011 and reinstated a waiting list, since first eliminating it in 2006. New applications are placed on a waiting list until a slot opens for enrollment. Individuals are moved from the ADAP waiting list to active status on a first-come first-serve basis. Currently in 2012, ADAP does not have a waiting list due to additional funding that will be available through March 2013.

HIV medications are added to the ADAP formulary when FDA approved and the National ADAP Crisis Task Force price negotiations are complete. The ADAP Coordinator surveys HIV clinicians and social workers seeking input regarding medication needs of their patients/clients. The Division Director completes a cost analysis and makes the decision to add a medication to the formulary based on results of the physicians' survey and budget projections.

ADAP sponsors a Medicare Part D cost assistance plan (MEDCAP) that assists HIV+ individuals with Medicare Part D. HIV+ individuals on MEDCAP usually do not qualify for

low-income subsidy assistance to pay for the cost of co-pays or monthly premiums. The MEDCAP program pays for insurance premiums and co-pays to assist clients. The program allows clients have full insurance and opens up slots on ADAP to provide medications for more clients.

D. The ADAP Adherence Project

The ADAP Adherence Project began in 2007 and will continue an active approach to cost containment and will include the following quality measures: (1) monitoring monthly drug utilization; (2) monitor monthly drug costs to ensure ADAP consistently receives accurate drug pricing; (3) monitor monthly medication pickups to improve medication adherence; (4) complete regular ADAP medication inventories at all clinics to decrease program costs by decreasing medication waste; (5) improve the current Client Satisfaction Survey to collect significant client data to impact improvement decisions; (6) implement the data collection system (DM/DI) to integrate data systems across programs by 2012; and, (7) implement the electronic ADAP application and prescription process. The State's ADAP will continue to monitor the centralized eligibility determination process to ensure client eligibility and to improve the Client Eligibility Review and application process.

3. HIV SURVEILLANCE

All data collected and/or obtained within the DHPC (i.e., Enhanced Referral Tracking System (ERTS), Counseling and Testing System (CTS), ADAP, Electronic HIV/AIDS Reporting System (e-HARS), are subject to sharing with any of its subordinate programs through generated files and Statistical Analysis System (SAS) programming. The Ryan White Part B database, ADAP, is matched monthly with the Medicare Beneficiary Database (MBD) to determine if Alabama's active ADAP clients are eligible for benefits. The ADAP database is also matched quarterly against Alabama's Department of Revenue (DIR) database to verify income used in determining ADAP eligibility.

All data collected by the DHPC staff is shared internally and externally as part of a cross-program practice of data collection and reporting. Data is shared statewide with providers writing grants for funding, services and educational forums. Statistics are regularly updated on the Division web site, www.adph.org/aids.

4. QUALITY MANAGEMENT

The mission of Alabama's Ryan White Quality Management and Improvement (QM/QI) program is based on the ideology that it is everyone's responsibility to ensure that all persons living with HIV disease in Alabama and their families have equal access to comprehensive quality HIV care and services. The vision of the State's QM/QI program is to provide a coordinated statewide approach to quality assessment and process improvement to ensure the delivery of HIV care and services meet Public Health Services (PHS) and State guidelines. The

goal of the State quality plan is to encourage participation of all key stakeholders in identifying clinical quality improvements (CQI) and quality improvement (QI) projects that focus on HIV care and service systems in the state and to collect on-going project outcome data to support improvement and funding decisions.

Part 5: Statewide ASOs & Community Service Providers

Even with the DHPC programs, gaps in services still remain. There is still a need to identify individuals who are at greatest risk of infection, unaware of their positive serostatus and not in care. The DHPC, in collaboration with ASOs and other community service providers, attempts to narrow these gaps by 1) increasing the provision of test kits to approved providers; 2) information dissemination about women and perinatal care to providers, especially physicians; 3) implementing a legislatively mandated reporting requirement for viral loads and CD4 counts

to identify HIV positive individuals; 4) expanding linkage services to further track clients beyond the first “kept” appointment; 5) enhancing post-test education of HIV positive clients and their partners; 6) expanding HIV education and testing to populations living in high-risk environments to prevent new infections; improving access to services in rural areas of the State; and, 7) supporting more coordination of services such as transportation, housing, and other daily living needs of HIV positive clients.

The Division of HIV/AIDS and Prevention has partnered with our AIDS Service Organizations (ASOs) and community based organizations (CBOs) to further expand treatment and prevention services beyond the scope of the health department. The following project descriptions written in the provider’s own words will highlight some of the ongoing HIV/AIDS activities conducted by our partners around the state.

Despite decreased funding and an increase in incidence of HIV in Alabama, community efforts highlight a tremendous dedication of many people working everyday across the state to provide prevention and care services. With a focus on diversity, creativity and reaching people where they are, the following represents just a fraction of services that support Alabama’s plan for implementation of the National HIV/AIDS Strategy.

Note: Consumers are persons living with HIV infection.

AIDS Alabama Inc. – Birmingham, AL

Goals

1. Reduce New HIV Infections - AIDS Alabama has 14 different treatment programs - Social Workers and HIV Educators work in all programs to provide at least monthly HIV secondary prevention education sessions as well as HIV counseling to all residents/participants. Ninety percent of all consumers in programs will receive at least six HIV secondary prevention sessions and counseling per year.

2. Increase access to care and improve health outcomes for people living with HIV – Case Management is a central component of all treatment and housing programs provided through AIDS Alabama. The transportation program provides over 24,000 trips annually to over 476 consumers in the Birmingham area to medical and social service appointments.

JASPER House – a State Certified Mental Health Residential Group Home for Adults living with mental illness and HIV/AIDS – served 19 individuals in the last program year. 100% kept HIV clinic primary health care appointments every three months; 100% had HIV case management services; 100% of those entering program without income or mainstream resources were linked to needed services before the end of the year; 100% of those discharged from program went onto permanent housing and were linked with follow-up medical care; 90% saw a staff psychiatrist;

and, 100% received medication assistance from certified medication assistance staff on a daily basis.

LIBCAP – 100 consumers served annually in this program that is focused on serving the homeless population who have both substance abuse and HIV/AIDS diagnoses; 100% receive case management; 100% receive transportation to medical care appointments; 75% saw a psychiatrist at least twice; 18 individuals completed the program and moved on to permanent housing in community.

Homelessness Prevention and Rapid Re-Housing – Operating a grant that covered the entire state – there were 270 individuals in 152 households with least one HIV+ member who were able to go from imminent or actual homelessness to stable housing within this program – since Housing is healthcare, those were 152 individuals who were able to have better access to improved health outcomes.

[Aletheia House – Birmingham, AL](#)

Aletheia House is a private not for profit community-based organization which provides substance abuse treatment and prevention, HIV prevention, transitional housing and permanent affordable housing to chronic low income individuals and their families. Listed below are two examples of the type of housing that is available through *specific programs that include efforts to increase knowledge and to reduce new HIV infections.*

Residential Treatment Programs

- ❖ Residential 66 bed facility. 90 days in length. For chronic substance abusing men who have had 2 prior treatment attempts. Men who are at risk for going to prison are only required to have one prior treatment attempt. Areas of focus would include individual needs, substance abuse, basic living skills to include job readiness and placement and HIV and Sexually Transmitted Disease (STI) education.
- ❖ Mother's Hope-residential 32 bed facility. 90 days in length. For pregnant and post partum women. Areas of focus include individual needs, substance abuse, family dynamics and structure, trauma, basic living skills and HIV and STI education.

Outpatient

- General outpatient program for adult men, who do not need the structure and intensity of inpatient treatment, includes substance abuse and HIV and STI education.
- Women's Hope-an intensive outpatient substance abuse treatment and HIV prevention program for adult women. HIV testing readily available. Funded by SAMSHA.
- Men of Honor 2-an intensive outpatient substance abuse treatment for men who are returning from prison within 24 months.

Prevention Programs

- Kids Who Care and Teens Who Care-a comprehensive substance abuse and violence program. Prevention summer camp program for children and adolescents who live in low-income communities. The camp focuses on increasing protective factors and decreasing risk factors, 8 weeks long.
- Ebony Pearls-a comprehensive HIV prevention program for African American females 14-24 years of age. The program utilizes SISTA, SHiLE and CLEAR interventions. Testing readily available. Funded by CDC.
- Power to Change-an integrated substance abuse, HIV and hepatitis and STI prevention program for males 18-39 that focuses on building skills to reduce behaviors that place them at high risk for HIV, testing readily available. Funded by CSAT.
- Project HOPE – HIV prevention for positive adult men.
- Project CLEAR – HIV prevention for positive adult women.

Specific programs that include efforts of reducing HIV related disparities are:

Employment programs

- ❖ Jobs for Vets - an employment training program for homeless male and female veterans.
- ❖ Work Wise-an employment training program to assist low-income individuals who have not earned a high school diploma an opportunity to complete a clerical training class.

Housing programs

- ❖ 30 subsidized single-family houses for pregnant women and women with dependent children (transitional). Funded by the U.S. Department of Housing and Urban Development (HUD).
- ❖ 18 subsidized beds for chronic substance abusing men (transitional). Funded by HUD.
- ❖ 30 subsidized beds for homeless veterans (transitional).
- ❖ 33 non-subsidized beds for single adult men who have completed a 90-day treatment program (transitional).
22-unit apartment building for persons who complete transitional housing (permanent).
- ❖ 32-unit apartment building opens to the community at large.
- ❖ Home for Hope open to the community at large. 27 single family homes for low-income families.
- ❖ Amberwood Apartments – 104 units of multi-family housing for individuals and families.
- ❖ The Cottages – a newly constructed 20 unit multi-family complex that houses individuals and families with special needs, including HIV positive individuals.

[Birmingham AIDS Outreach – Birmingham, AL](#)

The mission of Birmingham AIDS Outreach (BAO) is to enhance the quality of life for people and families living with HIV/AIDS and to prevent further spread of the disease through age appropriate prevention education programs.

BAO was incorporated in 1985 and was the first nonprofit organization dedicated to providing HIV/AIDS prevention education and services for persons/families living with HIV/AIDS in the State of Alabama and the Birmingham area.

May 1, 2012, BAO introduced an application for smart phones. The app will expand education outreach and be used as a tool to connect with the community even more. BAO is always looking for new ways to reach the community to offer prevention education as well as to urge people to get tested for HIV. The agency is one of the first AIDS Service Organizations to create an app for smart phones. The app is one of the first of its kind and will reach a new range of people. The app is now available in the app store by searching Birmingham AIDS Outreach. The app features...

- Summary of BAO's services
- Information about HIV/AIDS and prevention
- Locate free HIV testing sites with the AIDS Service Organization (ASO) Locator
- A glossary of terms related to HIV/AIDS for quick reference
- Stay up-to-date on BAO events and make reservations from your phone
- Tap to email BAO Staff

All programs at BAO are offered free of charge and include:

*Basic Support Services – Food Bank, clothing, transportation, medication and medical items, GED classes, Case Management, Pet Food in collaboration with The Greater Birmingham Humane Society

*Educational Services – Basic AIDS education, testing services, Youth Advisory Council, HIV prevention education for men.

*Emotional Support Services – Counseling, Friends and family night (dinner/social) Legal Services (Aiding Alabama).

Legal Services: The key goals for Aiding Alabama are, provide access to legal services for all people living with HIV/AIDS in Alabama, educate HIV+ individuals about their legal rights in the State of Alabama, and increase client access to services from all ten AIDS Service Organizations in the state. Long term goals; propose, pass and help implement legislation at the State Legislature for permanency planning alternatives and expand and maintain a referral network of attorneys.

Duration of the project: Aiding Alabama was started in 2006. It continues today as a permanent full time position at Birmingham AIDS Outreach.

Target audience, service area: any HIV+ individual in the State of Alabama and HIV+ individual's family members, children, and spouses/partner. Individuals who are diagnosed with HIV do not experience the disease alone or in a solitary manner. HIV affects those people closest to the person with the diagnosis and the ways in which HIV laws are written, other individuals may be affected legally.

Since 2006, Aiding Alabama has provided legal services to over 600 HIV+ individuals. The scope of legal requests made and legal services provided to HIV+ individuals ranges as follows: Permanency/future planning: Last Will and Testament, Advance Directive for Health Care, HIPAA Authorization, Powers of Attorney; Public benefits planning: applications for and appeals of eligibility for Social Security Disability Income and Supplemental Security Income, Social Security overpayment appeals, public welfare applications and appeals; privacy and confidentiality: filing HIPAA complaints, writing cease and desist letters; Domestic relations: divorce, child custody/visitation/support, paternity suits; Probate law: adoption, eminent domain, administering of will and estate, name change, public recording, guardianship/conservatorship, and commitment proceedings; Family/juvenile: juvenile justice, child custody, protective orders; financial exploitation: issuing cease and desist letters, small claims court, drafting contracts; Employment: wrongful termination, discrimination, workplace harassment, workplace HIV and/or STD testing; Criminal justice: assistance with post-sentencing motions, representation when health and/or HIV status is at issue during incarceration, prisoner's rights (to access adequate health care and legal representation; abuse of human rights and civil liberties); Immigration: providing information about status adjustment, providing information during removal proceedings, providing information on Alabama House Bill 56 (concerning immigration policy); Other rights violations: harassment based on sexual orientation, bullying.

Aiding Alabama represented numerous HIV+ individuals in legal proceedings in each of the following distinct courts or legal systems: Domestic Relations, Family/Juvenile, Probate, Civil Circuit, Civil District, Small Claims, Municipal, Social Security, Alabama Department of Industrial Relations (unemployment compensation), Alabama Department of Human Resources (food assistance division), Alabama Department of Public Safety (driver's license reinstatement), Veterans Affairs, and the Internal Revenue Services. Additionally, Aiding Alabama has assisted HIV+ individuals file motions (post-sentencing) in Criminal Court, and has provided legal materials in Spanish and English to immigrants in removal (deportation) proceedings in Federal Immigration Court.

Examples of Aiding Alabama success/advocacy stories in last three years:

- Represented an HIV+ individual in the first case of its kind on record in Alabama by defending a juvenile in a criminal STD exposure (as opposed to criminal transmission of an STD) case. Prior to this case, there had been no record of this charge having been filed and prosecuted in the state. Aiding Alabama received input from several private practice criminal defense attorneys for defense strategies. BAO Legal also worked with the Juvenile Probation Officer assigned to the case, and negotiated a satisfactory outcome following a full trial (closed to the public, as per all juvenile cases).

- Advocated for an HIV+ immigrant who was transferred from an Alabama correctional facility to a federal immigration detention center in Louisiana by providing legal materials and human rights reports in both Spanish and English, as well as a Spanish-English dictionary. To do so, Aiding Alabama worked with the UAB 1917 Clinic, the ACLU, Human Rights Watch, Amnesty International, HIV Law and Policy Center, US Department of Justice, LSU Pro Bono Law Clinic, Tulane Pro Bono Law Clinic, Loyola Pro Bono Law Clinic, Hispanic Interest Coalition of Alabama, Southern Center for Human Rights, Duke Pro Bono Law Clinic, and attorneys in private practice.
- Restored custody of three children to an HIV+ husband and HIV+ wife through Family Court proceedings lasting over one year, during which time the three children had been removed from parental custody and placed in foster care by the Department of Human Resources.
- BAO Legal gave a presentation on Human Rights and Civil Liberties at the AIDS Alabama Campus to approximately 60 individuals living with HIV/AIDS.
- Intervened on behalf of an HIV+ individual whose status was disclosed in a large workplace setting, resulting in mandatory comprehensive HIV and STD training and sensitivity training for all employees.
- Advocated and visited HIV+ inmates of several Alabama correctional facilities in order to ensure that these individuals have adequate access to medical care/treatment.

Franklin Primary Health Center – Mobile, AL

Project Title: Ryan White Program/Specialty Services

Key Goals Supported:

- Increase access to care and improve health outcomes for people living with HIV, especially in rural areas
- Achieve a more coordinated national response to the HIV epidemic

Project Description:

Franklin’s Ryan White program currently serves consumers throughout Mobile and Baldwin Counties as well as adjacent areas within the region. We provide Outpatient/Ambulatory care which includes a variety of services, such as early intervention services, primary care, vision, OB/GYN, oral healthcare, pharmaceutical assistance, medical case management, and a variety of support services.

In 2010, Franklin opened the Baldwin Family Health Center located in Foley, AL. This center has helped our Ryan White program, as it serves as a corridor to the Latino community in the Baldwin County area. Our Consumer Advocate works closely with the bilingual staff to conduct HIV/AIDS outreach which includes counseling and testing. In 2010, Franklin opened the J. R. Thomas Rehabilitation, Fitness, and Wellness Center. This new addition to Franklin has impacted our patients’ well-being tremendously. The program’s focus is to lower specific health disparities in the community by increasing health awareness and improving access to preventative lifestyle and behavior modification activities. The range of services include

therapeutic exercises, hydrotherapy, minor wound care, strength training, stress prevention/reduction, weight management, support groups, and various other advantageous services. While we have made great strides to meet our patient's needs, we are still open to new and innovative ways to assist our patients in living a healthier lifestyle.

GLBT Advocacy & Youth Services Inc. – Huntsville, AL

Services include support groups for all members of the Gay, Lesbian, Bisexual, Transgender and Queer community. Educational information and condom distribution are provided at the meetings and during community outreach in order to raise awareness, improve and increase prevention in our community.

Health Services Center Inc. (HSC) - Anniston, AL

Project REAL (Reentry Education And Linkages)

(Service Area – the 14 counties of N.E. Alabama designated as Public Health Areas V and VI) - Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) 2008-2013, as part of the Minority AIDS Initiative (MAI).

This project focuses on the provision of prevention services to minority adults returning to their community after being incarcerated. The evidence-based intervention chosen for this population is Comprehensive Risk Counseling Services – CRCS, which provides enrollees with 5-7 intensive, individual, prevention counseling sessions to develop a personal prevention plan to reduce the risk of HIV infection and to eliminate or reduce substance use. Annual goals include enrolling 100 persons per year in the CRCS intervention and outreach services including distribution of at least 35,000 pieces of prevention educational materials and safer sex supplies to an additional 6,000 persons per year. Additional goals include cross systems training for law enforcement and correctional facilities and providers in our service area; providing in-service sessions for professionals in the reentry field. A primary annual goal of the REAL Project is the facilitation of a regional conference on reentry; and after 3 years the conference has grown to an attendance of over 150 persons both consumers and providers and over 25 vendor/provider exhibit tables.

The Vortex Project

(Service Area – the 14 counties of N.E. Alabama designated as Public Health Areas V and VI) - 2010-2015, funded by SAMHSA, this five year MAI initiative will focus on substance abuse and HIV prevention services to minority young adult populations, especially African American women (ages 19-24) at Historically Black Colleges and other campuses in the N.E. Alabama service area of HSC.

Vortex currently collaborates with Jacksonville State University, Talladega College, and Gadsden State Community College for prevention activity and HIV testing and awareness events. The project is implementing the 2-Session intervention called RESPECT, which

provides HIV testing and counseling, plus an opportunity for the young adult enrollee to return for a second prevention counseling session within 30 days for additional information and support. A goal of Vortex is the use of a mobile testing vehicle (RV) for on-campus testing and awareness events, such as student-led awareness exhibits, football “tailgating” events, etc. Vortex staff provides support to a peer/student led Project Advisory Committee (PAC). PAC students add to the project’s success by reviewing all project materials, leading on-campus awareness events, volunteering at project events such as World AIDS Day, and helping to recruit fellow students for RESPECT services. Throughout the year, Vortex staff provides brief street outreach to an additional 5,000 persons on and around college campuses, and distributes educational materials and safer sex supplies.

The Revolution Project

2010-2015 - (Service Area – the 14 counties of N.E. Alabama designated as Public Health Areas V and VI) - Funded by SAMHSA, this five year MAI initiative will focus on substance abuse and HIV prevention services to minority young adult populations, especially African American women (ages 19-24) and their sexual and/or drug using partners in communities of color. The project’s environmental strategy is the operation of a “drop-in center” in downtown Anniston, Calhoun County. The staff is implementing the 2 session evidence-based intervention entitled RESPECT to provide HIV testing and counseling services to the targeted population and their friends, partners and social networks. The Revolution Center offers project participants, and the community at large, a safe and friendly place to receive prevention services, watch educational videos, receive prevention counseling, and pick up educational and safer sex materials. The center is located in an area accessible by the city’s trolley system, and within walking distance of the local homeless shelter, local churches, and the soup kitchen. Using minority young adult women from the community as a Project Advisory Committee (PAC) the center has been decorated and furnished to offer a culturally appropriate and pleasing environment for young women to gather and receive services. Additional efforts to reach out to the chosen population and provide a community-wide impact includes the use of digital billboards that flash prevention and HIV testing messages on a main thoroughfare through Anniston (983 ads per day). The center is open daily for the community to access services, gather to play cards or a prevention related game, with the 3rd Tuesday designated as a late night to allow for increased access to HIV testing services after work.

Legal Services Alabama, Montgomery, AL

HIV/AIDS REACH PROGRAM

Target audience, service area: low-income HIV+ individuals in the State of Alabama and HIV+ individual’s family members, children, spouses/partner; and those who are affected by HIV/AIDS. The program was started in 2010. It continues today as a permanent full time position at Legal Services Alabama.

The scope of legal requests made and legal services provided to HIV+ individuals ranges as follows: permanency/future planning: Last Will and Testament, Advance Directive for Health Care, HIPAA Authorization, Powers of Attorney; public benefits planning: applications for and appeals of eligibility for Social Security Disability Income and Supplemental Security Income, Social Security overpayment appeals, and public welfare applications and appeals; privacy and confidentiality: filing HIPAA complaints, writing cease and desist letters; family/domestic relations: divorce, child custody/visitation/support, protective orders; probate law: adoption, name change, guardianship/conservatorship; financial exploitation: issuing cease and desist letters, bankruptcy, defending against garnishment, defending in small claims actions; employment: wrongful termination, discrimination, workplace harassment, unemployment compensation; housing: eviction defense.

Goals:

Goal A: To provide free civil legal services to all low-income persons living with HIV/AIDS, their immediate family members, and those affected by HIV/AIDS in Alabama.

Goal B: Create and foster partnerships within the State of Alabama to improve access to legal services for those living with and affected by HIV/AIDS.

Goal C: Educate AIDS Service Organizations (ASO), those living with or affected by HIV/AIDS and members of the community who serve those living with HIV/AIDS on legal issues confronting the HIV/AIDS community.

Medical AIDS Outreach - Montgomery, AL

Medical AIDS Outreach of AL, Inc. (MAO) is a private, non-profit, Community Based AIDS Service Organization that was established in 1987. MAO serves 26 counties in central and southeast Alabama which covers over one third of the state which is heavily rural and has limited access to healthcare. Over 60% of the individuals who receive treatment services through MAO are at or below the poverty level. MAO is dedicated to providing services for those infected and affected by HIV and to offering HIV/AIDS treatment, prevention and educational services. It has transitioned from a volunteer education and service organization to a full-time primary care facility. Clients can access both medical and social services at our Montgomery and Dothan locations, and rural clinics located in Auburn, Clayton, Greenville, Selma and Troy. MAO has well established partnerships with community health and federally qualified health centers.

Alabama eHealth, an Access to Care Initiative of Medical AIDS Outreach of Alabama, funded by AIDS United and the Social Innovation Fund supports the NHAS goals, “increase access to care and improve health outcomes for people living with HIV especially in rural areas and reduce HIV related disparities.”

Medical AIDS Outreach of Alabama is completing the first year of a three-year Access to Care grant in collaboration with AIDS Action Coalition (Huntsville) and Whatley Health Services (Tuscaloosa). The project created telemedicine clinics at three remote rural clinic sites during

the first year and expands to additional rural sites in subsequent years. The project offers improved access to care for rural patients in Alabama, reduces the burden of transportation barriers, and leverages the expertise of HIV specialty providers.

Telemedicine allows the provider to be in “two places at once” magnifying the impact of limited resources. The provider is available at the telemedicine “hub” site (i.e. Montgomery, AL) and interacts with the patient and on-site nurse at the “spoke” site (i.e. Selma, AL). This project offers pharmacy adherence visits, Hispanic translation services and plans to expand to mental health services for our rural HIV patients. With a disparate number of rural minority patients at or falling below poverty levels, better access to health care can improve the disproportionate negative impact of HIV on rural Alabama communities. Because treatment has been researched as an effective prevention mechanism (people on treatment are 96% less likely to transmit the virus,) better access to care can create a decline in the incidence of new infections in underserved communities.

Case management services are provided by social workers who service MAO’s clients and their families. Funds are available for housing assistance through the Housing Opportunities for Persons with AIDS (HOPWA) program. Social workers can assist clients with such needs as food bank services, emergency financial assistance and social support. MAO also provides HIV education, testing and mental health counseling to patients and family members. MAO reaches migrant workers through a Linguistic Service Specialist. HIV testing and education are provided to migrant workers in central and southeast Alabama.

Educational programs are designed to meet the diverse needs of groups such as churches, schools, civic organizations and government agencies. MAO has designed programs for youth, adolescents, adults, and seniors.

Southwest AIDS Training & Education Center - Birmingham, AL

SEATEC-Alabama (local performance site affiliated with the regional, Southeast AIDS Training & Education Center based at Emory) exists to assist all licensed health care providers (HCPs) in the State of Alabama with identifying training opportunities and consultation services that enhance their capacity to offer state-of-the-art HIV diagnostics, care and treatment options. This service supports an increased access to care and improved health outcomes for people living with HIV. Health Care Providers are educated in the prevention of at-risk behaviors that could lead to HIV transmission which helps to reduce new HIV infections.

Alabama ATEC provides training and technical assistance (TA) to support, motivate, and educate a diverse group of providers. ATEC targets Ryan White Program-funded providers serving hard-to-reach and underserved populations. This service supports a reduction in HIV related health disparities across the state of Alabama.

In conclusion, Alabama ATEC is designed to improve the dissemination of new information to multidisciplinary HCPs through expert clinical consultation, intensive clinical rotations and preceptorships, workshops, hands-on supervised clinical experience and technical assistance to achieve a more coordinated national response to the HIV epidemic.

UAB Acute HIV Detection Laboratory, Birmingham, AL

Expanded HIV Testing Program – Historically Black Colleges & Universities, (HBCUs) is a 3-year project servicing African–American college students. The project covers Alabama’s 15 HBCUs and offers free comprehensive HIV/STI testing for gonorrhea, Chlamydia, syphilis, acute HIV infection and chronic HIV infection.

Key Goals

- Reduce new HIV infections by encouraging routine HIV testing
- Increase access to care and improve health outcomes for people living with HIV
- Reduce HIV related disparities by increasing awareness among disproportionately affected communities
- Improve sexual health by emphasizing the importance of comprehensive HIV/STD testing

The University of Alabama at Birmingham (UAB) Expanded HIV Testing Initiative

The UAB Department of Emergency Medicine (UED) kicked-off an expanded HIV testing initiative in August 2011 with the primary goal of offering a free, confidential HIV test to all patients ages 19-65 years. This project is jointly supported by the Centers for Disease Control and Prevention (CDC), and the Alabama Department of Public Health (ADPH).

The UAB 1917 Clinic is a critical component of UAB’s expanded HIV testing initiative, as all UED patients diagnosed with HIV are referred to the UAB 1917 Clinic for linkage-to-care services. The primary goal of the UAB 1917 Clinic’s linkage-to-care service includes linking all UED patients diagnosed with HIV into treatment and counseling services.

To achieve these goals, significant investments were made in the UED’s infrastructure, including the addition of electronic UED triage questions to determine patients’ HIV testing history and eligibility for HIV testing, automated HIV test orders, additional laboratory technicians devoted to managing HIV testing demands, sensitivity training for UED physicians regarding disclosing positive HIV test results, redundant protocols for referring HIV+ patients to the UAB 1917 Clinic, and encrypted databases used to report HIV testing data to 1917 Clinic partners who complete data collection on HIV+ patients and “push” all HIV testing data to the DHPC. In addition to enhanced data sharing capabilities, the UAB 1917 Clinic also made significant investments in its infrastructure to achieve its goal of linking all UED patients diagnosed with HIV into treatment and counseling services. Specifically, the UAB 1917 Clinic hired a Linkage-

to-Care Coordinator devoted to following up with UED patients diagnosed with HIV and linking these patients to treatment and counseling services.

Unity Wellness Center - Auburn, AL

Unity Wellness Center's (UWC) mission is in alignment with the National HIV/AIDS Strategy set forth in 2010, to reduce the number of people who become infected with HIV. UWC conducts counseling, testing, outreach and prevention education programs for populations and locations that exhibit risk behaviors for contracting HIV in Lee, Macon, Chambers, Russell and Tallapoosa counties. UWC collaborates with colleges, schools, churches and other community partners to increase the awareness of why testing is critical to stopping the spread of HIV.

In May of 2011, Unity Wellness Center opened a HIV Primary Care Clinic in Auburn, Alabama to reduce the waiting list of HIV+ individuals waiting to get into care, thereby increasing access to care and optimizing health outcomes for people living with HIV. By providing HIV Primary Care, the clinic staff in collaboration with our social workers provides medical and supportive services that reduce HIV-related health disparities. Our goal is to prevent infections where possible and to treat our HIV+ patients so they are less likely to spread the virus to another.

In 2011, UWC provided 232 individuals with a range of services including medical treatment, diagnostic labs, specialty appointments, oral health, mental health, access to HIV medications, post-test education, medical and non medical case management, housing and transportation. Additionally UWC tested 311 individuals, educated 414 youth and 840 adults on prevention, provided 47 clients with housing assistance and reached out to 1493 residents on HIV awareness.

West Alabama AIDS Outreach - Tuscaloosa, AL

The mission of West Alabama AIDS Outreach (WAAO) is to promote a healthy, aware, and compassionate community through EDUCATION, SUPPORT, SERVICE, and ADVOCACY for people living with or affected by HIV/AIDS. Currently, WAAO provides services to Tuscaloosa, Lamar, Fayette, Bibb, Pickens, Greene, Hale, Walker, Perry and Sumter Counties.

WAAO provided comprehensive case management services to 221 individuals in 2011. These services included medical supervision, transportation, housing, and provision of food and hygiene items, emergency financial assistance, and group counseling services. WAAO also provided prevention education to over 4,000 individuals (the majority of whom reside in areas considered to be high-risk) and free HIV testing to over 700.

In 2011, WAAO implemented the Rural Testing Program of West Alabama. The goal of this program is to provide HIV testing to at least 600 individuals in rural West Alabama over a one-year period. Testing is being conducted in Walker, Hale, Fayette, Bibb, Lamar, Greene, Pickens, Perry, and Sumter Counties. During the year, 619 individuals were tested.

In the same year, WAAO also developed the Liaison Program. The Liaison, a client with deep ties to many WAAO clients and to the community in general, was hired in order to contact clients deemed ‘difficult to contact’. The Liaison Program was designed to increase the rate at which specific WAAO clients made contact with Case Managers and increase client attendance at the HIV clinic. In the first 6 months of the program, 93 of 102 ‘difficult to contact’ clients were successfully contacted, made face-to-face contact with their Case Manager, and attended an appointment at the HIV clinic.

In 2011, WAAO began property management services for clients after a benefactor donated 3 homes to WAAO for clients. Through this service WAAO was able to house the following clients: 1) a female client, her husband, and his disabled mother who were previously living in subpar housing with an abusive family member, 2) a female client with a history of substance abuse issues who was previously living in a drug-infested community, and 3) a male client working out-of-county whose commute from his previous home cost him over \$150 weekly in gas alone.

Part 6: Community Responses to the National AIDS Strategy

A survey was distributed to HIV Community Network members. The state HIV Program Coordinators schedule the meetings and serve as chair and consultant to the members. The Coordinators distributed the surveys to solicit a direct response regarding HIV prevention and treatment in a variety of communities across the state. A total of 50 members completed the survey.

1. Reduce new infections.

Do you feel this goal has been met in your community? Yes – 29 No – 19

- There is still a need to reach the African American community.
- Based on the latest statistics of ADPH, it doesn’t seem to be slowing down.
- I think we are making progress; however, we continue to see new cases weekly.

- I think it is important that we continue to educate the community through testing and education.
- There may in fact be an overall reduction, but my major concern is the younger age of individuals that are being newly diagnosed with HIV.

2. Increase access to care and improve health outcomes for people living with HIV.

Do you feel this goal has been met in your community? Yes - 44 No – 6

- I think health care facilities are doing a good job. I think people need to take responsibility and the initiative to protect their self.
- There is a lot of room for improvement.
- The drug assistance program can only assist a fraction of the population.
- We recently got a new doctor in our community. The clinic had not had a doctor for years.
- Yes, I feel like more people know about health care and are accessing it.
- Agencies across the state have provided care to hundreds of individuals to lengthen and better their quality of life.
- Telemedicine has increased access to care.

3. Reduce HIV-related disparities, health inequities and stigma?

Do you feel this goal has been met in your community? Yes - 28 No – 24

- Discrimination is very prevalent
- We have much better resources than before, but stigma and limited funding is still a battle.
- If education is the key to reducing disparities and stigma we have made major steps
- Sadly, stigma is largely prevalent in all areas of the south.
- I think this goal has been met, but stigma associated with HIV is still in people’s minds and even after they receive education they still have negative reactions to HIV and being around people with HIV.
- Stigma is one goal that has improved. People do not seem to be as afraid as when HIV was first discovered.
- HIV is still seen as some “Gay” disease
- No, not enough money for medications, counseling and medical services
- People are still viewing HIV as “death sentence” and a disease of “unhealthy lifestyle” therefore it is still not talked about openly.

4. People in the rural communities are still not comfortable with talking about HIV because of the stigma that is related to it.

Tell us how you feel Alabama has grown in HIV community involvement for prevention and treatment issues.

- Alabama has strong community-based organizations that provide care and counseling to HIV infected individuals. The CBO’s also offer screening opportunities to the community.

- An increased emphasis is visible in the areas of education, prevention and support. However, an emphasis on younger students is needed.
- I think there is definitely a heightened sense around the need for HIV prevention in the State of Alabama. With that said, I feel we fall far from meeting the need where funding for treatment, access to drugs and funding for mental health and social services needs are concerned. I feel for too long this disease has been an after-thought of the administrations over the years and thus the Legislature has not seen the need to increase funding annually in its budget cycles.
- Alabama has grown through the HIV prison release initiative and reporting of HIV sexual offenders involved in cases of rape.
- Community Network Groups have provided an opportunity for more health related organizations to become more aware of HIV/AIDS.
- For prevention every effort is being made to promote community awareness, the Peer Mentor program has made it easier to get clients involved in their treatment and be aware of the importance of adherence.

Part 7: Additional Innovative Solutions

1. Statewide Training Calendar

In order to increase the communication and training opportunities between providers and the community a statewide training calendar has been designed and launched on the Division of HIV/AIDS Prevention and Control's web site, www.adph.org/aids. This web based communication tool will allow everyone working in the field of HIV to communicate with each other about HIV/AIDS activities being held across the state. The HIV web site and calendar will serve as a link to other educational and testing services throughout the state.

For those persons without access to the internet, ADPH provides regional and community-based communication system that works at the local level. Through public service announcements,

community awareness campaigns and printed brochures, education resources are available for everyone. This new approach will be a more efficient, streamlined and coordinated across Alabama.

2. HIV/AIDS Stigma Survey

The DHPC, in collaboration with the University of Alabama at Birmingham, Department of Health Care Organization and Policy is proposing to disseminate (pending approval) a survey to healthcare employees titled “The Finding Respect and Ending Stigma around HIV (FRESH) Study.” Survey results will provide the basis for continuing education workshops and training opportunities.

The University of Alabama recently announced a multiyear grant that will examine the role that African -American faith based congregations play in reducing HIV/AIDS stigma in rural Alabama. The overall goal of the project, "Faith-Based Anti-Stigma Intervention toward Healing HIV/AIDS," or Project FAITHH, is to decrease both individual stigma and community wide stigma in the targeted churches. This new initiative clearly addresses the goals of the NHAS in reducing stigma. According to Dr. Pamela Foster, Principal Investigator of the grant, "We know from previous research that HIV-positive persons value spirituality in their overall healing process." "However, they have often not become active members of rural congregations because of the stigma. We hope to turn that around with the study."

3. Medical AIDS Outreach Telemedicine Project

Alabama eHealth, an Access to Care Initiative of Medical AIDS Outreach of AL, funded by AIDS United and the Social Innovation Fund supports the NHAS goals, “increase access to care and improve health outcomes for people living with HIV especially in rural areas and reduce HIV related disparities.”

Medical AIDS Outreach of Alabama is completing the first year of a three-year Access to Care grant in collaboration with AIDS Action Coalition (Huntsville) and Whatley Health Services (Tuscaloosa). The project created telemedicine clinics at three remote rural clinic sites during the first year and expands to additional rural sites in subsequent years. The project offers improved access to care for rural patients in Alabama, reduces the burden of transportation barriers, and leverages the expertise of HIV specialty providers. Telemedicine allows the provider to be in “two places at once” magnifying the impact of limited resources. The provider is available at the telemedicine “hub” site (i.e. Montgomery, AL) and interacts with the patient and on-site nurse at the “spoke” site (i.e. Selma, AL). This project offers pharmacy adherence visits, Hispanic translation services, and plan to expand to mental health services for our rural HIV patients. With a disparate number of rural minority patients at or falling below poverty levels, improved access to health care can improve the disproportionate negative impact of HIV on rural Alabama communities. Because treatment has been researched as an effective

prevention mechanism (people on treatment are 96% less likely to transmit the virus,) better access to care can create a decline the incidence of new infections in underserved communities.

4. Birmingham AIDS Outreach (BAO) App

May 1, 2012 BAO introduced an app for smart phones. The app will expand education outreach and be used as a tool to connect with the community even more. BAO is always looking for new ways to reach the community to offer prevention education as well as to urge people to get tested for HIV. Birmingham AIDS Outreach is one of the first AIDS Service Organizations to create an app for smart phones. The app is one of the first of its kind and will reach a new range of people. The app is now available in the app store by searching Birmingham AIDS Outreach. The app features...

- Summary of BAO's services
- Information about HIV/AIDS and prevention
- Locate free HIV testing sites with the AIDS Service Organization (ASO) Locator
- A glossary of terms related to HIV/AIDS for quick reference
- Stay up-to-date on BAO events and make reservations from your phone
- Tap to email BAO Staff

5. Community Health Worker's (CHW)

Alabama faces a series of challenges in prevention and care in HIV/AIDS. Lack of primary care physicians, coupled with lack of transportation create serious barriers to health care that are often hard to overcome. CHWs working in rural Alabama could greatly assist in reducing stigma, which is a major barrier to care. This program clearly demonstrates an excellent example of what can be done to achieve the goals of the NHAS. Analysis of Medicaid claims reveals a 16% net savings in total medical expenditure two years after enrollment. This is attributed to a 35% reduction in length of stay and inpatient costs. Recent state experience suggests that States and Medicaid programs are increasingly using community health workers to expand the health care safety net to reach underserved populations.

The DHPC, in collaboration with the AIDS Service Organizations is proposing to create a statewide network of community client/patient navigators (promotora (o) - Spanish) or CHW using the Prevention and Access to Care and Treatment (PACT) Model. Since 1997, PACT has recruited and trained CHWs to work with the most vulnerable HIV/AIDS patients in Boston, individuals who suffer from mental illness, substance use, stigma and poverty and who are dying despite readily available care and life-saving medications. CHW accompany patients as they reclaim their health, improve their disease-management skills, develop meaningful relationships with the healthcare system, and improve their wellbeing. For two decades, Partner's In Health has hired and trained community health workers (CHW) as a solution to these problems. In addition to the CHW PACT trains middle management supervisors of the CHWs and provides training for the employees who create the systems of prevention and treatment services, and

organizational intervention. One year post-enrollment in PACT’s HIV program, 70% of patients witness significant improvement in their health (viral load suppression and CD4 improvements).

Utilizing the PACT Model as a systems approach to HIV prevention and care in Alabama would be a start to addressing many of the unmet needs and structural barriers. Persons from within the community hired as client/patient navigators/promotora (o) (CPN), who know their community, can bridge the gap by creating a working atmosphere of trust. CPN would assist with prevention education, testing, linkage, retention and re-engagement to medical care services. CPN would be able to avert a health crisis before it starts thus saving thousands of dollars in Emergency Department visits and hospitalizations per year. The CPN would be similar to the health department’s Peer Mentors. Since this will be a statewide network, they will meet as a group at scheduled times during the year for additional training and support. This network will be coordinated by a DHPC employee.

Part 8: Division of HIV/AIDS proposed Actions and Recommendations

To support the overall goals of the National HIV/AIDS Strategy (NHAS), Alabama has developed proposed sub-goals and strategies.

NHAS Goal 1: reducing the number of people who become infected with HIV;

Alabama Sub-Goal	Strategies
<p><u>Routine HIV screening in clinical settings</u></p> <p>Increase the number of Alabama residents who receive HIV screening as part of their medical care.</p>	<ol style="list-style-type: none"> 1. Work with key stakeholders to create recommendations for third party payers and Alabama’s Insurance Administration related to reimbursement in order to maximize HIV screening. 2. Provide training, capacity building and technical assistance to providers to increase routine HIV testing /screening in clinical settings. 3. Support expanded HIV testing in federally qualified health centers (FQHCs) located in

<p><u>Targeted HIV testing in non-clinical settings</u></p> <ol style="list-style-type: none"> 1. Ensure HIV testing resources are focused on the most effective geographic areas, settings, agencies and testing strategies. 2. Increase HIV testing among the populations at greatest risk for HIV infection. 	<p>high prevalence areas.</p> <ol style="list-style-type: none"> 1. Increase utilization of epidemiological and surveillance data for program targeting. 2. Increase accountability for HIV testing resources (both funding and rapid test kits) through enhanced program monitoring. 3. Work with CDC -supported HIV testing programs to develop strategies to increase reach to high-risk populations. 4. Continue to fund community-based organizations for new/expanded outreach testing programs serving the populations at greatest risk for HIV infection. 5. Increase coordination of HIV testing programs.
<p><u>Decrease the number of perinatally acquired pediatric HIV cases</u></p> <ol style="list-style-type: none"> 1. Increase the percentage of pregnant women who receive HIV testing during their first trimester. 2. Increase the percentage of women at high-risk for HIV infection during pregnancy who receive repeat testing in the third trimester. 3. Increase the percentage of women who present for labor and delivery with undocumented HIV status who receive rapid testing. 4. Increase the percentage of women at high-risk for HIV infection during pregnancy who receive rapid testing in labor and delivery (regardless of maternal HIV testing history). 	<ol style="list-style-type: none"> 1. Continue to work with the AIDS Education and Training Center (AETC), the state’s medical society, the Regional Perinatal Advisory Groups and the Family Health Administration (FHS) to educate perinatal providers regarding Alabama laws and regulations for HIV testing during pregnancy and clinical recommendations. Work with the AETC, medical providers and FHS 2. FHS to develop and disseminate guidelines for repeat testing in the third trimester for women at high risk for HIV infection during pregnancy. 3. Work with the AETC, Medical Society, and FHS to develop and disseminate guidelines for rapid HIV testing in labor and

	<p>delivery (regardless of maternal HIV testing history) for women at high risk for HIV infection during pregnancy.</p> <p>4. Continually assess, monitor, and work to improve service systems and community resources for women, infants, and families using an action-oriented community process.</p>
<p><u>Initial and ongoing HIV/STI partner services</u></p> <p>1. Increase the number of newly-diagnosed HIV-positive persons who are provided with HIV/STI partner services.</p> <p>2. Increase the quality and effectiveness of HIV/STI partner services.</p>	<p>1. Increase the availability of trained HIV/STI partner services field staff.</p> <p>2. Increase supervision staff in jurisdictions with the highest morbidity to ensure appropriate oversight and management of HIV/STI partner services.</p> <p>3. Increase staff at PHPA for HIV partner services program monitoring and quality assurance.</p> <p>4. Transition to PRISM, a statewide integrated HIV/STI data system customized to meet local STI surveillance and HIV/STI partner services data collection, data management, program implementation, program monitoring and quality assurance needs.</p> <p>5. Conduct provider outreach and education with private providers and Medicaid MCOs in high prevalence areas.</p>

NHAS Goal 2: increasing access to care and improving health outcomes for PLWHAs;

Alabama Sub-Goal	Strategies
<p><u>Ensure people who are newly diagnosed HIV-positive and those not in HIV care enter HIV health care by collaborating with HIV Testing and Linkage to Care programs and facilitating connections to care and support services.</u></p> <p>Increase the percentage of HIV-positive clients who are successfully linked to HIV medical care and support services.</p>	<p>1. Support additional linkage-to-care staff to assist clients in accessing HIV medical care and support services, and maintaining ongoing HIV care.</p> <p>2. Provide training on evidence-based linkage-to-care models to linkage-to-care staff.</p> <p>3. Increase coordination between HIV testing programs, linkage-to-care programs and HIV care providers to support effective referral and linkage to care.</p> <p>4. Support linkage-to-care staff to maintain contact with newly identified HIV-positive individuals referred into care to ensure the client has attended at least two medical appointments before closing the linkage-to-</p>

	care case.
<p><u>Improve health outcomes by ensuring access to comprehensive, high quality, culturally competent health care for all persons living with HIV/AIDS, emphasizing the importance of retention in care, treatment adherence support, and prevention with HIV-positive individuals.</u></p> <ol style="list-style-type: none"> 1. Increase the percentage of HIV-positive clients who are engaged in ongoing, comprehensive HIV medical care and support services. 2. Increase the percentage of HIV-positive clients who are adherent to their antiretroviral treatment regimen. 3. Ensure that PLWHA are linked to appropriate medical and social services. 4. Ensure timely and on-going access to life-saving medications for all uninsured and underinsured persons living with HIV/AIDS in Alabama 	<ol style="list-style-type: none"> 1. Support additional case management staff to assist clients in remaining engaged in ongoing HIV medical care and adherent to antiretroviral treatment regimens. 2. Train providers in best practices for treatment adherence support. 3. Implement system-level utilization of HIV surveillance data, including CD4 and viral load results, to (a) increase our ability to effectively prioritize and properly assign HIV partner services and linkage-to-care (LTC) staff follow-up activities, and (b) trigger active follow-up on clients who have fallen out of HIV medical care, with a focus on Alabama’s six high morbidity areas: Lowndes, Montgomery, Hale, Chambers, Jefferson and Conecuh counties. 4. Continued investment in Alabama’s strong HIV care delivery system, including a safety net system of care provided through Ryan White funds, a state-funded pharmacy assistance program (PAC), a high-risk insurance plan for those with pre-existing conditions (Alabama Health Insurance Plan), Medicaid, the Alabama AIDS Drug Assistance Program (MADAP). Currently, any person with HIV & an income up to 500% of the federal poverty level has free access to all available antiretroviral medications.
	<ol style="list-style-type: none"> 5. Provide mental health, substance abuse treatment, psychosocial support, non-medical case management, medical nutritional counseling, housing assistance, transportation, and emergency financial assistance, and treatment adherence services through the Ryan White care system.
<p><u>Expand provision of risk assessment and risk reduction interventions for PLWHA in partnership with HIV care providers</u></p> <ol style="list-style-type: none"> 1. Increase the percentage of PLWH who receive ongoing risk assessment and risk reduction counseling (when applicable) as part of HIV medical care and support services. 2. Increase the percentage of high-risk PLWH 	<ol style="list-style-type: none"> 1. Provide education and training to HIV care staff on skills for assessing risk and providing client-centered risk reduction counseling. 2. Increase the availability of individual and group-level behavioral interventions for high-risk persons living with HIV.

<p>who receive intensive behavioral interventions to support them in reducing their high-risk sexual and needle-sharing behaviors.</p>	
<p><u>Increase condom distribution and social marketing/education efforts targeted to PLWHA and persons at highest risk for HIV infection</u></p> <ol style="list-style-type: none"> 1. Increase the number of condoms distributed to HIV-positive persons and persons at the highest risk of acquiring HIV infection. 2. Utilize social marketing campaigns to: Increase knowledge of HIV transmission and prevention strategies; Build perception of HIV risk among African Americans; Encourage African Americans to know their HIV status; Combat HIV stigma; and Increase awareness of the availability of HIV prevention, care and treatment services. 3. Increase knowledge of HIV transmission and prevention strategies, and increase awareness of the availability of HIV prevention, care and treatment services. 	<ol style="list-style-type: none"> 1. Increase the number of agencies and sites distributing condoms to HIV-positive persons and persons at highest risk of acquiring HIV infection. 2. Implement the Greater Than AIDS, and Know-Manage-Live Campaign. 3. Purchase and distribute culturally, developmentally and linguistically appropriate HIV/AIDS educational materials in the Identified high HIV morbidity areas.
<p><u>Increase HIV testing and risk reduction interventions with HIV-negative persons at high risk for HIV infection</u></p> <ol style="list-style-type: none"> 1. Ensure that resources for behavioral interventions for HIV-negatives persons are targeting to persons at highest risk for HIV infection. 2. Maximize the reach of HIV prevention interventions for HIV-negative persons at highest risk for HIV infection. 3. Increase the number of Alabama residents who receive HIV screening as part of behavioral health services (mental health and substance abuse). 	<ol style="list-style-type: none"> 1. Partner with Health Education/Risk Reduction (HERR) providers to more effectively target HERR interventions for HIV-negative clients to persons at highest risk for HIV infection. 2. Expand the implementation of brief, evidence-based interventions with evidence of effectiveness for HIV-negative persons in high-risk communities and populations. 3. Use funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to work with substance abuse and mental health providers to establish protocols to integrate risk assessments, risk reduction counseling/interventions, and HIV testing services into existing services.

NHAS Goal 3: reducing HIV-related health disparities.

Alabama Sub-Goal	Strategies
<p><u>System-wide coordination of HIV prevention and care services</u></p> <p>Increase collaboration between HIV prevention and care across all Ryan White parts and with other service providers.</p>	<p>Convene monthly meetings that include statewide HIV prevention and care staff, statewide HIV surveillance staff, and representatives from Ryan White Parts A, B, C and D to share information on existing services and initiatives and to explore opportunities to increase coordination and collaboration between HIV prevention and care services.</p>
<p><u>Reduce disparities in access and services among affected subpopulations and historically underserved communities</u></p>	<p>Using epidemiological data, specifically target testing and other resources to high incidence/prevalence communities and racial and ethnic minorities disproportionately impacted by HIV/AIDS.</p>

Implementation plans and specific objectives in support of these sub-goals and strategies are described in Alabama’s HIV prevention and health services funding applications. These applications are developed annually and submitted to CDC and HRSA for HIV prevention and HIV health services funding, respectively.

Part 9: In collaboration with the Alabama HIV/AIDS Policy Partnership (AHAPP), ADPH proposes the following Policy Actions and Recommendations

The Alabama HIV/AIDS Policy Partnership (AHAPP) is a statewide advocacy coalition dedicated to improving Federal, State, and local policies that impact Alabamians living with or at risk for HIV/AIDS. The partnership consists of state legislators, public health officials, directors from all nine AIDS Service Organizations, leading HIV physicians, pharmaceutical representatives, and advocates living with HIV.

INTRODUCTION

As we enter the fourth decade of the epidemic, Alabama continues to be disproportionately impacted by HIV/AIDS. Alabama’s HIV infection rate ranked 12th in the nation in 2010, despite the state ranking only 23rd in the U.S. for population size. The Centers for Disease Control and Prevention estimated that 788 Alabamians were diagnosed with HIV in 2010. According to the Alabama Department of Public Health, the proportion of people living with HIV/AIDS in

Alabama increased 32.4% from 2007 to 2011. More than 18,000 Alabamians have been diagnosed with HIV/AIDS since 1982.

EXPANDING ACCESS TO CARE, TREATMENT AND SUPPORTIVE SERVICES

Priority 1: Ensure that critical components of the Patient Protection and Affordable Care Act are implemented in ways that meet the care and treatment needs of Alabamians living with HIV/AIDS

Systemic challenges involving access to care and health insurance coverage remain a public health crisis for people living with HIV/AIDS and other chronic conditions in Alabama. This crisis is characterized by high rates of the uninsured, restrictive Medicaid eligibility requirements, and barriers to accessing routine health care. The Patient Protection and Affordable Care Act (ACA) include a number of provisions that greatly expand access for uninsured and underinsured Alabamians living with HIV/AIDS.

- A. Medicaid Expansion:** The most notable change for HIV systems of care under the ACA is the potential expansion of Medicaid. Alabama's current Medicaid program has highly restrictive eligibility criteria and a limited benefits package for those who are able to qualify. In fact, Alabama's income eligibility standard for families (approximately 11.5% FPL) is the lowest in the nation. Beginning in January 2014, Alabama will have the opportunity to expand its Medicaid program to include most individuals less than 65 years of age living below 133% FPL. This expansion is estimated to result in a 37% increase in Medicaid enrollment.

In June 2012, the U.S. Supreme Court ruled that the mandatory expansion of Medicaid exceeds federal power to require states to comply with federal regulations. Consequently, the Department of Health and Human Services (HHS) cannot withdraw all federal funding should Alabama refuse to expand its Medicaid program. However, the ACA provides substantial incentives for Alabama to expand its program. For instance, the federal government will pay for the overwhelming majority of the costs of the expansion, including 100% of the funding for those people who are newly eligible until 2016 and at least 90% thereafter. This is still well above the 68% federal share for current enrollees. The Urban Institute has estimated that over the first six years, expanding Medicaid will cost Alabama \$600 million but will bring in over \$10 billion new federal dollars. Moreover, the cost of the state share of newly eligible will be offset by the savings realized in reduced spending on uncompensated care. Over this same period, Alabama will see savings in uncompensated care of \$400 to \$860 million.

Federal: The Department of Health and Human Services (HHS) must ensure that both newly eligible and previously eligible Medicaid beneficiaries have access to a benefits package that meets the care and treatment needs of persons living with HIV/AIDS and other chronic conditions. Furthermore, HHS should ensure that the application and enrollment systems for Medicaid are simple and coordinated with the Ryan White Program.

State: The Governor and the Alabama Legislature must expand the state’s Medicaid program, pursuant to the ACA, extending eligibility to all individuals living under 133% FPL. The Alabama Legislature should work to reduce fragmentation of care, expand access to community-based services, and increase the quality and efficiency of services by expanding Patient Care Networks across Alabama.

- B. Essential Health Benefit Package:** In 2014, thousands of people living with HIV/AIDS will have access to insurance, many for the first time. But to be meaningful, insurance coverage must include the comprehensive services that people living with HIV/AIDS need to stay healthy. Services that play a vital role in effective management of HIV disease include comprehensive prescription drug coverage, preventive services such as routine HIV testing, routine access to medical providers and appropriate laboratory testing, chronic disease management services, and mental health and substance abuse services. Such services are necessary to ensure that people living with HIV/AIDS are diagnosed early, stay in regular care and treatment, and realize the lifesaving benefits of HIV treatment.

The ACA requires both Medicaid plans and private health insurance plans sold on state-based insurance exchanges to provide a minimum set of essential health benefits (EHB). The law includes ten broad categories for the EHB: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavior health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care. These ten mandatory categories of services, as well as the explicit protections against discrimination, were meant to guard against insurance underwriting practices that can be used to discourage enrollment by people living with HIV/AIDS and other chronic, expensive conditions, leaving these populations without access to medically necessary care and treatment.

Federal: The Department of Health and Human Services (HHS) should enforce the anti-discrimination provisions of the ACA and ensure that implementation of the essential health benefits requirement includes protections for people living with HIV/AIDS and other chronic conditions.

State: The Alabama Department of Insurance (Commissioner Ridling) and other state officials should ensure that the state’s EHB package will provide comprehensive coverage of the essential care and treatment services needed by people living with HIV/AIDS.

- C. Alabama Insurance Exchange:** In 2014, states are required to operate “exchanges,” regulated marketplaces where consumers can compare and purchase health insurance coverage. The Department of Health and Human Services (HHS) has already published several comprehensive proposed regulations indicating that many key details for exchange design and implementation will be left to the discretion of the states.

Federal: The HHS should minimize interruptions in care and treatment for persons living with HIV/AIDS by ensuring simple application procedures and effective coordination between the exchanges, Medicaid and Ryan White providers.

State: The Alabama Department of Insurance and other state officials should design an exchange that includes Ryan White providers in the network as well as patient navigator programs that support outreach to Alabamians living with HIV/AIDS and other vulnerable populations.

Priority 2: Maintain a safety net to cover gaps in services and affordability for Alabamians living with HIV/AIDS by reauthorizing the Ryan White Program

The Ryan White Program has saved the lives of thousands of people with HIV/AIDS in Alabama. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first enacted to address the devastating HIV tragedy and mortality of the 1980s. It has been reauthorized four times since 1990 (1996, 2000, 2006, and 2009), each time evolving to accommodate for new and emerging needs within the community. Notably, the 2006 reauthorization mandated the inclusion of both HIV and AIDS cases in the funding formula, assuring for the first time that funding would follow the shift of the epidemic to the South.

As Americans prepare for historic health care reform in the United States with the implementation of the ACA, the Ryan White Program must once again evolve. However, the Ryan White Program will continue to be an irreplaceable safety net for the nearly 12,000 Alabamians currently living with HIV/AIDS.

Federal: Congress should reauthorize and adequately fund the Ryan White Program. The Health Resources and Services Administration (HRSA) should evaluate the scope, content, and framework of the program in order to meet the otherwise unmet care, treatment, and service needs of persons living with HIV/AIDS. Finally, AHAPP calls for Congress to preserve the more than two decades of valuable experience and expertise of the Ryan White clinic through adequate Medicare and Medicaid reimbursement rates.

State: The Alabama Legislature to adequately fund the Alabama AIDS Drug Assistance Program (ADAP) in fiscal year (FY) 2014.

Priority 3: Increase safe, affordable housing opportunities for Alabamians living with HIV/AIDS.

Federal: Congress and the U.S. Department of Housing and Urban Development (HUD) should target the current HIV epidemic by realizing the HOPWA funding formula based on living HIV/AIDS cases, poverty rates, and local Fair Market Rent (FMR).

State: AHAPP and ADPH calls for the Alabama Legislature to identify a dedicated revenue source for the Alabama Housing Trust Fund.

PREVENTING NEW HIV AND OTHER STI INFECTIONS

Priority 1: Expand Access to HIV Prevention and Testing Services.

The Alabama Department of Public Health estimates that between 2,000 and 4,000 Alabamians are living with HIV but are undiagnosed. According to recent studies, over 50% of new infections are attributable to people who are unaware of their status. People who are HIV positive must be made aware so that they may take steps to avoid transmitting the virus to others. Further, HIV treatment, itself, can prevent transmission. Specifically, when someone is diagnosed with HIV, engaged in care, adherent to an antiretroviral regimen, and virally suppressed, they are up to 96% less likely to transmit the virus. Accordingly, the Centers for Disease Control and Prevention (CDC) recommends that HIV screening be a part of routine medical care for all patients between the ages of 13 and 64.

The ACA makes critical investments in prevention, wellness, and public health activities to improve public health surveillance, community-based programs, and outreach efforts. Specifically, the law requires new private health plans to cover those services rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF), eliminates Medicare cost-sharing for A and B rated services, and provides a one percent increase in federal matching payments for preventive services in Medicaid for states that offer coverage with no patient cost sharing for A and B rated services. The USPSTF currently differs from the CDC in its recommendations for HIV screening. While the USPSTF recommends HIV screening for those at increased risk for HIV infection and for pregnant women, it has not yet provided a recommendation for routine HIV screening more broadly.

Federal: AHAPP and ADPH calls for the U.S. Preventive Services Task Force (USPSTF) to give routine HIV screening a Grade A recommendation.

State: AHAPP and ADPH calls for the Alabama Department of Insurance and other state officials to cover routine HIV testing under the state’s essential health benefits (EHB) package.

Priority 2: Improve Sexual Health Education for Young People

Alabama currently has the highest rate of sexually active high school students in the nation. According to the CDC’s 2011 Youth Risk Behavior Survey, 57.7% of high school students in Alabama have had sexual intercourse, and more than 40% of those students failed to use a condom during their last sexual encounter. While the overall number of new HIV infections is relatively stable in Alabama, the proportion of those infections among young people is increasing. Currently, one in three new HIV infections in Alabama occurs in young people between the ages of 13 and 24 years (ADPH Quarterly Statistics, Third Quarter 2012), and many others are undiagnosed. In fact, the CDC estimates that nearly 60% of young people with HIV are unaware of their status. Further, rates for gonorrhea and Chlamydia are among the highest in

the nation (5th and 6th highest in 2010, respectively), and young people are approximately five times more likely to be infected than the general population in Alabama. Persons under the age of 24 accounted for 69% of new gonorrhea infections and 75% of new Chlamydia infections in 2010.

Despite the alarming rate of HIV and other STIs among the state's youth, Alabama fails to mandate any sexual health education coursework for its primary and secondary public school students. If a school elects to provide sexual health education, however, Alabama law requires the curriculum to emphasize abstinence until marriage (Ala. Code § 16-40A-2). In addition, schools that teach sexual health education must condemn homosexual conduct as a "criminal offense" that is "not acceptable to the general public." Unfortunately, abstinence-only programs have been proven ineffective and neglect to address the more than 125,000 high school students who are already sexually active in Alabama.

Federal: AHAPP and ADPH call for Congress to set forth a policy vision for comprehensive sexual health education.

State: AHAPP and ADPH call for the Alabama Legislature to support an inclusive learning environment where all students feel safe and protected by removing from the minimum contents all references to "homosexuality" and "homosexual conduct." Also, the Alabama State Department of Education should evaluate and approve a list of evidence-based sexual health education curricula for use in school throughout the state.

Priority 3: Increase Funding for HIV Prevention Education Specifically

A central tenet of the *National HIV/AIDS Strategy for the United States* is that all Americans should be educated about the threat of HIV and how to prevent it. The strategy emphasizes that "HIV awareness and education should be universally integrated into all educational environments" and that "educating young people about HIV before they begin engaging in risk behaviors that place them at risk for HIV infection should be a priority." Although Alabama state law does not require the teaching of sexual health education, a resolution adopted by the Board of Education in 1987 does require that students in grades five through 12 receive instruction about HIV/AIDS through a health education program.

AIDS Service Organizations (ASOs) play a critical role in helping Alabama's schools comply with the mandate to provide HIV/AIDS education. Additionally, the CDC's Division of Adolescent and School Health (DASH) provides funding and technical assistance that enables state and local education agencies to deliver HIV prevention programs in Alabama's schools. As a result of these efforts, 86% of Alabama's students were taught about HIV/AIDS in 2011, slightly above the national average of 83.7%.

Federal Target: AHAPP calls for Congress to increase federal funding for the Division of Adolescent and School Health (DASH).

State: AHAPP calls for the Alabama Legislature to increase the Education Trust Fund budget allocation for HIV prevention education to \$400,000 in fiscal year (FY) 2014.

PROTECTING LEGAL & HUMAN RIGHTS

Priority 1: Reduce stigma and discrimination by opposing efforts to criminalize HIV/AIDS at all levels of government.

According to the *National HIV/AIDS Strategy for the United States*, “working to end the stigma and discrimination experienced by people living with HIV is a critical component to curtailing the epidemic.” However, 34 states perpetuate stigma with criminal statutes based on perceived exposure to HIV. Further, prosecutions for alleged exposure to HIV have occurred in at least 39 states, including Alabama.

These criminalization statutes reinforce misperceptions about the routes and risks of HIV transmission, fuel fear and myths about people living with the disease and, ultimately, undermine the public health goals of promoting HIV screening and treatment.

Priority 2: Improve future planning options for families living with HIV/AIDS and other chronic conditions

The Governor of Alabama’s Commission on Children, Youth and Adults has identified the issue of AIDS orphans as a growing problem in the State. Historically, states have offered limited options for terminally ill parents. They can opt to designate a legal guardian in their will, or they can transfer parental rights through an adoption or guardianship prior to their death. In recent years, the legal issues surrounding a custodial parent’s right to choose a future caregiver have become increasingly complex. Medical advances have prolonged the lives of people infected with HIV. However, their uncertain life spans, punctuated by intermittent periods of sickness and good health, have complicated traditional legal arrangements.

Standby guardianship laws, originally designed in response to the AIDS crisis, allow custodial parents to make future care plans that do not take effect until circumstances require, removing the requirement that the guardian immediately assume custody, care, and control of the minor. In addition, it permits a parent to testify and participate in a court adjudication of the factual issues involved in the appointment of the guardian. This mechanism would enable parents to grant temporary custody to a person of their choosing. In other words, the custodial parent is putting the chosen guardian on “standby.” In the event of recovery, custody reverts to the parent. If the parent dies, custody passes to the predetermined guardian with court approval.

Standby guardianship would allow parents to plan for their children’s future without sacrificing any parental rights. In the Adoption of Safe Families Act, Congress urged all states to adopt standby guardianships. However, standby guardianships are currently unavailable in Alabama.

Conclusion:

HIV is a complex epidemic that requires all of us to address this critical state and national public health issue. This *Federal Implementation Plan* includes timelines for actions supporting the high-level priorities outlined in the strategy. This approach reflects a commitment to act with the urgency that the HIV/AIDS epidemic requires. Federal agencies will strive to take the steps described in this plan and take other steps to work with other partners to advance the goals of the *National HIV/AIDS Strategy*. The Federal Government, however, is only one of component of the broad effort needed to improve our response to the domestic epidemic. New partnerships and a commitment to better coordination and improved accountability will help us move forward.

With governments at all levels doing their parts, a committed private sector, and leadership from people living with HIV and affected communities, Alabama and the United States can dramatically reduce HIV transmission and better support people living with HIV and their families.

See Attachment 2 for Alabama plan endorsements.



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