

**State of Alabama
Ryan White HIV/AIDS**

Statewide Coordinated Statement of Need (SCSN)

and

HIV/AIDS Comprehensive Plan

2012 - 2015

Submitted to:

**The U.S. Department of Health and Human Services,
Health Resources and Services Administration,
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Submitted By:

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INTRODUCTION

Purpose and Expectations

The purpose of the *Statewide Coordinated Statement of Need (SCSN)* is to provide a collaborative mechanism to identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWH/As); and to maximize coordination, integration and effective linkages across Ryan White (RW) funding Parts. Goals outlined in the SCSN are used to: (1) set measurable objectives, (2) inform resource allocation decisions, (3) update the state *Comprehensive Plan (CP)*, and to guide activities by all providers to improve HIV care and service delivery statewide.

The SCSN is to identify broad goals and critical gaps in life extending care needed by people living with HIV/AIDS (PLWH/As) who are both in and out of care. The Early Intervention of Individuals Living with HIV/AIDS (EIIHA) Initiative is a legislative requirement that focuses on (1) individuals who are unaware of their HIV status, (2) how to bring HIV positive individuals into care and (3) linking HIV negative individuals to services in an effort to keep them HIV negative. Beginning in 2012, needs of individuals who are unaware of their HIV status are to be included in the SCSN and CP.

The HIV/AIDS Bureau (HAB), Division of Service Systems (DSS) expects RW Part B grantees to submit an updated SCSN and CP plan every three years. This document contains Alabama's updated SCSN and CP for the next three year planning cycle 2012-2015 submitted to the Health and Resources Administration (HRSA) on June 15, 2012.

I. PARTICIPATION IN THE DEVELOPMENT OF THE SCSN

Language in section 2617(b)(6) of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) requires grantees to conduct activities to enhance coordination across all RW Parts to ensure a collaborative process to update the SCSN and CP on a three year planning cycle.

To meet HRSA requirements every effort was made to include multiple participants and resources in the updating process to ensure the collection of significant data and diverse viewpoints to provide an informative as well as comprehensive overview of HIV care and service needs and gaps in services in Alabama.

The Alabama Department of Public Health (ADPH), the Bureau of Communicable Disease and Prevention, and the Division of HIV/AIDS Prevention and Control (Division) would like to thank everyone who offered their time and resources to participate in Alabama's SCSN and CP development and updating process.

Acknowledgements

Over 500 HIV Consumers who participated in the AIDS Alabama 2010 Consumer Survey
Peer Mentors serving through the Minority AIDS Initiative (MAI grant)
Alabama's Consumer Advisory Board (ACAB) Representatives
RW Part C and D funded clinic Representatives
RW Part B funded clinics and AIDS Service Organization (ASO) Representatives

Professionals from other state agencies offered valuable data in their comprehensive plans and publications referenced in Alabama's 2012 SCSN and CP documents to describe the state's diverse population, varied socio-economic backgrounds; and specific care and service needs included:

- The Division of Rural Health
- The Office of Minority Health
- The Division of Health Disparities
- The State TB Division
- The State STI Division
- The State Immunization/Hepatitis Division
- The Department of Mental Health and Substance Abuse
- The Alabama Center for Health Statistics
- The United Way of Central Alabama

The Division of HIV/AIDS Control and Prevention staff actively participated in the updating process included:

- The HIV/AIDS Surveillance Branch
- The Quality and Evaluation Branch
- The Education and Information Branch
- The HIV/AIDS Peer Mentor Consultant
- The HIV/AIDS Prevention Branch
- The Prevention Nurse Coordinators
- The HIV/AIDS Direct Care Branch

II. PROCESS FOR THE DEVELOPMENT OF THE SCSN

Grantees are expected to use needs assessments and comprehensive plans to identify cross cutting issues and barriers to care identified by all RW funding Parts to form the foundation of the SCSN. The Division, as Alabama's RW Part B grantee, is responsible for guiding the State's SCSN and CP updating process. Since the early years in Alabama's HIV epidemic, the Division has nurtured relationships with state and community partners to gain acceptance as a recognized leader and partner in reducing the spread of HIV disease. The ADPH, through the Division, sets program policies and provides guidance, technical assistance and financial support to AIDS service organizations (ASOs), the University of Alabama medical and hospital systems, the University of South Alabama medical and hospital systems, select Primary Care affiliates, fifteen Historically Black Colleges and Universities(HBCUs), the State STD program; and other public and private partnerships. Alabama's system of HIV/AIDS programs is supported by ADPH through a network of direct care and prevention services. A wide range of those affected/infected, agency representatives and other interested community partners including the HIV Prevention Community Planning Groups (CPG) participate in the State's annual Direct Care and Prevention Collaborative meeting that has evolved into the recognized forum for the State to conduct direct care and prevention planning activities. The Collaborative meeting is an annual state event to bring Consumers, other

stakeholders from HIV Prevention and Direct Care, and community partners together to participate in the needs assessment process. The Collaborative also provides an opportunity for participants to identify challenges the HIV/AIDS epidemic raises, and to discuss ideas to improve the effectiveness and coordination of HIV care and services in Alabama across all RW funding Parts.

The Division supports Consumer participation in the State Prevention Community Planning Group (CPG) and through the Alabama Consumer Advisory Board (ACAB) by sponsoring an annual state Consumer Conference to focus specifically on Consumer issues. The ACAB consists of Consumers from across the state representing various Public Health Areas (PHAs). Consumers participate in the local consumer group to brainstorm ideas, discuss community needs, advocate for medical/dental and social services, and offer support to newly diagnosed persons. ACAB representatives participate in local prevention network meetings, consortia meetings, patient advisory board meetings and consumer advocacy meetings. The ACAB also provides a voice for consumer issues at the state level by participating in state community planning, primary and secondary prevention activities and direct care service planning.

ADPH also supports the Peer Mentor Program through the State's Minority AIDS Initiative (MAI) grant. The program consists of Peer Mentors representing PHAs across Alabama. Peer Mentors play an important role in providing education; and offering referrals and linkages to care and services for other PLWH/As in the state. Because Peer Mentors are very knowledgeable about HIV care and services offered in their local areas, including gaps in HIV care and services, they are important participants in the State's SCSN and CP updating process.

Consumer data presented in *AIDS Alabama's 2010 Consumer HIV Needs Assessment Survey* is an important resource used each three-year planning cycle to guide the development of HIV care and service goals presented in the SCSN, and to provide the framework for developing plans to improve care and services presented in the CP.

The HIV/AIDS Division Surveillance Branch operates an active surveillance program for both AIDS and HIV infection reporting to collect extensive area specific epidemiological data used by each CPG, funded care and service agencies; and planning groups to develop prevention interventions, and to plan HIV care and services. Surveillance is responsible for the development of the State's HIV/AIDS epi profile. *The Alabama 2011 Epidemiological Profile* is an important resource used to update Alabama's SCSN and CP every three-year planning cycle.

III. HRSA EXPECTATIONS

HAB defines a continuum of care as, *"An integrated service network that guides and tracks clients through a comprehensive array of clinical, mental, and social services in order to maximize access and outcomes."* The purpose of this section is to identify population in most need of HIV care and services in Alabama. This section will also describe barriers to care, and provide an overview of the current state of HIV healthcare and service delivery to include progress made in meeting previous goals as well as shortfalls in meeting planned goals.

SECTION I WHERE ARE WE NOW?

a. A Description of Populations With HIV/AIDS in Alabama Including the Epi-Profile

According to Kaiser State Health Facts, Alabama's estimated total population in 2011 was 4,660,300 residents. Greater than 26% of the state's population is reported to be younger than 19 years of age, and 14% is reported to be 65 or older. The remaining 60% of people in the state are ages 20 to 64. The state's median age is 37.8 years old. The incidence of HIV infection in Alabama between the ages of 13-44 is over 81%, with over 60% of those being male. Men account for nearly 74% of all cases in the state. Ninety-one percent of all HIV infections in Alabama are reported as African-American males (45.22%), White males (26.16%), and African-American females (19.82%). Although African-Americans comprise 26.4% of the state's population, they represent over 65% of the HIV/AIDS cases.

Alabama ranks 42nd among US states in per capita income with 23% reported living in poverty. In December 2011, Alabama's unemployment rate was 8.1% compared to the 8.5% rate in the US. New infections are disproportionately occurring in Alabama's Black population (68.35%) and young people under the age of 34 (56.85%). Increased longevity due primarily to positive HIV/AIDS treatment outcomes; as well as increased testing, have significantly stressed Alabama's public health care system and resources to keep up with the care and service needs of an increasing number of HIV residents living both in the State's urban and rural areas.

Considered primarily rural with 55 of the 67 counties located outside of the state's major population centers, Alabama's agricultural 'Black Belt' and Delta region counties, located in the western and southwestern part of the state respectively, encounter some of the highest HIV incidence rates, as well as the highest poverty and unemployment rates in the State. Though only representing 13.25% of the state's population, the 'Black Belt' region has reported 22.8% (3574) of all cases.

Alabama's population can be divided into 3 population groupings: Major, Minor, and Rural. The Major Urban population centers include (Huntsville-Birmingham-Montgomery and Mobile). These Major Urban centers represent 34.2% (1,636,632) of the State's population, and 69.7% (10,912) of the HIV/AIDS cases reported in the state. Alabama's Minor Urban centers (population < 200,000) comprise 24.2% (1,156,292) of the State's population, and 13.9% (2179) of the reported cases. The third population grouping belongs to the State's rural areas that make up 41.6% (1,987,792) of the population, and account for 23.8% of cases reported.

Alabama continues to experience an HIV/AIDS epidemic of moderate magnitude when contrasted to the experience of other states. This epidemic has affected persons in all gender, age, race, ethnicity, socioeconomic groups, and every county in Alabama. However, the effect has not been the same for all groups. Recent trends suggest a shift in the HIV/AIDS epidemic toward Black males and Black females, and high-risk heterosexual activity. With the number of deaths among people diagnosed with HIV/AIDS continuing to decline, and the number of people living with HIV/AIDS continuing to increase, it is extremely important to identify

those populations most affected and most at risk for HIV infection to plan for HIV/AIDS prevention and care, and allocation of limited resources.

As of December 2011, HIV infection has been reported in over 15,000 Alabama residents, but only over 10,000 of these people are still living. It is likely that between 2,000 and 4,000 additional Alabama residents are also infected and unaware of that infection.

Between 1982 and 2011, 17,858 Alabama residents had been diagnosed with HIV/AIDS and reported to the Alabama Department of Public Health (ADPH). Of those reported, 67.1% (12,189) were known to be living at the end of 2011. Currently 33.78% of the prevalent HIV/AIDS cases are between the ages 25-34 years and 28.06% live in Public Health Area IV.

Seven hundred and nineteen Alabamians were diagnosed with HIV/AIDS and reported to ADPH in 2011. Furthermore, the rate of HIV/AIDS diagnosed among Blacks (38.4/100,000) was more than seven times higher than among Whites (5.3/100,000).

Black females accounted for 78% (131) of the HIV/AIDS cases diagnosed among females in 2011. The rate of HIV/AIDS diagnosis for Black females (19.4 per 100,000) was higher than both White females (1.6 per 100,000) and White males (9.1 per 100,000).

Black males represented 65.8% of the HIV/AIDS cases diagnosed among males in 2011. The rate of HIV/AIDS diagnosis among Black males (60.2/100,000) was more than six times higher than White males (9.1/100,000).

In 2011, the rate of HIV/AIDS diagnosis was highest in Lowndes (53.10), Montgomery (38.37), Hale (38.07), Chambers (35.07), Jefferson (31.44) and Conecuh (30.24) counties. Among Blacks in 2011, heterosexual sex and male-to-male sex (69.9%) were predominate modes of exposure (excluding no identified risk). Among Whites, predominate mode of exposure reported was male-to-male sex (60.7%).

HIV clinics and service organizations make application to ADPH for RW Part B funding to provide HRSA defined core service priorities and support services with appropriate justification based on HRSA's 75/25 requirement. Funding decisions are made using a formula based on Alabama's current HIV/AIDS Epidemiologic Profile, service utilization and unmet need data.

Social workers/Case managers and Clinicians employed in the State's RW funded HIV clinics and service organizations are responsible for the coordination of direct care and service delivery. HIV care and services in Alabama are primarily located in the State's urban areas, however, alternate care and services are offered at satellite clinics located in many rural areas across the State.

As of December 2011, Alabama's ADAP offers medication services with an enrollment cap of 1700 and a waiting list for applicants to receive medication services. The ADAP formulary offers 72 medications including at least one from each class of HIV medications to remain in compliance with HRSA funding requirements. In addition, 13 "Other Medications" are available that include hepatitis medications.

The Integrated Epidemiologic Profile provides information about the current HIV/AIDS epidemic in Alabama. This profile describes the socio-demographic, economic and geographic characteristics of people living with HIV/AIDS and at risk for HIV infection in Alabama. The profile is a resource for guiding prevention interventions and service delivery efforts; to justify and obtain funding for the implementation of prevention and service programs, and to improve and evaluate HIV-related programs and policies in Alabama. (The *Alabama 2011 Epidemiological Profile* is included in the SCSN- Attachment 1)

The profile is divided into 5 key sections:

1. What are the socio-demographic characteristics of the general population for Alabama?
2. What is the scope of the HIV/AIDS epidemic in Alabama?
3. What are the indicators of risk for HIV/AIDS infection in Alabama?
4. What are patterns of utilization of HIV/AIDS services?
5. What are the number and characteristics of persons who know they HIV positive, but are not receiving primary medical care?

Data Sources

Data was compiled from a variety of sources. Anyone citing or interpreting data should acknowledge that the data sources have strengths and limitations.

HIV/AIDS Surveillance Data

ADPH has been collecting confidential AIDS and HIV information since 1982 and 1987 respectively. Standardized case report forms are used to collect socio-demographic information, mode of exposure, laboratory and clinical information and vital stats. HIV data may underestimate the number of recently infected individuals because some infected persons have not been tested and do not know they are infected. In addition, newly diagnosed cases may be reported to the health department at any point during the clinical spectrum of disease. Therefore, HIV infection provides an estimate of the number of persons known to be HIV infected.

STD Case Reporting

The ADPH Division of STD Control conducts statewide surveillance to determine the number of reported cases of STDs and to monitor trends. Services provided by the Division of STD Control include partner counseling and notification to help reduce the spread of STDs, referral services for examination, treatment, and social services. Cancroids, Chlamydia, gonorrhea, HIV, and syphilis are reportable STDs in Alabama. STD surveillance data can serve as a surrogate marker for unsafe sexual practices and demonstrate the prevalence of changes in a specific behavior. STD data are widely available at the state and local level. Because of shorter incubation periods between exposure and infection, STDs can serve as a marker of recent unsafe sexual behavior. In addition, certain STDs (e.g. ulcerative STDs) can facilitate the transmission or acquisition of HIV infection. Finally, changes in trends of STDs may indicate changes in characteristics of persons who delay testing, or who are not tested at all.

Birth and Death Data

The Center for Health Statistics for the ADPH receives information on all births and deaths occurring in Alabama. The birth certificate includes demographic information on the newborn

and the parents, insurance status, prenatal care, prenatal risk factors, maternal morbidity, mode of delivery, pregnancy history, and clinical characteristics of the newborn. Death certificates include demographics, underlying cause of death, and contribution of selected factors to death. The data can be used to determine the number of deaths related to HIV/AIDS across the state or in a specific area. Deaths resulting from or whose underlying cause was HIV/AIDS might be under reported on a death certificate. Clinical information related to HIV/AIDS may be missing.

U.S. Bureau of the Census

The Census Bureau collects and provides information about the people and economy of the United States. The Census Bureau's website (<http://www.census.gov/>) includes data on demographic characteristics (e.g. race, ethnicity, gender, age) of the population, family structure, educational attainment, income level, housing status, and the proportion of persons who live at or below the poverty level. State and county-specific data (e.g. reports on population changes) are easily accessible, and links to other websites with census information are included.

State Healthcare Access Research Project (SHARP)

The project details the successes, challenges, and opportunities for healthcare access in Alabama. The Health Law Clinic of Harvard Law School and the Treatment Access Expansion Project (TAEP) with support and collaboration from Bristol-Myers Squibb conducted the project. The purpose of the project is to provide a tool to bring healthcare to more people living with HIV/AIDS.

Direct Care Update Report

The HIV/AIDS Direct Care and Services Branch oversees Alabama's RW Part B program activities that includes medical and social services, medical and non-medical case management and Alabama's AIDS Drug Assistance Program (ADAP). Alabama's HIV care and service providers make application for RW funding to provide HRSA defined core medical and support services, and are funded based on a formula that is calculated using agency documented patient population. ADAP's goal is to reduce associated morbidity and mortality among HIV infected persons by delaying the progression of HIV disease through prevention and treatment of HIV disease.

Alabama's Enhanced Referral Tracking System (ERTS)

Alabama's Enhanced Referral Tracking System (ERTS) provides significant data in determining the demographics and location of Alabama residents who know their HIV/AIDS status and are not in care.

Youth Risk Behavior Surveillance Survey (YRBSS)

The YRBSS is a self-administered questionnaire given every two years to a representative sample of students in grades 9 – 12 at state and local levels. In Alabama, the survey is administered at the state level and includes questions related to sexual behavior and drug use. The YRBSS is a standardized questionnaire, so comparisons can be made across participating jurisdictions.

Jurisdictions may also add questions of local interest. However; because the YRBSS project relies upon self-reported information, sensitive behavior information may be under or over reported. Because the YRBSS questionnaire is administered in school, the data are representative only of adolescents who are enrolled in school and cannot be generalized to all adolescents. For example, students at highest risk, who may be more likely to be absent from school or to drop out, may be under-represented in this survey, especially those in upper grades. In interpreting this data in regards to HIV/AIDS, it is important to note that the questionnaire does not include questions about homosexual or bisexual behavior.

The Socio-Demographic Characteristics of Alabama's General Population

Population

The U.S. Census Bureau estimates of the population of Alabama for 2011 was 4,660,300. Alabama is composed of 67 counties. County populations ranged from a low of 9,045 persons (Greene County) to the most populated county, Jefferson, with 658,466. The newly-defined, seven county "Birmingham-Hoover MSA" was defined in 2003 as encompassing Bibb, Blount, Chilton, Jefferson, St. Clair, Shelby and Walker counties and represents over one million persons and 24.2 percent (1,128,047/4,660,300) of Alabama's population. The state is considered largely rural with four large metropolitan statistical areas (MSAs): Birmingham-Hoover, Huntsville-Decatur, Mobile, and Montgomery.

Demographic Composition

The 2010 U.S. Census Bureau count reflects that the racial and ethnic composition of Alabama was 68.5% White, 26.2% Black, 3.9 % Hispanic, 1.1% Asian, and 0.6% Native American.

Age and Sex

In 2010, the median age of Alabamians was 37.8 years. More than 34% of the population was younger than 24 years old, and 13.8% of the population was 65 or older. The female to male ratio in the total population was 1.06.

Poverty, Income, and Education

The median household income in the state of Alabama for 2011 was \$40,976; ranking Alabama 46th in the nation. Personal income in the state was 42nd in the ranking at \$33,516. As indicated in AmericasHealthRankings.org 2011 data, people with lower income tend to experience higher incidence of illness and death. Twenty-eight percent of households received Social Security income. In 2010, 23% of all Alabamians were living below the poverty level. Thirty-two percent of children less than 18 years-of-age were living below the federal poverty level. That places Alabama as 39th in the national rankings for children living in poverty. Fourteen percent of people age 65 years and older were reported living below the poverty level. Unemployment in the state was ranked 31st nationally at 9.5. Twenty-one percent of all families and 38.5 percent of families with a female head of household and no husband present had incomes below the poverty level. The 2010 census reported that 82.1% of Alabama residents age 25 years and older attained a high school diploma or higher with 21.9% reporting a bachelor's degree or higher. Among the same 25-year and older age group, 6.2% reported less than a 9th grade education and 11.7% reported some high school without graduation.

DEMOGRAPHICS

In 2010, the population of Alabama was 4,660,300 persons (Table 1). The largest proportion of the population was 24-44 years and 44-64 years of age (~26% overall). It should be noted that the distribution of age among men and women was similar i.e. 48.5% to 51.5% respectively. However, the proportion of women aged ≥ 65 years was significantly higher than that of their male counterparts i.e. 57.6 to 42.4 respectively.

Table 1 Percentage Distribution of the General Population by Age Group and Gender, Alabama, 2010

Age group (yrs)	Males	%	Females	%	Total Population	%
	2320188		2461981		4785298	
<5	155196	6.7%	149644	6.1%	304840	6.4%
5-14	320516	13.8%	306923	12.5%	627439	13.1%
15-24	342342	14.8%	335763	13.6%	678105	14.2%
25-44	604687	26.1%	624560	25.4%	1229247	25.7%
45-64	620967	26.8%	664878	27.0%	1285845	26.9%
≥ 65	279609	12.1%	380213	15.4%	659822	13.8%

Source: Center for Business and Economic Research, The University of Alabama 2010

Note: Percentages may not sum 100% due to rounding.

The collection of race and ethnicity information was expanded in the 2000 census to allow persons the opportunity to report belonging to more than one race, as well as to report Hispanic ethnicity. Despite this expansion, more than 70.3% of Alabama's population reported themselves as non-Hispanic whites (Table 2). Non-Hispanic Blacks comprised 26.4% of the population, with Hispanics, Native Americans, and Asians constituting approximately 3.3% of the total population.

Table 2 Percentage Distribution of the General Population by Race/Ethnicity and Gender, Alabama, 2010

Population Race/Ethnicity	Males	%	Females	%	Total Population	%
	2323317		2461981		4785298	
White, not Hispanic	1656912	71.3%	1707553	69.4%	3364465	70.3%
Black, not Hispanic	588483	25.3%	673858	27.4%	1262341	26.4%
Hispanic	34703	1.49%	35271	1.43%	69974	1.46%
Native American	16854	0.73%	16154	0.66%	33008	0.69%
Asian	26365	1.13%	29145	1.18%	55510	1.16%

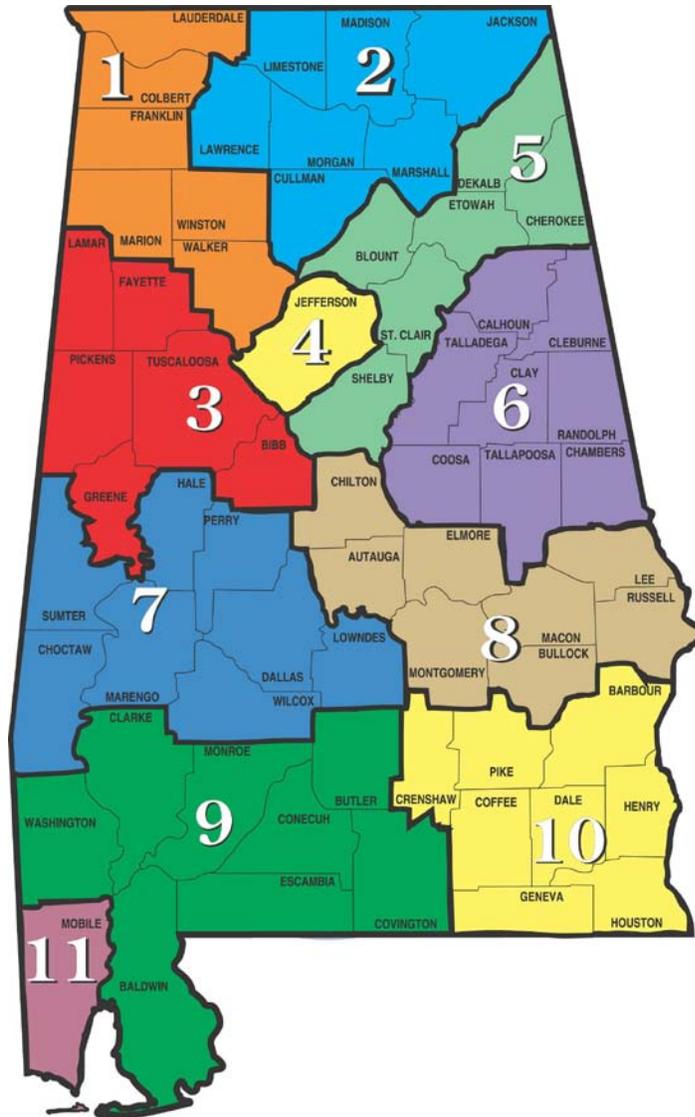
The State of Alabama is divided into eleven public health areas (PHAs) for the purpose of public health planning and disease intervention (Figure 1). PHA II has the largest combined population and is composed of seven counties. PHA IV, a one county PHA, has the second largest population of all the PHAs. PHA VII is the least populated. The proportion of persons across Alabama reporting themselves as White ranges from a low of 1.5% in PHA VII to 18.9% in PHA II (Table 3).

Table 3 Percentage distribution of the General Population by Race/Ethnicity and Public Health Area, Alabama, 2010

PHA	White	%	Black	%	Hispanic	%	Other	%	Total Population	%
PHA I	260144	86.4%	24281	8.1%	10463	3.5%	6236	2.1%	301124	6.3%
PHA II	606127	75.9%	111824	14.0%	45756	5.7%	34367	4.3%	798074	16.7%
PHA III	183765	66.1%	81536	29.3%	7121	2.6%	5745	2.1%	278167	5.8%
PHA IV	340213	51.7%	275511	41.8%	25488	3.9%	17254	2.6%	658466	13.8%
PHA V	444985	82.8%	46379	8.6%	31366	5.8%	14798	2.8%	537528	11.2%
PHA VI	239121	70.3%	85088	25.0%	8727	2.6%	7114	2.1%	340050	7.1%
PHA VII	48593	34.3%	90637	63.9%	1233	0.9%	1326	0.9%	141789	3.0%
PHA VIII	356247	56.3%	233376	36.9%	22699	3.6%	20118	3.2%	632440	13.2%
PHA IX	263566	73.4%	74203	20.7%	10187	2.8%	11050	3.1%	359006	7.5%
PHA X	217737	68.0%	79330	24.8%	12626	3.9%	10407	3.3%	320100	6.7%
PHA XI	243904	59.1%	142272	34.4%	9936	2.4%	16880	4.1%	412992	8.6%
Total	3204402	67.0%	1244437	26.0%	185602	3.9%	145295	3.0%	4779736	100.0%

Source: The University of Alabama Center for Business and Economic

Figure 1 Alabama Public Health Area



According to the 2010 census statistics, the distribution of race/ethnicity varied in Alabama counties with populations of more than 200,000 (Table 4). In Jefferson County, 53.0% of the population indicated their race/ethnicity as White, non-Hispanic compared with 68.2% in Madison County, 60.2% in Mobile County, and 39.5% in Montgomery County. Montgomery County reported the highest proportion of Black, non-Hispanics (54.7%). Madison County reported the highest proportion of Hispanics (4.6%). Less than 1% of the state’s population reported themselves as Native American.

Race/Ethnicity	Jefferson N=658,466	Madison N=334,811	Mobile N=412,992	Montgomery N=229,363	State N=4,779,736
White, Non-Hisp	53.0	68.2	60.2	39.5	72.4
Black, Non-Hisp	42.0	24.0	34.6	54.7	12.6
Hispanic	3.9	4.6	2.4	3.6	16.3
Native American	0.3	0.8	0.9	0.3	0.9

SOCIO-ECONOMIC STATUS

In 2008, the highest proportion of persons living below the poverty level in Alabama and in the four most populous counties was less than 25 years old (Table 5). Mobile County had the highest percentages among the 0-24 year group with 8.7% males and 10.4% females living below the poverty level in 2008 followed closely by Montgomery County with 8.7% males and 10.0% females. In each of the four most populous counties and statewide, a greater proportion of women were living below the poverty level, compared with men, in all age groups.

Table 5 Percentage Distribution of People Living Below the Poverty Level by Gender and Age Group for Counties >200,000 population, Alabama 2008

Age	Jefferson		Madison		Mobile		Montgomery		State	
	Males	Female	Male	Female	Male	Female	Male	Female	Male	Female
<25	6.6	6.4	6.4	5.3	8.7	10.4	8.7	10.0	7.4	7.7
25-44	2.0	3.7	2.3	2.4	3.4	5.4	1.9	4.3	2.8	4.3
45-64	2.3	2.9	1.2	1.8	2.8	3.8	2.7	3.6	2.4	3.3
≥64	0.8	1.8	0.2	1.1	0.9	1.9	0.9	2.1	0.9	2.3
Total	11.7	14.8	10.0	10.5	15.8	21.5	14.2	20.0	13.6	17.7

Source: 2008 American Community Survey Estimates, U.S. Bureau of the Census.

Note: Percentages may not sum 100% due to rounding.

The 2010 census reported that 82.1% of Alabama residents age 25 years and older attained a high school diploma or higher with 21.9% reporting a bachelor's degree or higher. Among the same 25-year and older age group, 6.2% reported less than a 9th grade education and 11.7% reported some high school without graduation. The most common level of education among people aged 25 years and older, regardless of location or gender, was a high school diploma or its equivalent (Table 8).

Table 8 Percentage Distribution of the Population ≥25 Years of Age By Educational Attainment for Counties of ≥200,000 population, Alabama 2010

Education	Jefferson	Madison	Mobile	Montgomery	State
High School Grad.	28.1	22.2	34.3	27.5	30.4
Some College	22.7	21.5	20.9	21.1	20.5
Associate	7.0	6.7	7.3	5.5	5.4
Bachelor Degree	18.1	23.9	13.1	18.2	12.2
Graduate or more	10.7	13.5	6.7	12.3	6.9

Source: 2010 Site and County Quick facts for Alabama, U.S. Bureau of the Census.

Note: Percentages may not sum 100% due to rounding.

In a population survey conducted by the Kaiser Family Foundation in 2010, 18% of males and 16% of females aged 19-24 years reported they did not have health insurance coverage. More than two-thirds (66% of men and 68% of women) received health insurance coverage through their employer. State percentages of persons utilizing Medicaid/Medicare were similar to national percentages. Forty-nine percent of Alabama children, aged 0-18 years, were covered under a parent/guardian employers health insurance. Nine percent of children in Alabama were uninsured (Table 7).

Table 7 Percentage Distribution of Children (Aged 0-18 years) by Health Insurance Coverage, Alabama (2007-2008), US(2008)		
Health Insurance Coverage	Alabama	United States
Employer	49%	50%
Individual	NSD	4%
Medicaid	39%	34%
Other Public	NSD	2%
Uninsured	9%	10%

Source. Kaiser Family Foundation, 2010.

Note: Percentages may not sum 100% due to rounding.

The HIV/AIDS epidemic has affected persons in all gender, age, race/ethnicity, and socioeconomic groups and every county in Alabama. However, the effect has not been the same for all groups. In the beginning of the epidemic, the number of HIV/AIDS cases increased most dramatically among White men who had sex with men. Recent trends suggest a shift in the HIV/AIDS epidemic toward Black males and Black females, and high-risk heterosexual activity. To plan for HIV/AIDS prevention and care and to allocate limited resources as the epidemic continues to change and the number of persons living with HIV/AIDS continues to increase, it is extremely important to identify those populations most affected and most at-risk for HIV infection. This section provides detailed information about demographics, risk characteristics, and trends of HIV/AIDS cases diagnosed

HIGHLIGHTS

- There are persons living with HIV/AIDS in every county in Alabama. The number continues to increase each year.
- In 2011, more HIV/AIDS cases were diagnosed in Public Health Area IV (Jefferson County) than any other PHA.
- The number of deaths among people diagnosed with HIV/AIDS continues to decline since 2007 from 93 to 24 (74%).
- Among Blacks, male-to-male sexual activity and heterosexual contact continue to be the predominate modes of exposure.
- The predominate exposure among Whites remains male-to-male sexual activity.

- The proportion of new HIV/AIDS cases reported among females in Alabama has averaged 28% over the past 5 years.
- In 2011, the rate of HIV/AIDS diagnosis for Black males was 6 times the rate for White males.
- The rate of HIV/AIDS diagnosis for Black females was more than 12 times that for White females and twice that for White males.

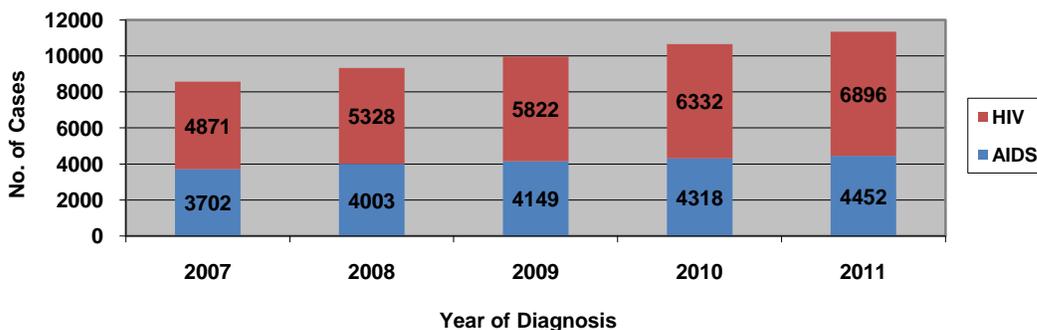
OVERALL HIV/AIDS TRENDS

The state of Alabama continues to experience an HIV/AIDS epidemic of moderate magnitude when contrasted to the experience of other states. Through December 31, 2011 the Alabama Department of Public Health has received a cumulative total of 17,839 HIV/AIDS case reports among Alabama residents since reporting began. During 2011, 635 new HIV/AIDS cases were diagnosed among Alabama residents.

The number of persons living with HIV/AIDS infection has increased each year (Figure 2). At the end of 2011, a total of 11,348 persons were known to be living with HIV/AIDS in Alabama and 4452 persons (39.2%) of these individuals have progressed to AIDS.

The proportion of persons living with HIV/AIDS increased 32.4% from 2007 to 2011 (Figure 2). This trend is largely due to the introduction of effective drug treatment and therapies, which can often delay the progression from HIV to AIDS and from AIDS to death.

Figure 2 Persons Living with HIV/AIDS, Alabama 2007 – 2011



Currently 35.3% of the prevalent HIV/AIDS cases are between the ages of 25-34; 8.3% are 50 years of age or older; 24.6% are between the ages of 35-44; 24.6% are under the age of 25; and 7.2% are 45-49. The majority of the persons diagnosed with HIV/AIDS in 2011 were between ages 25-34. Twenty-seven percent of the HIV/AIDS cases were diagnosed in teenagers and young adults. Two pediatric HIV/AIDS cases were diagnosed in Alabama in 2011 (Table 9).

The HIV/AIDS population is aging because of effective use of drug treatment and therapies. This is predicted to have an impact on the State of Alabama’s ability to provide adequate medical and social services (i.e. R W and Medicare) for the aging HIV/AIDS population.

Blacks continue to be disproportionately affected by HIV/AIDS in Alabama. Although only 26.2% of the state’s population is Black, this group represented 68.35% of the HIV/AIDS cases diagnosed in 2011 and 66.3% of all persons living with HIV/AIDS (Table 9). In 2011, 23.1% of the persons living with HIV/AIDS were females.

	HIV/AIDS Cases Diagnosed, 2011			Persons Living with HIV/AIDS Through 2011	
	No.	%	Rate	No.	%
Total	745	100	15.6	10320	100
Gender					
Male	480	76	20.66	7299	70.7
Female	155	24	6.30	3021	29.3
Race/Ethnicity					
White, Not Hispanic	162	25.5	5.06	3000	29.1
Black, Not Hispanic	434	68.4	43.84	6840	66.3
Other/Unknown	39	3.62	26.84	480	4.7
Age Group(years)					
0-12	2	31	0.63	127	1.2
13-24	175	27.6	25.78	2411	23.4
25-34	184	29	30.22	3639	35.3
35-44	118	18.6	19.05	2540	24.6
45-49	68	10.7	19.63	747	7.2
50+	84	13.2	5.27	856	8.3
Public Health Area					
I	13	2	2.3	192	1.9
II	57	8.9	9.6	931	9
III	31	4.8	12.3	411	4
IV	183	28.6	30.7	2949	28.6
V	29	4.5	5.9	392	3.8
VI	39	6.1	9.7	466	4.5
VII	27	4.2	15.2	312	3
VIII	119	18.6	25.4	1933	18.6
IX	28	4.4	7.7	456	4.4
X	29	4.5	15.4	623	6
XI	86	13.4	28.1	1605	15.6

- a. Persons Living with HIV/AIDS age group represent current age.
- b. Persons diagnosed with HIV/AIDS in 2011 are included in the PLWHA through 2011 if still living.
- c. Calculated as the percentage of all cases diagnosed. Percentages do not add up to 100 due to rounding
- d. rates per 100,000 persons in racial/ethnic groups.

HIV/AIDS by RACE/ ETHINCITY and GENDER

The epidemic significantly affects both males and females in the Black community (Table 13). In 2011, the rate of HIV/AIDS diagnosis among Black males (60.2/100,000) was more than six times higher than White males (9.1/100,000). The rate of HIV/AIDS diagnosis for

Black females (19.4 per 100,000) was higher than both White females (1.6 per 100,000) and White males (9.1 per 100,000).

Table 13 HIV/AIDS Diagnosis and Rates by Race/Ethnicity and Gender, Alabama 2011

Race/Ethnicity	Males			Females			Total		
	No.	%	Rate	No.	%	Rate	No.	%	Rate
White, Not Hispanic	150	27.9	9.1	28	16.7	1.6	178	25.2	5.3
Black, Not Hispanic	354	65.8	60.2	131	78.0	19.4	485	68.7	38.4
Hispanic	15	2.8	43.2	2	1.2	5.7	17	2.4	24.3
Other/Unknown	19	3.5	44.0	7	4.2	15.5	26	3.7	29.4
Total	538	100	23.2	168	100		706	100	16.0

Note. Dash indicates the rate could not be calculated because of small numbers.

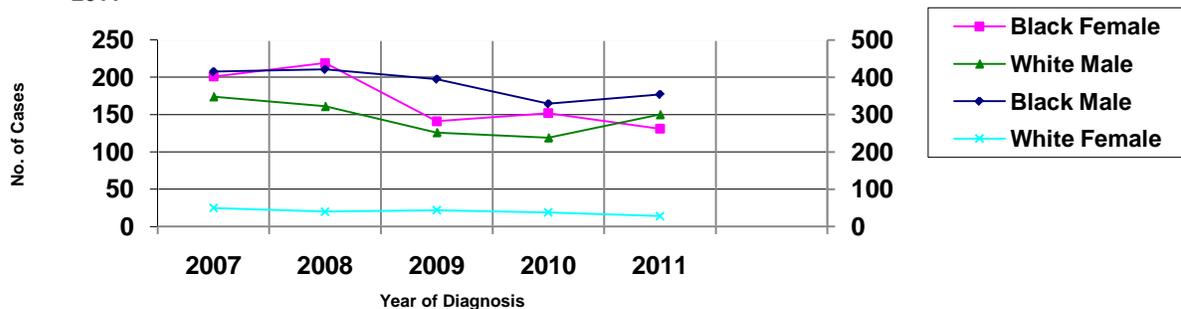
a. Calculated as the percentage of all cases diagnosed in 2011. Percentages do not add up to 100 due to rounding

b. Rates per 100,000 per persons in racial/ethnic groups

Overall, the number of HIV/AIDS cases diagnosed each year has remained steady among White females (Figure 4). Since 2004, the annual number of HIV/AIDS cases diagnosed among Black females continues to be higher than among White males.

HIV/AIDS by Age Group

Figure 4. HIV/AIDS Cases by Race/Ethnicity, Gender and Year of Diagnosis, Alabama 2007-2011



In 2011, persons aged 13-34 years accounted for more than half (55.8%) of newly diagnosed HIV/AIDS cases while 35-44 years of age has decreased (26.9) in 2011 (Table 14).

Table 14 HIV/AIDS Cases by Age Group and Gender Alabama 2011

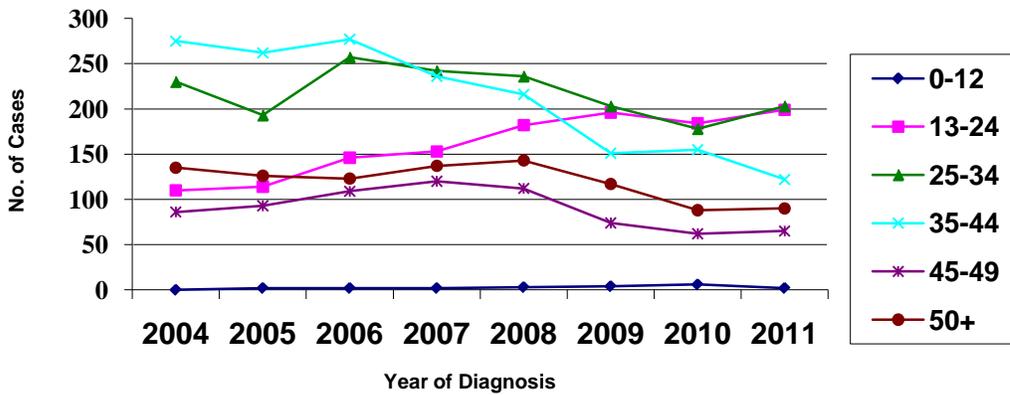
Age Group (yrs)	Males		Females		Total	
	No.	%	No.	%	No.	%
0-12	0	0.0	2	1.2	2	0.3
13-24	168	31.2	33	19.6	201	28.5
25-34	163	30.3	49	29.2	212	30.0
35-44	88	16.4	40	23.8	128	18.1
45-49	51	9.5	17	10.2	68	9.6
50+	68	12.6	27	16.1	95	13.5
Total	538	100	168	100	706	100

a. Calculated as the percentage of all cases diagnosed in 2011. Percentages do not add up to 100 due to rounding

In 2011, as in the past, the highest number of newly diagnosed cases was among persons 25-34 years of age and 13-24 years of age. Although the diagnosis of HIV/AIDS for persons age 13-24

has increased (44.7%) from 2004 to 2011(Figure 5), the diagnosis of HIV/AIDS for persons 35-44 years of age has decreased (26.9%).

Figure 5 Trends in HIV/AIDS by Age Group, Alabama 2004-2011



Seven of Alabama’s 67 counties consistently accounted for over 69.3% of the HIV/AIDS cases diagnosed in any year from 2007– 2011 (Table 10). Jefferson County has approximately 27% of the HIV/AIDS cases diagnosed every year.

Figure 3 Population and HIV Cases by Percentage, Alabama 2011

	Population	Pop %	Cases	Case %
Alabama	4779736		15660	
Major Urban		34.2%		
Jefferson	658466		4540	
Montgomery	229363		1901	
Madison	334811		751	
Mobile	412992		2565	
total	1635632		9757	62.3%
Minor Urban Areas		24.2%		
Baldwin	182265		358	
Calhoun	118572		248	
Etowah	104430		178	
Houston	101547		360	
Lee	140247		257	
Morgan	119490		168	
Shelby	195085		155	
Tuscaloosa	194656		455	
total	1156292		2179	13.9%
Rural Areas	1987812	41.6%	3724	23.8%

Table 10 HIV/AIDS Case Percentages by Year of Diagnosis and County, Alabama 2007 – 2011

County	2007		2008		2009		2010		2011	
	No.	%								
Lowndes	7	0.8%	2	0.2%	3	0.4%	6	0.8%	6	0.8%
Hale	3	0.3%	4	0.4%	1	0.1%	7	1.0%	6	0.8%
Montgomery	116	13.0%	122	13.7%	95	12.8%	78	11.0%	87	12.1%
Chambers	7	0.8%	7	0.8%	11	1.5%	9	1.3%	12	1.7%
Jefferson	202	22.7%	223	25.0%	202	27.1%	191	27.1%	205	28.6%
Conecuh	4	0.4%	1	0.1%	1	0.1%	4	0.6%	4	0.6%
Mobile	155	17.4%	116	13.0%	25	3.4%	102	14.4%	97	13.5%
Total	890	55.5%	892	53.3%	745	45.4%	706	56.2%	717	58.2%

The highest rate of HIV/AIDS diagnosis occurred in 2011 in Lowndes County followed by Hale, Montgomery, and Chambers Counties (Table 11).

Table 11 HIV/AIDS Case Rates by Year of Diagnosis and County, Alabama 2007 – 2011

County	2007		2008		2009		2010		2011	
	No.	Rate								
Lowndes	7	61.95	2	17.70	3	26.55	6	53.10	6	53.10
Hale	3	19.04	4	25.38	1	6.35	7	44.42	6	38.07
Montgomery	116	50.57	122	53.19	95	41.42	78	34.01	87	37.93
Chambers	7	20.46	7	20.46	11	32.15	9	26.30	12	35.07
Jefferson	202	30.68	223	33.87	202	30.68	191	29.01	205	31.13
Conecuh	4	30.24	1	7.56	1	7.56	4	30.24	4	30.24
Mobile	155	37.53	116	28.09	25	6.05	102	24.70	97	23.49
Total	890	42.10	892	42.19	745	35.24	706	33.39	717	33.92

As of December 31, 2011, a total of 10,787 persons were reported to be living with HIV/AIDS in Alabama. More than 69.4% of the persons living with HIV/AIDS in Alabama reside in PHA IV, PHA VIII, or PHA XI (Table 9). Currently, there are HIV/AIDS infected persons living in every county in Alabama.

As of December 31, 2011, 69.8% of Alabama's prevalent HIV/AIDS cases resided in Baldwin, Houston, Jefferson, Madison, Mobile, Montgomery, and Tuscaloosa counties (Table 12).

Table 12 Prevalent HIV/AIDS Cases by County, Alabama 2011

County	No.	%
Baldwin	358	2.3
Houston	360	2.3
Jefferson	4540	29.0
Madison	751	4.8
Mobile	2565	16.4
Montgomery	1901	12.1
Tuscaloosa	455	2.9
Total	10930	100

a Calculated as the percentage of prevalent cases as of December 31, 2011.

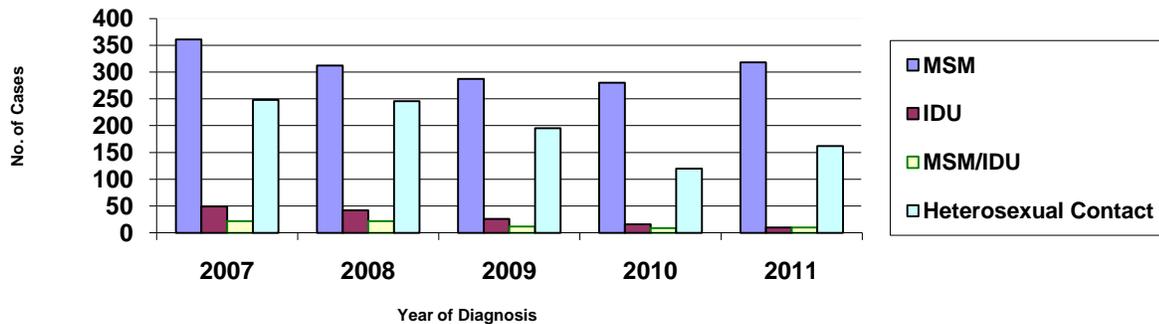
b. Percentages do not add up to 100 due to rounding

c Rates per 100,000 persons in the county.

HIV/AIDS BY MODE OF EXPOSURE

Throughout the epidemic, most HIV transmission has occurred among MSM. The rate of infection has remained stable over the last five years (Figure 6). However, the proportion of cases attributed to MSM/IDU and IDU activity has been declining. The percentage of cases among persons who report specific heterosexual contact with a person with, or at increased risk for HIV infection (i.e. an IDU, an MSM, or HIV infected person) has remained stable.

Figure 6 HIV/AIDS Cases by Year of Diagnosis & Exposure Category, Alabama 2007-2011



The largest percentage of cases diagnosed in 2011 (45.3%) were reported among MSM (Table 15). Heterosexuals constitute an important risk group as well. Persons in this exposure category account for 26.1% of the newly diagnosed cases and for 26.9% of persons living with HIV/AIDS.

Table 15 Risk characteristics of persons with HIV/AIDS, Alabama 2011

HIV/AIDS Cases Diagnosed, Persons Living with HIV/AIDS Through 2011

Exposure Category	No.	%	No.	%
MSM	324	45.3	4159	40.3
Injection drug use	10	1.6	737	7.1
MSM/IDU	11	1.8	374	3.6
Heterosexual contact	170	26.1	2773	26.9
Transfusion/hemophilia	0	0.0	28	0.3
Mother with HIV infection	2	0.0	83	0.8
Risk not reported/not identified	189	25.3	2166	21.0
Total	706	100	10320	100

a. Calculated as the percentage of all cases diagnosed in 2011. Percentages do not add up to 100 due to rounding

Among Blacks, adult male-to-male sexual contact has emerged as the leading exposure category, accounting for nearly 41.6% of all newly diagnosed cases. Among Whites, the predominant exposure remains male-to-male sexual activity (60.7%), and male-to-male sexual activity plus injection drug use (Table 16).

Table 16 HIV/AIDS Diagnosis by Race/ethnicity and Exposure Category, Alabama 2011

Exposure Category	White		Black		Other		Total
	No.	%	No.	%	No.	%	No.
MSM	108	60.7	202	41.6	14	35.9	324
Injection drug use	4	2.2	5	1.0	1	2.6	10
MSM/IDU	5	2.8	5	1.0	1	2.6	11
Heterosexual contact	24	13.5	137	28.2	9	23.1	170
Mother with HIV infection	0	0.0	2	0.6	0	0.0	2
Risk not reported/not identified	37	20.8	134	27.6	14	35.9	189
Total	178	100	485	100	39	100	706

a. Calculated as the percentage of all cases diagnosed in 2011

b. Percentages do not add up to 100 due to rounding

In 2011, 87.5% of new cases diagnosed among females were attributed to heterosexual contact, 1.2% was reported with no identified risk, and 4.8% were attributed to injection drug use (Table 17).

Among females diagnosed with HIV/AIDS in 2011, Blacks accounted for 80.7% of the cases reported with an exposure category of heterosexual contact compared to 14.3% for Whites.

Among males, 62.3% of the new cases occurred in MSM (including MSM who inject drugs). Twenty-eight point six percent of the new cases diagnosed among males were reported with no identified risk, 6% were heterosexual contact, and 3.7% were attributed to injection drug use.

Black males accounted for 62.0% of the HIV/AIDS cases diagnosed among males. The primary exposure category of this group was MSM (including MSM who inject drugs).

Thirty-three point eight percent of White males diagnosed with HIV/AIDS in 2011 were reported with risk a factor of MSM (including MSM who inject drugs).

Table 17 HIV/AIDS Diagnosis by Gender and Exposure Category, Alabama 2011

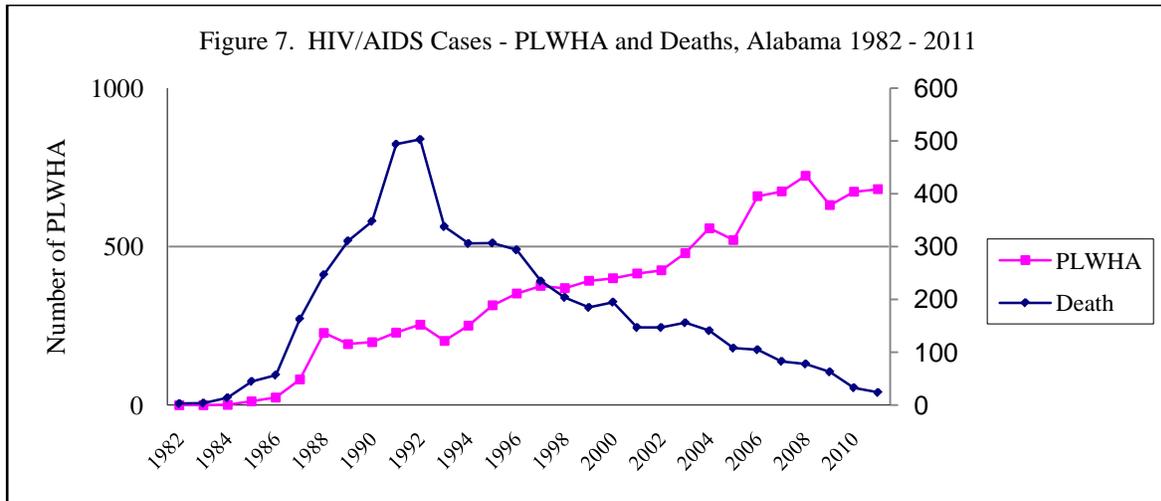
Exposure Category	Male		Female	
	No.	%	No.	%
MSM	324	60.2	-	-
Injection drug use	2	0.0	8	4.8
MSM/IDU	11	2.0	-	-
Heterosexual contact	23	4.3	147	*87.5
Mother with HIV infection (perinatal)	0	0.0	2	1.2
Child, no risk	1	0.0	2	1.2
Risk not reported/not identified	177	32.9	9	5.3
Total	538	100	168	100

a. calculated as the percentage of all cases diagnosed in 2011

b. percentages do not add up to 100 due to rounding

HIV/AIDS MORTALITY

Although the number of deaths among people diagnosed with HIV/AIDS continues to decline since 2006 (52%), the number of people living with HIV/AIDS continues to increase (Figure 7). The longevity of PLWH/As in Alabama has had a significant impact on the State's resources to provide care and social services to those infected with the disease. The introduction and widespread utilization of HAART has contributed to the decrease in the number of deaths among HIV/AIDS cases. Beginning in 1982, the reported number of deaths among HIV/AIDS cases steadily increased to a peak of 503 in 1992. Nineteen years later, only 24 deaths were reported in 2011.



Indicators of Risk for HIV/AIDS Infection in Alabama

It was reported in America's Health Rankings for 2011 that Alabama ranked 46th in the nation based on certain selected health indicators. Also included in this report, Alabama ranked 43rd in public health efforts to manage and control STD's; ranked 43rd for health insurance; but ranked 10th in funding from CDC, which is indicative of proactive implementation of preventive and educational programs targeted at improving the health of at-risk populations within the state. Also according to this report, the percentage of mothers receiving early prenatal care (receiving prenatal care within the first trimester of their pregnancy) was 83.8%, which was 28th among the 50 states.

The Alabama Youth Risk Behavior Survey indicates that among high school students (students in grades 9-12) that 57% of participants had sexual intercourse. The 2008 Alabama School Health Profiles states that 68% of high schools had policies for students and staff who HIV infection that addressed attendance of students with HIV infection, procedures to protect HIV-infected students and staff from discrimination and maintaining confidentiality of HIV for both students and staff. Twenty-one percent of high schools had a gay/straight alliance or similar club (Table 18).

Table 18 High School Youth Risk Behavior Survey, Alabama 2009

Question	Total*	Female*	Male*
Sexual Behaviors	Percent/number		
Ever had sexual intercourse	56.6 (1,296)	51.4 (715)	61.8 (577)
Had sexual intercourse for the first time before age 13 years	10.1 (1,306)	4.1 (719)	16.2 (583)
Had sexual intercourse with four or more persons (during their life)	19.9 (1,297)	14.4 (716)	25.7 (577)
Had sexual intercourse with at least one person (during the 3 months before the survey)	41.5 (1,296)	42.0 (713)	40.9 (579)
Drank alcohol or used drugs before last sexual intercourse (among students who were currently sexually active)	21.2 (547)	14.7 (304)	27.9 (240)
Did not use a condom during last sexual intercourse (among students who were currently sexually active)	41.5 (535)	45.3 (298)	37.5 (234)
Did not use birth control pills before last sexual intercourse to prevent pregnancy, among students who were currently sexually active)	79.3 (538)	75.3 (303)	83.5 (232)
Were never taught in school about AIDS or HIV infection	15.4 (1,404)	12.6 (759)	17.7 (635)
Did not use Depo-Provera before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	94.3 (538)	92.8 (303)	96.1 (232)
Did not use birth control pills or Depo-Provera before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	73.6 (538)	68.1 (303)	79.6 (232)
Did not use both a condom during last sexual intercourse and birth control pills or Depo-Provera before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	88.4 (528)	85.7 (297)	91.2 (228)

SEXUALLY TRANSMITTED DISEASES

STD surveillance data offer information that may help to identify the potential occurrence of high-risk behavior. In interpreting this data, citing an increase in STD does not directly indicate that HIV exposures are increasing; however, these surrogate measures of HIV may point toward an increase in unprotected sex. (Table 19)

Table 19 STD Cases by Public Health Area, Alabama 2011

Table 19. STD Cases by Public Health Area, Alabama 2011				
PHA's	Chlamydia	Gonorrhea	Syphilis	Total
1	1232	118	24	1374
2	3333	877	56	4266
3	1903	601	38	2542
4	5591	2367	238	8196
5	1612	282	37	1931
6	2032	503	29	2564
7	1455	350	34	1839
8	5209	1765	99	7073
9	1593	409	73	2075
10	2223	546	65	2834
11	3173	1224	55	4452
Grand Total	29356	9042	748	39146

Note: Updated STD Morbidity CY 2011 Reported by STD Division, ADPH

GONNORRHEA

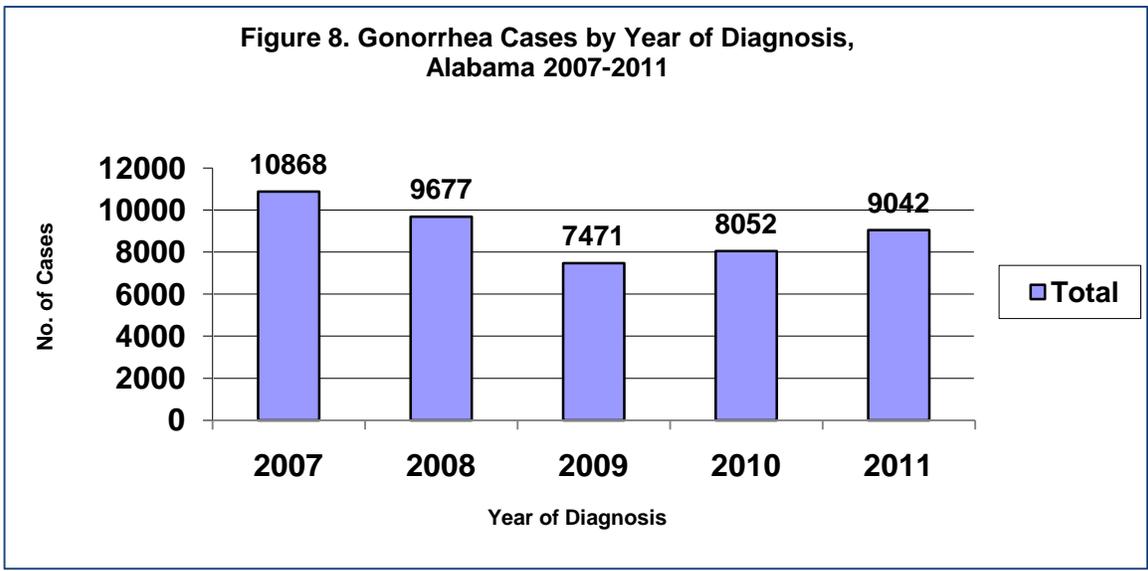
In 2011, 9042 Alabama residents were reported to be diagnosed with gonorrhea, which represents a 12.3% increase from 2010.

Table 20 Gonorrhea Diagnosis by Gender and Race, Alabama 2011

Race	Male		Female	
	No.	%	No.	%
White, Not Hispanic	223	6.0	500	10.0
Black, Not Hispanic	2711	71.0	3067	60.0
Hispanic	9	0.0	8	0.0
Native American	2	2.0	6	0.0
Asian	11	0.0	17	0.0
Unknown	872	23.0	1508	56.0
Total	3828	100	5106	100

Note: Updated STD Morbidity CY 2011 Reported by STD Division, ADPH

Percentages do not add up to 100 due to rounding



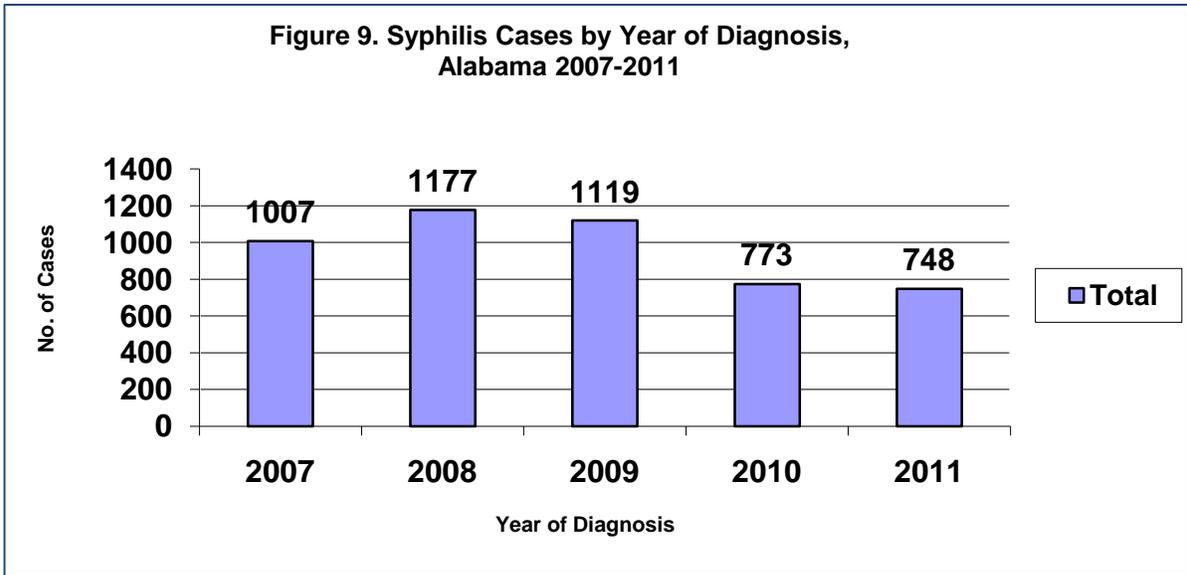
SYPHILIS

In 2011, 748 Alabama residents were reported to be diagnosed with syphilis, a 4.3% decrease from 2010. (Table 21, Figure 9)

Table 21 Syphilis Diagnosis by Gender and Race, Alabama 2011

Race	Male		Female	
	No.	%	No.	%
White, Not Hispanic	92	18.0	49	20.0
Black, Not Hispanic	352	68.0	157	65.0
Hispanic	13	3.0	6	2.0
Native American	0	0.0	1	0.0
Asian	1	0.0	0	0.0
Unknown	59	11.0	29	12.0
Total	517	68.0	242	32.0

Percentages do not add up to 100 due to rounding



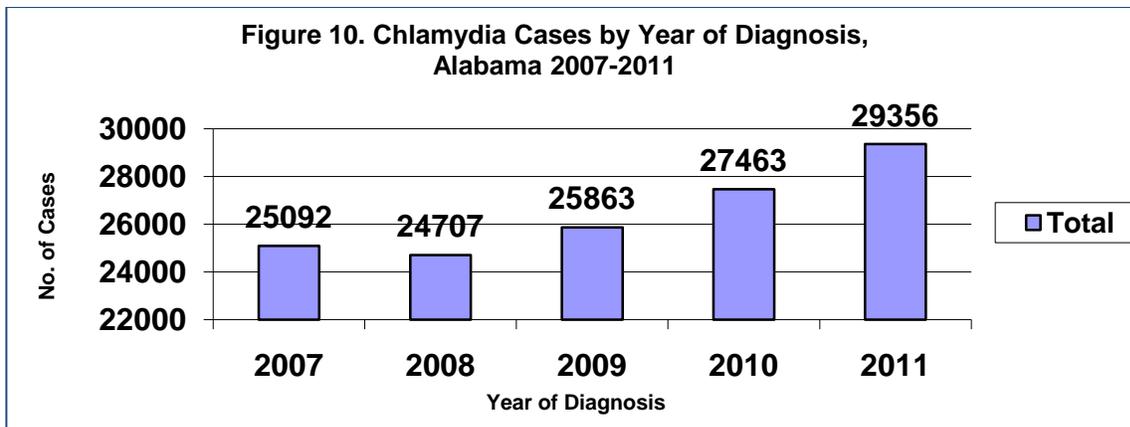
CHLAMYDIA

In 2011, 29356 Alabama residents were reported to be diagnosed with Chlamydia, which represents a 6.9% increase from 2010. (Table 22, Figure 10.)

Table 22 Chlamydia Diagnosis by Gender and Race, Alabama 2011

Race	Male		Female	
	No.	%	No.	%
White, Not Hispanic	1182	15.0	3265	15.0
Black, Not Hispanic	4668	61.0	10241	48.0
Hispanic	48	1.0	107	1.0
Native American	14	0.0	22	0.0
Asian	18	0.0	57	0.0
Unknown	1734	23.0	7550	36.0
Total	7664	26.0	21242	72.0

Percentages do not add up to 100 due to rounding



Note: Updated STD Morbidity CY 2011 Reported by STD Division, ADPH

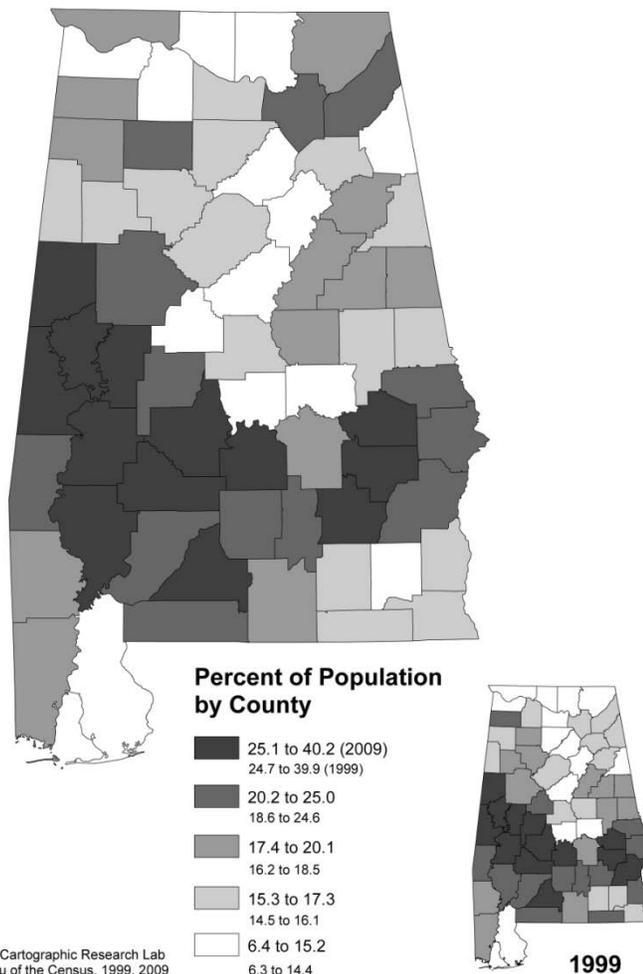
b. A Description of Needs Obstructing Access to Care for HIV Positive Individuals

People living with HIV disease in Alabama face multiple challenges that affect their well-being, their quality of life and their ability to enter care or fully engage in care. The impact of the HIV/AIDS epidemic on the Black population and other minority populations living in the state also reflects important issues related to extreme poverty, lack of education, lack of consistent support systems, and access to care and housing. According to the Southern AIDS Coalition’s “*Southern States AIDS Manifesto Update 2008*,” HIV/AIDS in the south has multiple challenges. Rural areas often face different and even greater challenges than urban areas in addressing health issues including HIV in these populations.(1) These important issues offer formidable challenges for Alabama to be able to reduce new HIV infections. Barriers to care and services identified in needs assessment surveys are listed here in no particular order of importance.

Poverty-Uninsured - Underinsured

Limited financial resources and inadequate health insurance or third party coverage are serious challenges for PLWH/As in Alabama living in urban and rural areas. Uninsured individuals in the State’s general population reported decreased access to routine and preventative care, decreased access to health information, as well as decreased access to private doctors and outpatient clinics. Nearly 1 in 5 women under the age of 65 in the US are uninsured. Women who are younger and have low income are particularly at risk of being uninsured, as are women of color, especially Hispanic women. Women without insurance lack sufficient access to care, get lower quality of care when they do enter the health system, and have poorer health outcomes.(2) Birth data supports that uninsured pregnant women are less likely than insured women to seek and receive adequate health care and prevention interventions. Access to care for pregnant women is critical for reducing HIV infection in infants. Almost one of every five women without health insurance in Alabama reported having no prenatal care.(3)

Poverty Rate, 2009



Restrictive Medicaid

Residents seeking health coverage through Alabama’s Medicaid face challenges accessing the program, and if enrolled in Medicaid, these individuals face further challenges due to the limited scope of services covered. Alabama has no “medically needy” Medicaid eligibility category. A medically needy category allows people who are categorically eligible for Medicaid (such as the disabled or PLWAs), but slightly over the income limit, to become eligible by ‘spending down’ their ‘excess’ income until they meet the income requirements (3).

Fewer Physicians Accepting Medicaid Patients

Because Alabama’s Medicaid reimbursement rates have been historically low, fewer medical providers across the state are willing to take new Medicaid patients creating barriers to equal access to medical care for residents who rely on Medicaid to pay for their health care costs.

Socio-Economic and Cultural Issues Especially for Women

Women and teens of all races and ethnicity in Alabama experience socio-economic and cultural barriers to seeking prenatal care and medical care to detect and treat potentially life-threatening conditions including HIV disease. Most women who are HIV positive live in poverty. In addition, when women face unmet needs such as housing, food, and childcare, they have little time to devote to their own health. Beliefs about gender roles, knowledge of sex and sexuality, level of education, fear of physical abuse and gender inequality in relationships all play important roles in determining risk factors and risky behaviors.(2)

Limited Housing Resources

Lack of housing facilities and funding to create additional housing facilities for HIV Consumers and their families creates additional challenges in maintaining the over-all health of PLWH/As in Alabama.

Lack of HIV Education

Lack of community education specifically in rural populations in Alabama related to acceptance and decreased discrimination of people with HIV disease can create significant barriers for individuals to access HIV testing, care and services both in urban and rural areas in Alabama.

Stigma

Physical and socioeconomic barriers are influenced by persistent stigma surrounding HIV disease in Alabama regardless of sexual orientation, gender, or ethnic background. Transmission through sex and/or sharing needles only helps to create further gaps in connecting HIV residents to quality care and services especially in rural Alabama.

Fear of Discovery and Lack of Anonymity

Lack of anonymity and fear of discovery, especially in the smaller rural areas in the state where everyone knows everyone, (HIV status, sexual orientation, injecting drug use) may inhibit PLWH/As from accessing care and services.

Cultural and Language Differences

Lack of cultural sensitivity as well as language and cultural differences present barriers for to accessing HIV care and services for minorities especially the Hispanic population in rural areas in the state due to fear of new Alabama immigration laws and the loss of confidentiality in their community.

Incarceration in County or City Jails

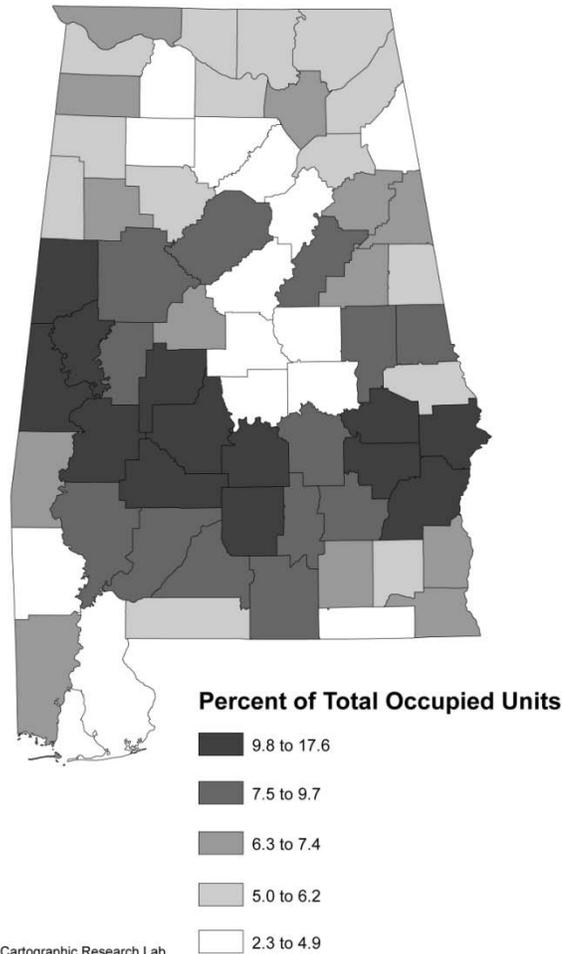
Alabama has a discharge planning process for PLWH/As incarcerated in a Federal or State prison. However, for inmates in city or county jails that do not have the funding to contract with a health care provider for inmates, the care delivery system is fragmented creating barriers to HIV care and adherence for these inmates to continue medical care including their HIV medications.

Limited Transportation Resources

Lack of transportation is a major barrier to accessing medical care and services that is common for residents living in rural areas where there is no public transportation infrastructure. With no

alternate means of transportation, individuals often pay someone in the community to drive them to medical appointments that may cause an additional barrier to accessing care or services or to remaining adherent to care.

Occupied Housing Units with No Available Vehicles, 2010



Lack of HIV Care and Services Outside of Urban Areas

Barriers to quality treatment of HIV disease presents more of a challenge for those who must access resource poor and compromised health care systems outside of the metropolitan areas in Alabama.

Metropolitan Statistical Areas



Distrust of the Public Health System

Distrust of the public health system especially among Blacks and Latinos is an important barrier that cross cuts all categories of risk behaviors. Undocumented immigrants fear community rejection and deportation that can create significant barriers to accessing care and services especially for Alabama’s Hispanic population.

c. Description of Needs of Individuals Aware of their HIV Status but Not in Care

Unmet Need Estimate for CY 2010

There are over 11,000 Alabama residents reported living with the HIV virus and the ADPH projects an additional 2,000 - 5,000 unreported cases. Although the number of deaths among people diagnosed with HIV/AIDS continued to decline by 52% since 2006, the number of

PLWH/As in need of care and treatment continues to increase. The number of persons living with HIV/AIDS infection in Alabama has increased by 24% from 2006 to 2010.

Alabama has had HIV reporting by name since 1987, but prior to June 2011 when the reporting law was changed, ADPH only required private, public and hospital laboratories to report positive HIV Western Blots; CD4 cell count <200 per µl or <20%; and all AIDS defining diseases to be reported to the HIV/AIDS Surveillance Branch. However, several private and hospital laboratories voluntarily reported all tests indicative of HIV infection and HIV disease management to the HIV/AIDS Surveillance Branch. As a result, measuring Alabama's unmet need had limitations prior to changes in the State's reporting law because HIV viral loads, CD4 cell counts ≥200 per µl or ≥20%; and other tests indicative of HIV infection and HIV management were not reportable.

As of June 30, 2011, the ADPH updated the notifiable disease laws from HIV infection (including asymptomatic infection and AIDS) to HIV infection (including asymptomatic infection, AIDS, CD4 counts, and viral load). The changes now require all private and public laboratories to report CD4 counts and viral loads to the HIV Surveillance Branch. Before the law change, measuring Alabama's unmet need had limitations because HIV viral loads, CD4 cell counts ≥200 per µl or ≥20%; and other tests indicative of HIV infection and HIV management were not reportable.

The primary objective is to ensure that Alabama's Unmet Need Framework is based on the definition provided in "HRSA's Practical Guide to Measuring Unmet Need for HIV-Related Primary Medical Care." Unmet need for HIV Primary Medical Care is defined by HRSA as no evidence of any of the following three components of HIV primary medical care during a 12-month time period: (1) viral load (VL) testing, (2) CD4 count, or (3) provision of anti-retroviral therapy (ART). However, a second objective is to collect unmet service need to assist in the service planning and funding allocation decision-making process. The HIV/AIDS Division Surveillance Branch Director and staff have always collaborated with Alabama's Ryan White Grantee to provide an annual assessment of unmet need. The assessment of Alabama's unmet need for CY2010 is provided below.

Assessment of Unmet Need CY 2010

a = number of persons living with AIDS (PLWA)

b = number of persons living with HIV (PLWH)

c = number of PLWA who received specified services in 12 month period

d = number of PLWH who received specified services in 12 month period

a = 4,391

b = 6,483

c = 1,908 (43.5%)

d. - 1,920 (29.6%)

$$\begin{aligned} \text{Unmet need} &= [a * (1-c)] + [b * (1-d)] \\ &= [4,391 * (1 - 0.435)] + [6,483 * (1 - 0.296)] \\ &= [4262 * 0.565] + [5937 * 0.704] \\ &= 7,046 \end{aligned}$$

In an effort to find people not in care and get them into primary care, the ADPH established the Enhanced Referral Tracking System (ERTS) in 2005 to be able to monitor linkages of new HIV positives into care. Eleven ERTS program HIV Coordinators located statewide utilize strong relationships with AIDS Service Organizations; state and county STD staff, traditional and university based hospital and institutions to refer newly diagnosed HIV positive clients to the ERTS program.

The goal of the ERTS program was to link 50% of all HIV clients referred to the program; ERTS outcome data for 2011 indicates that 784 individuals or 78% of newly reported HIV-positive clients are in care. ERTS program objectives require that 5% of clients refusing care initially should be linked to HIV care because of Coordinator Linked into Care (CLIC) activities.

Alabama ERTS Service Data through CY2011

ERTS focuses on early treatment access for newly identified infected individuals in Alabama to provide follow-up contact to HIV positive clients to ensure access to treatment services. In each of the eleven public health areas, the division employs an HIV Area Coordinator who works with ERTS. The coordinator investigates unreported HIV-positive individuals to determine if they are “in-care” or to aid the referral process so they may gain entry into medical care for HIV and AIDS treatment. The ERTS Program Manager reviews the ERTS list from each coordinator to assess how investigations were closed. Evaluation of the ERTS codes such as “coordinator-linked into care” and “in-care,” including other closed investigation codes, aid in monitoring the success of the program.

Report end of CY2011

- 1,002 individuals were tracked through ERTS
- 998 were infected with HIV/AIDS
- 784 of 1,002 were reported as receiving treatment (78% for 2011)
- 647 of the 1,002 tracked were African-American
- 291 of the 1,002 tracked were Caucasian
- 64 of the 1,002 tracked were reported as Other/Unknown race
- 487 of the 784 “in care” are African-American
- 248 of the 784 “in care” are Caucasian
- 49 of the 784 in care” are Other/Unknown race

The distribution of clients by race and gender indicate that Non-White and Males account for two-thirds of cases reported “In Care.” The same distribution is similar across PHAs. (Figures 14 and 15)

IN CARE

Females	187	24%
Males	597	76%
White	248	32%
Non-White	536	68%

Clients documented as receiving “No Care” include those who refused referral; were investigated and determined to be deceased, and those lost to follow-up.

NO CARE

Of New HIV Diagnosis for 2011 no care reported

Females	40	19%
Males	174	81%
White	43	20%
Non-White	171	80%
Total	214	

Figure 14. ERTS Clients in Care by Race, Alabama Jan-Dec 2011

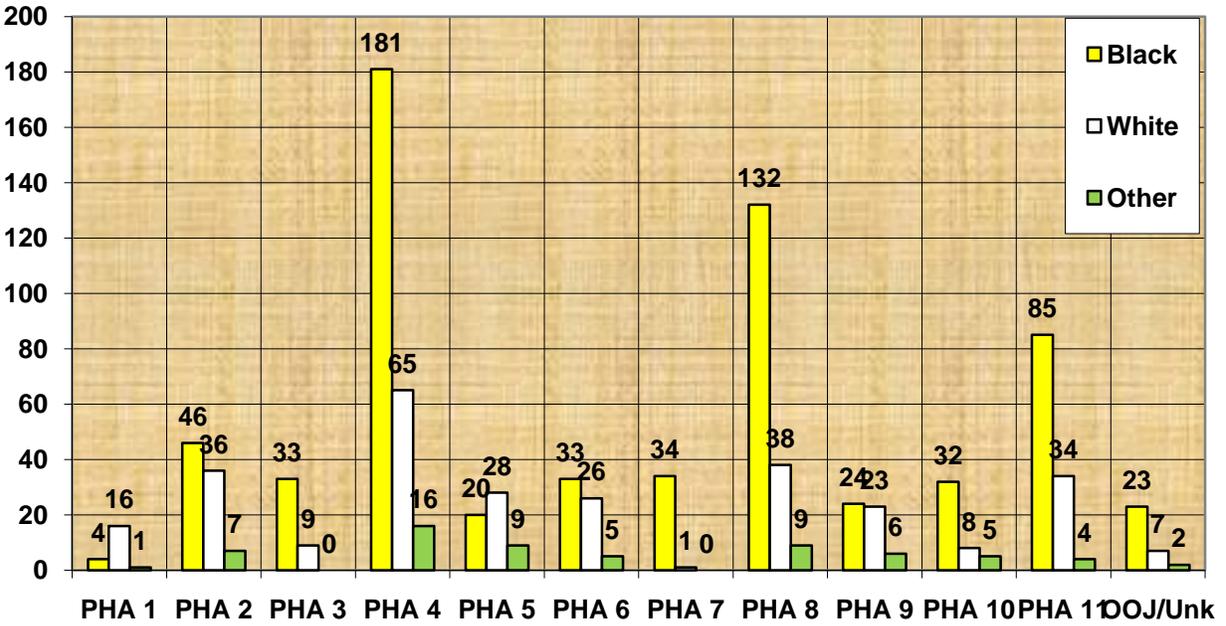
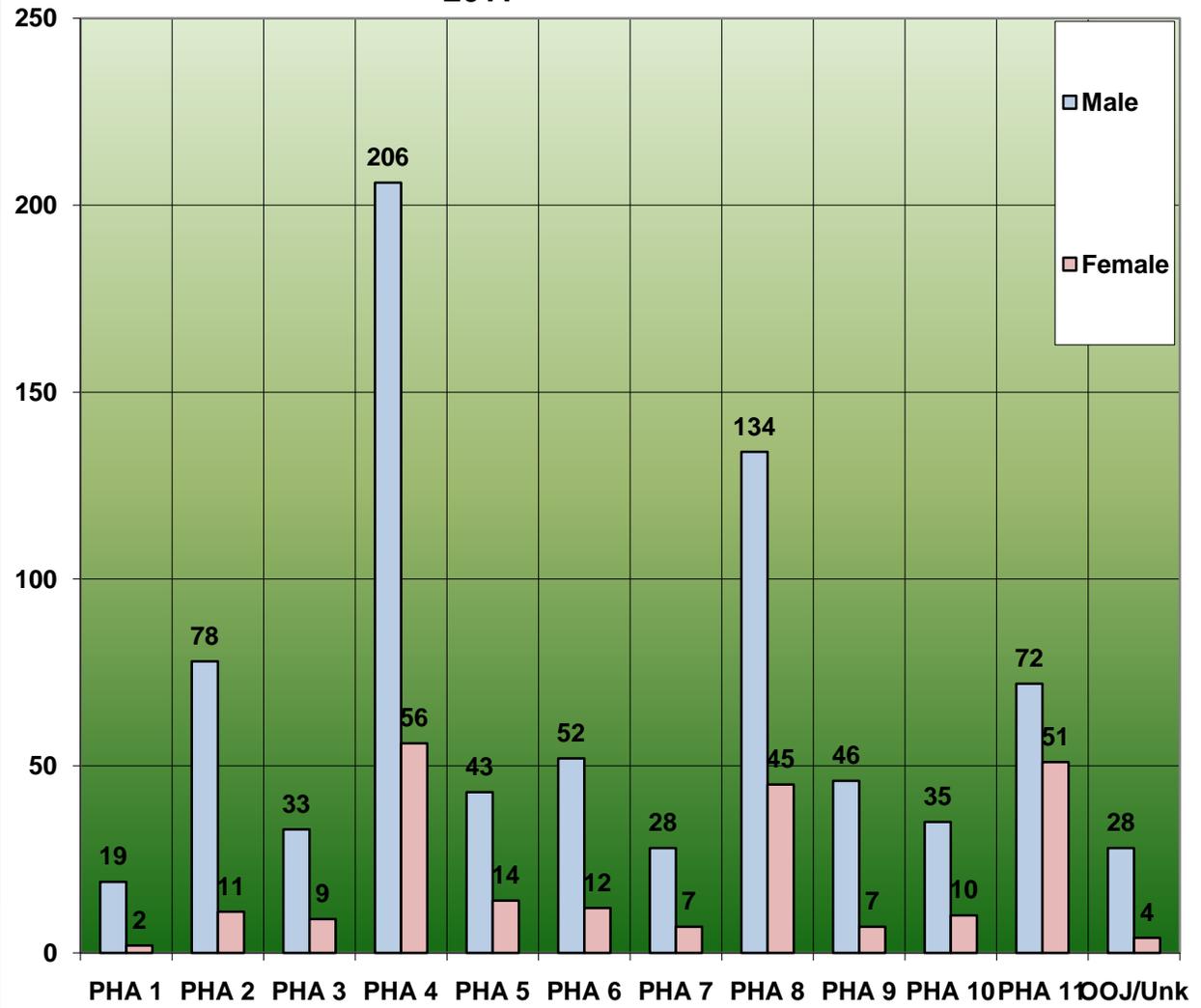


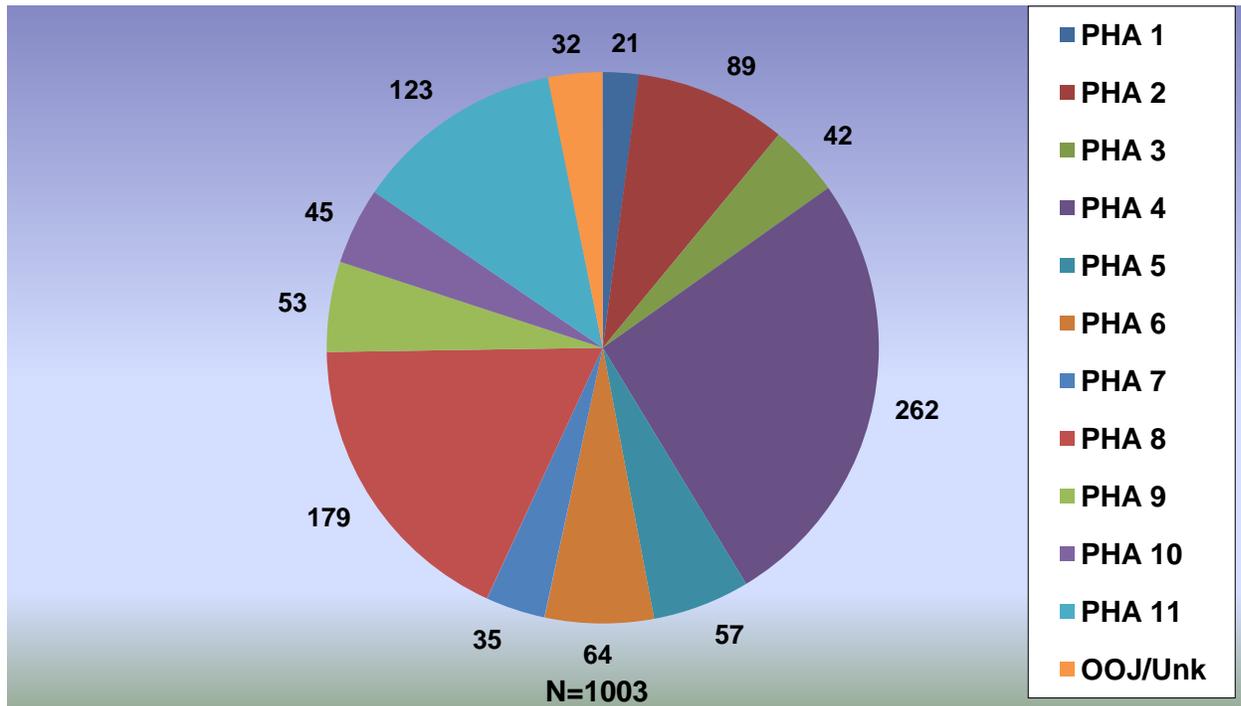
Figure 15. ETS Clients in Care by Gender, Alabama Jan-Dec 2011



PHA 4 had the highest number of ERTS cases for this period with 262 cases investigated.

PHA 1 had the least with only 21 cases documented. (Figure 11)

Figure 11 ERTS Newly Reported Clients by Public Health Areas, Alabama 2011



Data from these investigations also support the most common reasons and challenges to clients not accessing medical care and services.

1. **Many individuals are transient and move frequently leaving no reliable contact information**
2. **Individuals are not ready to receive care at this time because of the following primary reasons:**
 - 1) **Denial,**
 - 2) **Fear loss of confidentiality,**
 - 3) **Feeling well so do not access care, and**
 - 4) **Not ready to face the responsibility of medical care and medications**

d. Description of Needs of Individuals Unaware of Their HIV Status

The estimated number of living HIV positive individuals in Alabama who were unaware of their status as of December 31, 2009 totaled 2,705 individuals.

(a) Estimated Back Calculation (EBC) Methodology:

(**ALL** applicants **must** use the following formula to calculate the local size of the HIV positive unaware population, which is based on CDC's national estimate.)

1. **Formula:**

National Proportion Undiagnosed HIV = 21%

Number of individuals diagnosed with HIV and living as of December 31, 2009 = 10,176

$$\begin{aligned} \text{Local Undiagnosed} &= \frac{p}{(1-p)} \times N \\ &= \frac{0.21}{(1-0.21)} \times 10,176 \\ &= 2,705 \text{ undiagnosed} \end{aligned}$$

Example:

National Proportion Undiagnosed = 21%

$.21 \times 1,000$ (diagnosed living) = 266 (undiagnosed)

(.79)

Gaps in services remain to identify individuals who are at greatest risk of infection, unaware of their positive sero-status and PLWH/As not in care. The Division attempts to narrow these gaps by:

- Providing test kits to approved providers;
- Information dissemination about women and peri-natal care to providers especially physicians;
- Implementing a legislatively mandated reporting requirement for viral loads and CD4 counts to identify HIV positive individuals;
- Expanding linkage services to further track clients beyond the first “kept” appointment;
- Enhancing post-test education of HIV positive clients and their partners;
- Expanding HIV awareness, 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
- Supporting more coordination of services such as transportation, housing, and other daily living needs of HIV positive clients

Even with these activities in place, individuals who are at greatest risk of infection and are unaware of their HIV status are often not ready to receive care due to multiple reasons that may include:

- Denial;
- Fear of others knowing their HIV status;
- No sense of urgency to seek testing because they feel well;
- Not ready for the responsibility of medications or medical visits;
- Physical and socioeconomic barriers;
- Persistent stigma surrounding HIV disease;
- Transmission through sex and/or sharing needles creates additional barriers in

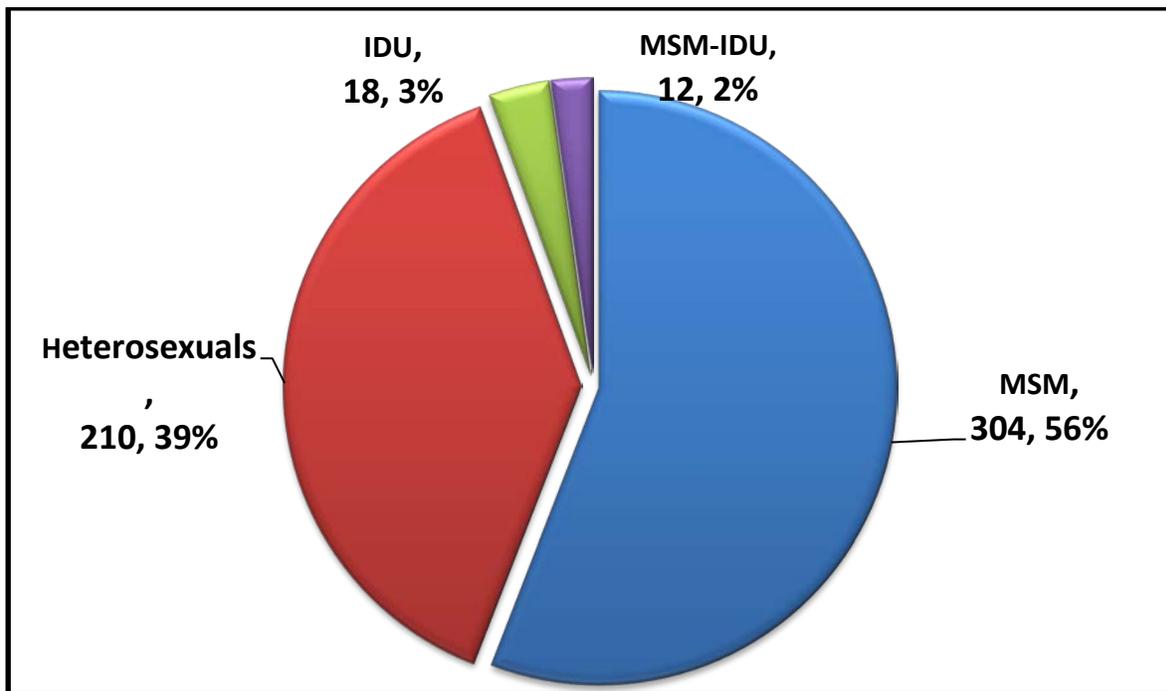
- connecting HIV residents to care and services;
- Lack of anonymity and fear of discovery and,
- Language and cultural differences present barriers including fear created by new Alabama immigration laws and the loss of confidentiality

In each of the eleven public health areas, the division employs an HIV Area Coordinator who works with ERTS. The coordinator investigates unreported HIV-positive individuals to determine if they are “in-care” or to aid the referral process so they may gain entry into medical care for HIV and AIDS treatment. The ERTS Program Manager reviews the ERTS list from each coordinator to assess how investigations were closed. Evaluation of the ERTS codes such as “coordinator-linked into care,” and “in-care,” as well as other closed investigation codes, aid in monitoring the success of the program.

e. Special Populations

To plan HIV/AIDS care and services, to provide appropriate prevention education, and to allocate limited resources as the epidemic continues to change and the number of persons living with HIV/AIDS continues to increase, it is extremely important to identify those populations most affected and most at risk for HIV infection. Review of Alabama’s HIV/AIDS surveillance data supports the following top three priority populations in Alabama at greatest risk for HIV exposure:

- **MSM (Men who have Sex with Men),**
- **WSM (Women who have Sex with Men), and**
- **MSW (Men who have Sex with Women).**

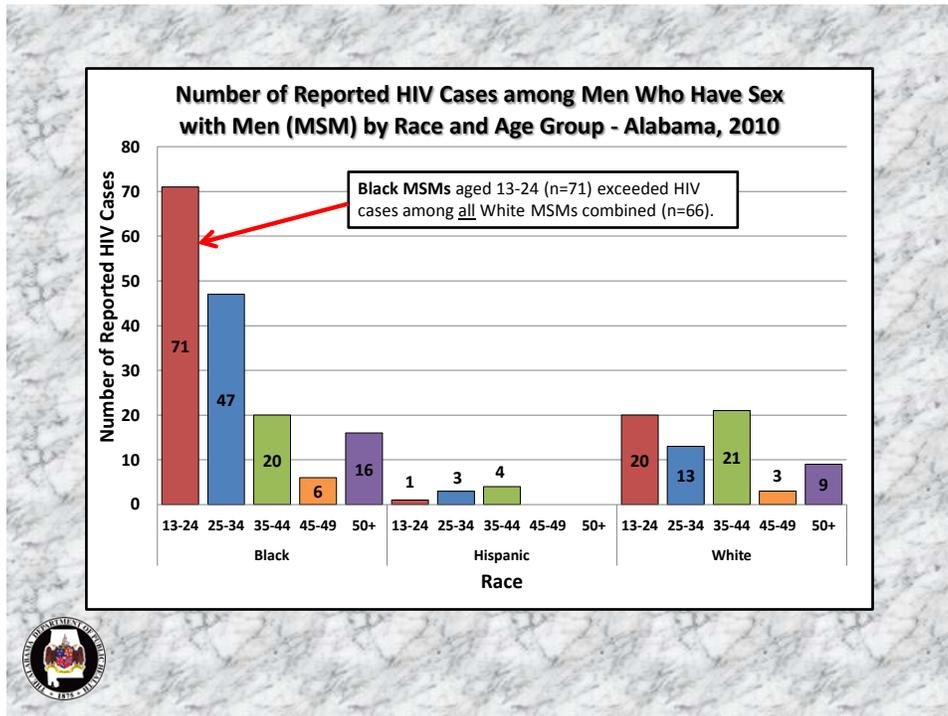


MSM

MSM especially younger men may underestimate their personal risk and make inaccurate assumptions about their partners HIV status. (5) In addition, MSMs may experience stigma from being “gay” and HIV positive resulting in this special population delaying or not seeking testing or care especially in rural areas in Alabama fearing loss of confidentiality.

Minority MSM/ and Transgender

HIV prevalence among MSM places this population at greater risk for infection with each sexual encounter (5). Minority MSM often face poor access to health care because of socioeconomic factors, including lack of health insurance and poverty. MSM and transgender individuals, especially in minorities living in rural Alabama, may experience stigma but being HIV positive as well only adds to the fear associated with the diagnosis. As a result, MSMs, transgender population and minorities may delay HIV testing as well as accessing care and services.



Young Black MSMs aged 13-24

From 2006 to 2010, the number of newly reported HIV/AIDS cases increased by 35 % for Black MSM Males aged 13-24. For young, Black MSM, partnering with older Black men (among HIV prevalence is high) can lead to increased risk (5). Young gay men have also become the victims of bullying in school settings creating an additional barrier to receiving prevention messages as well as accessing HIV care and services.

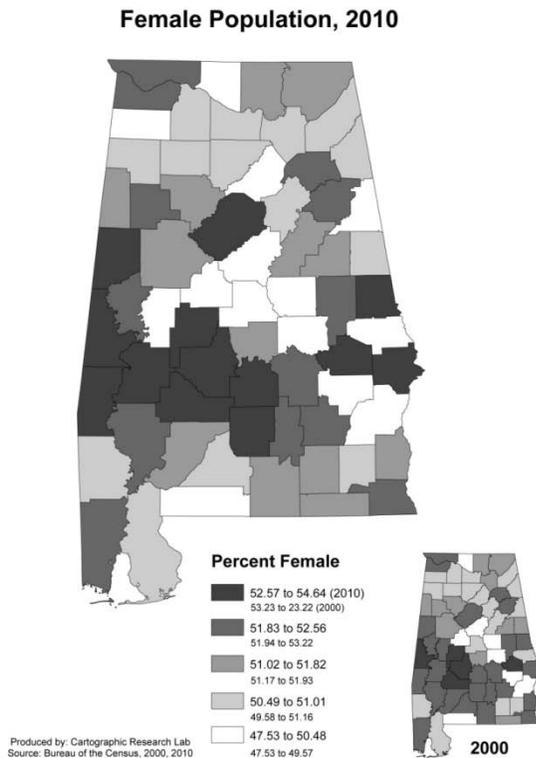
Youth

Critical issues for youth include drug abuse and lack of education related to sexuality and prevention practices. Adolescents who engage in high-risk health behaviors or have a history of psychological problems may not access HIV testing or care due to fear of loss of confidentiality especially youth living in rural Alabama (6). Many of the school systems in the state still support abstinence only education which creates additional constraints on students exploring their sexuality.

Women

Women and HIV/AIDS often face barriers to care associated with poverty, being uninsured or underinsured with children especially women of color and Hispanics. Women without insurance lack sufficient access to care, get lower quality of care when they do enter the health system and poorer health outcomes.

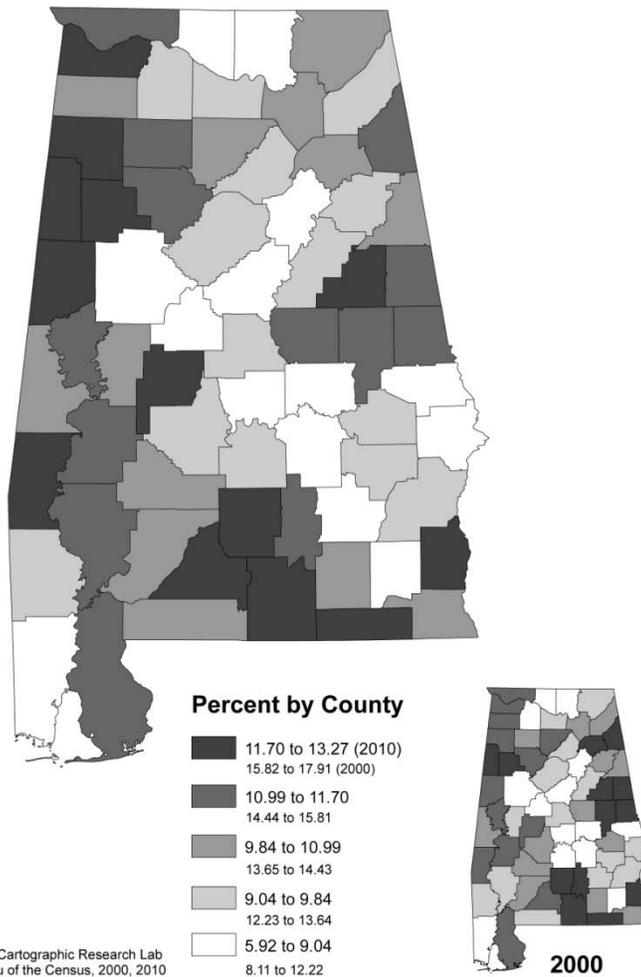
According to the *Alabama's Health Disparities Report 2008*, infant mortality is a good indicator to characterize the over-all health status and health disparities in the state. This report noted that factors contributing to infant mortality in Alabama include poverty, lower formal education, teen pregnancies, maternal chronic health conditions that exist before pregnancy; short intervals between pregnancies, previous pre-term births, and drug abuse (3b).



Elderly

Individuals in the elderly population often do not consider themselves at risk for exposure to HIV. They often lack education regarding HIV exposure so they may take part in unprotected sexual activity increasing their risk of exposure to HIV infection and STDs. The elderly may not access care for symptoms of HIV infection because of viewing these symptoms as just related to the natural aging process while health care providers may also relate complaints to aging and not related to possible HIV exposure.

**Population
Age 65 Years and Older, 2010**



Veterans

VA hospitals in Alabama are located in Birmingham, Mobile, Montgomery, Tuskegee and Tuscaloosa. Each VA facility has an HIV Coordinator to assist HIV positive veterans and their families in linking them to HIV care and services. However, the Birmingham Veterans Administration Medical Center is the principle provider of HIV outpatient and inpatient clinical services for Alabama's veterans. Distances required to travel to the VA in Birmingham for veterans living in other areas of the state, presents a significant barrier for these veterans to access HIV care in the state's VA system.

Transient Population

Transient populations are special populations in the state that move frequently, and do not have or provide stable contact information to ensure they receive post-test counseling and linkage to care.

Hispanics and Other Minorities

Alabama's rural population has greater ethnic diversity primarily due to the relatively sudden increase in the Hispanic/Latino population. This sudden increase in Alabama's Hispanic/Latino population has posed challenges in counties where this growth has been the greatest. The presence of a language barrier in many instances makes the services of an interpreter necessary. There is a lack of knowledge and experience with regard to cultural differences in providing health care to persons of Hispanic/Latino ethnicity. There have also been financial challenges in some areas where Alabama's new Hispanic/Latino population is uninsured.

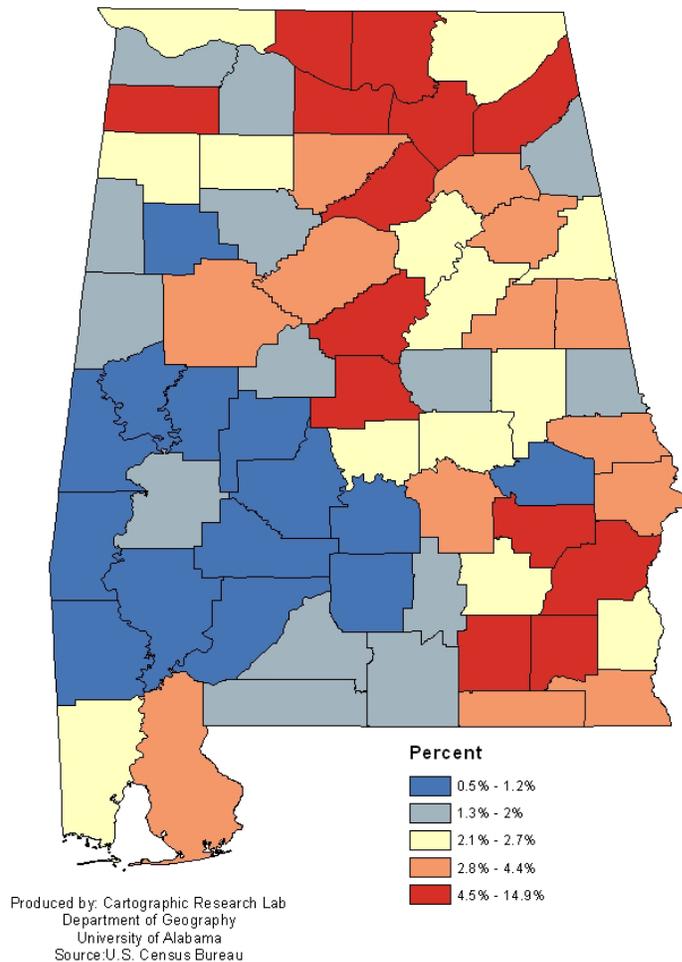
Identified Challenges for Hispanics and Other Minority Populations in Alabama:

Cultural differences

Language barriers

Fear of disclosing undocumented citizenship status

Hispanic Population, 2010



Asian American

In the latest US census report, Alabama's Asian population, which includes (Asian Indians, Chinese, Filipino, Japanese, Korean and Vietnamese residents) at 31,346 residents. (3)

Alabama's Asian American population increase in the past several years may be partly due to the increase in the State's foreign car manufacturing and auto parts suppliers opening in central and eastern Alabama.

Indian and Alaska Native

Alabama's American Indian and Alaska Native population in the 1980 US Census report was 7,583, in 1990, the population in Alabama totaled 16,506; and by 2000, the US Census reported the state's Indian and Alaska Native population at 33, 171. (3)

According to *The State Plan to Reduce and Eliminate Health Disparities 2008* report, Alabama currently has nine (9) tribes recognized by the state, with only one tribe recognized by the Federal government. Alabama's American Indians and Alaska Natives are experiencing alarming high rates of many health conditions known to be disparities nationally. (3)

Current HIV surveillance data shows the rate of HIV/AIDS cases reported in American Indian and Alaska Native population in Alabama at less than (1%).

f. Description of Shortfalls in Alabama's Health Care Work Force

Identified gaps in services across all regions consistently listed as access and funding for dental care, transportation, mental health services, including substance abuse treatment, support groups, follow-up counseling; and referral to services. In addition, statewide access to clinical drug and vaccine trials, dentists and physicians willing and able to care for clients, nutrition supplements and nutritional counseling, nursing home and long-term care; and primary and secondary prevention education and information.

The *Southern AIDS Manifesto 2008* reported that historically the South has faced challenges in creating quality health care systems. These challenges are reported to stem from a geographically dispersed population unable to afford specialized health care to manage communicable and chronic diseases (1b).

Shortage of Mental Health Care Professionals

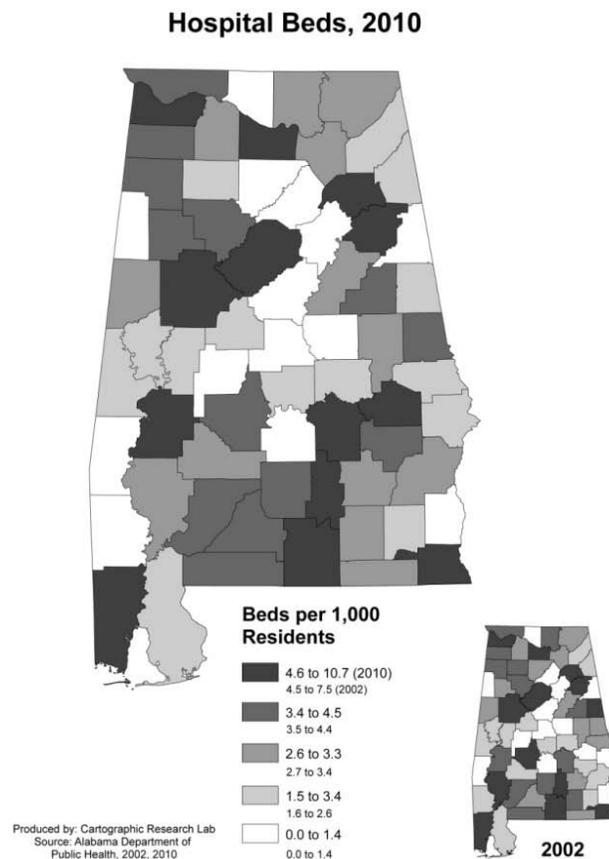
On the state level, Alabama's HIV/AIDS, STD and TB programs work jointly with the Alabama Department of Mental Health and Mental Retardation (ADMH/MR), and Substance Abuse Treatment programs to establish Qualified Service Organization Agreements (QSOA), which allow for the exchange of patient information between ADPH and MHMR, primarily related to persons in drug rehabilitation. However, the lack of mental health practitioners for low-income populations across the US and in Alabama leads to physical health care disparities especially in rural areas.

Many rural health care clinics or hospitals do not do mental health assessments or have a mental health referral network to support the clinician in meeting the mental health treatment needs of their patients. (7) Professional counselors and psychologists are not allowed to write prescriptions under Alabama law. Only psychiatrists are licensed to prescribe medications. Most rural Alabama counties only have the services of a visiting psychiatrist for a few hours per week at the local outpatient mental health center. Many rural hospital emergency rooms do not have adequately trained professionals to care for drug abuse and psychiatric cases. Consequently, waiting times to schedule an appointment to see a mental health professional can often be long. (7)

Because there is a limited number of treatment centers, referral options are limited especially when the patient must travel long distance to be seen at the nearest treatment facility. Transportation many times presents a major barrier to connecting a patient with mental health and substance abuse services especially those patients living in rural areas in the state. (8)

Stigma of a possible mental illness or substance addiction diagnosis often presents a barrier to an individual seeking care and treatment especially when living in small rural areas in Alabama. Often patients present only with their substance abuse for treatment. Their fear of disclosing HIV/AIDS status, their denial of a substance abuse problem, lack of training by the staff and patients make treatment very difficult. (8)

According to *Alabama's Rural Health Plan – 2008*, hospitals across the state, especially in rural Alabama, are facing growing challenges. The extreme poverty experienced by residents in both rural and urban counties in the State has resulted in hospitals having to provide more care that is indigent. In the poor economic climate facing the State, hospitals and clinics are being challenged to keep up with increasing costs and less available funding to provide care and services for a growing population. (9)



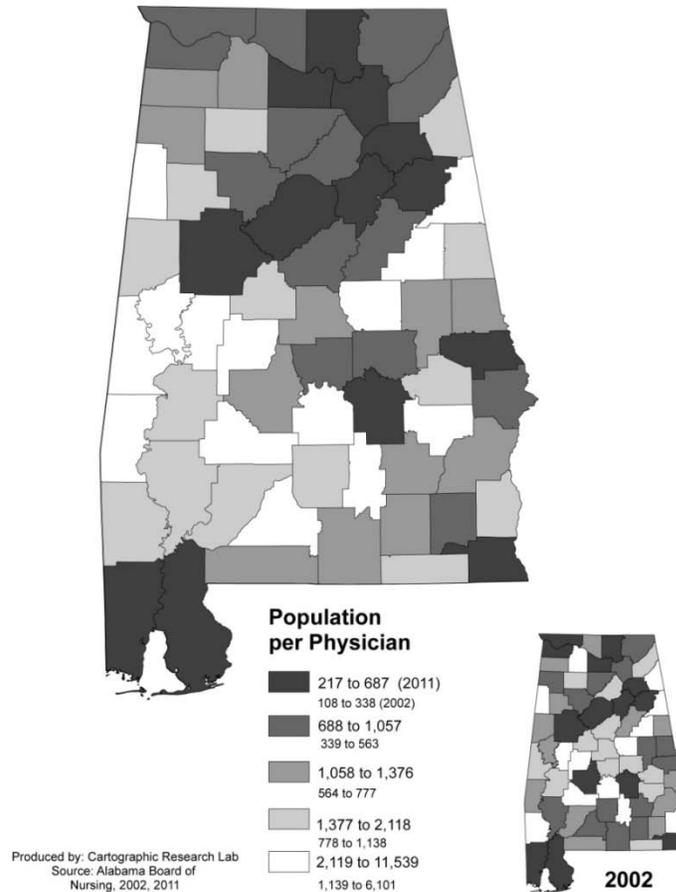
Shortage of Medical Providers and HIV Specialists

Fewer medical providers are willing to care for HIV/AIDS patients, or have little or no expertise to provide care and services for HIV residents outside of the four major metropolitan areas in the state. There is a critical need for “HIV Specialists” in both urban and rural areas in Alabama. According to a HRSA report, 54 of Alabama’s 55 rural counties have

shortages of primary care physicians to provide medical care. HRSA estimated that Alabama needs approximately 474 additional primary care physicians for the state’s rural health care system to offer an acceptable level of medical services for its residents.

Data supports that currently there are 4.6 primary care physicians per 10,000 rural resident populations compared to the 8.0 per 10,000 urban resident populations in Alabama. In 2006, there were a reported 3,048 actively practicing primary care physicians in the State. Projections supported that by 2011 more than half of these physicians would be over 55 years of age; while fewer new graduates surveyed plan to enter into the primary care field of medicine. (10)

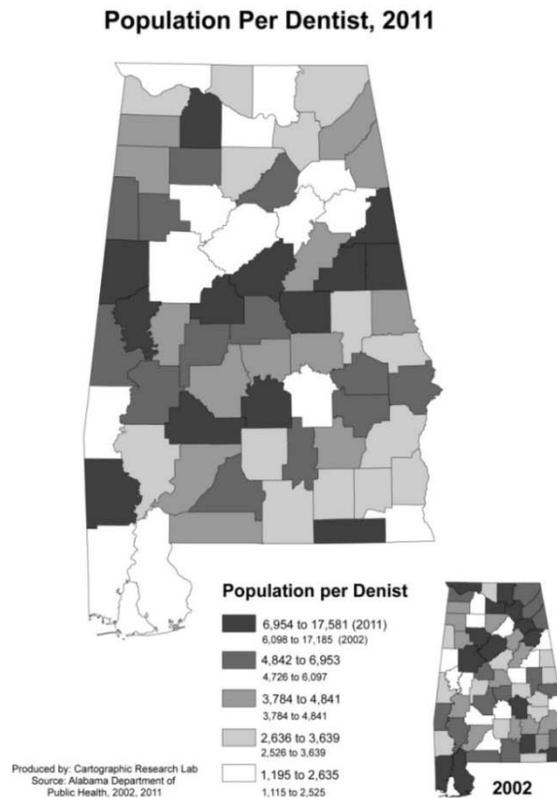
Population Per Physician, 2011



Shortage of Dentists

There are fewer dentists in the state, especially in rural Alabama creating barriers to accessing dental care for the general population but especially for PLWH/As who may have specific dental needs. Dental care among PLWH/As especially those who have no insurance, low income and no counseling are also associated with lower use or no use of dental services.

HRSA estimates that Alabama currently needs 294 additional dentists to help eliminate shortages across the state. (11)



Poor Adherence Support System

Adherence programs to encourage consistent treatment are limited or non-existent in a majority of areas in Alabama. PLWH/As who have access to adherence programs to encourage adherence to medical treatment including medications are less likely to be infectious to others.

Stressed State Public Health System

The HIV care and service system in Alabama for the most part occurs outside of the private medical sector relying primarily on local health departments, or RW funded care or service agencies to provide care and services for HIV Consumers. Most county health departments are not equipped to handle a complex disease like HIV and Physicians in rural areas, if there is a physician in these rural areas, usually lacks the medical expertise to treat a disease as complex as HIV and co-morbidities.

Poor Reputation of the Rural Health Care System

To gain confidence and support there is a need to improve the reputation of Alabama's rural health care system by assuring delivery of adequate and quality health care for residents living in rural areas across the state. The State's rural population must have confidence that the quality of the medical care they will receive in their small rural hospital or clinic is the same quality of care received in the larger urban hospital or clinic (9)

No State Health Insurance Continuation Program (HICP)

Lack of insurance or no insurance presents a major barrier for the State’s residents in seeking routine medical care, and can lead to significant loss of income to pay for routine medical care. Individuals will often elect not to access life saving HIV medications due to the high co-pay costs. Because the Medicare program provides health insurance for most people age 65 and over the State’s uninsured are primarily under the age of 65. The largest number of uninsured are people in the 30-49 age group, but the rate of people with no insurance is highest for young adults, aged 19-29 (Figure 1).

Figure 1 Distribution of Uninsured in Alabama by Age

Age	Number	Percent
0-18	111,600	9.3%
19-29	168,500	26.9%
30-49	197,700	14.7%
50-64	97,400	14.2%
Total	575,200	

Poor Medicaid Program

Alabama residents seeking health coverage through Medicaid face challenges accessing the program, and if enrolled, face further challenges due to the limited scope of services covered. Alabama’s Medicaid program has lower income eligibility levels and is more restrictive than many other states’ programs. *Alabama’s Rural Health Plan 2008* referred to Medicaid as “Rural Alabama’s Health Insurance.” Extreme rural counties in Alabama reported a rate of (23.3%) or nearly one (1) in every four (4) residents were eligible for Medicaid assistance compared to (19.4%) of residents living in the State’s urban counties. Residents living in two extremely rural areas in Alabama referred to as the “Black Belt” reported (35.5%) of its population eligible for Medicaid assistance, and (30.9%) of the Delta Region population eligible for Medicaid. (9)

Non-elderly adults in Alabama generally get Medicaid coverage in one of two ways: 1) by being part of a low-income family with children, or 2) by receiving SSI disability benefits from the federal Social Security Administration.

Medicaid for Low-Income Families (MLIF) is a healthcare program that covers the parents or caretaker relatives in very low-income families with children under 19. The Alabama Medicaid Agency itself notes that MLIF meets federal income requirements, “but is well below the national average” and “covers only the poorest of the poor” at 11.5% of the Federal Poverty Level which is one of the lowest standards in the nation.

To be eligible for SSI benefits, the Social Security Administration, an arduous process that often takes several years, must find claimants disabled. In Alabama, simply being HIV-positive and low-income is not enough to qualify for benefits. A person must also have another medical condition severe enough to prevent the individual from working.

Alabama has no “medically needy” Medicaid eligibility category. A medically needy category allows people who are categorically eligible for Medicaid (such as the disabled), but slightly over the income limit to become eligible by “spending down” their “excess” income until they meet the income requirements.

Limited Referral Sources for HIV Care and Services

A greater number of primary care physicians in the state are electing not to take new Medicaid patients, resulting in fewer referral resources for HIV care and services. Consequently, there is an increased demand for safety net care and service providers. Lack of local referral sources for HIV care and services, and lack of transportation alternatives for rural counties to access services located in urban areas has put an increased burden on HIV Consumers in Alabama and their Caseworkers and/or Clinicians to maintain treatment adherence.

Challenges to the State’s Health Care System to Meet Needs of the State’s Elderly Population

Between 2000 and 2025, the elderly population is projected to increase by 79.6 percent in Alabama’s rural counties compared to a 66.0 percent increase in the urban counties. This dramatic increase in the elderly population will seriously challenge Alabama’s rural health care industry. The National Ambulatory Medical Care Survey estimated more than 904,000 additional annual office visits to primary care physicians in Alabama by 2025. This increase in primary care visits is primarily due to the aging population. Additional visits may be needed due to the growing trends in diabetes and obesity in rural populations. This steady increase in the elderly population will create serious challenges for the State’s health care system.

Challenges to the State’s Health Care System to Meet the Needs of the State’s Hispanic Population

The increase in Alabama's Hispanic/Latino population has posed challenges in counties where this growth has been the greatest. The presence of a language barrier in many instances makes the services of an interpreter necessary. There is a lack of knowledge and experience with regard to cultural differences in providing health care to persons of Hispanic/Latino ethnicity. There have also been financial challenges in some areas where Alabama's new Hispanic/Latino population is uninsured.

g. A Description of Input from Each Entity Incorporated Into SCSN

Ryan White Part C – D and B funded Clinics in Alabama

Alabama’s HIV medical care and support services are provided by nine (9) Ryan White Part C grantees; two (2) Part D grantees and six (6) Part B funded AIDS Service Agencies (ASO). The following provides a brief description of each clinic including how each clinic or service organization shared their time and expertise to update Alabama’s SCSN and CP for the 2012-2015 planning cycle.

The 1917 Clinic

Part C Grantee - Part B funding

The 1917 Clinic is located in Birmingham in North Central Alabama, and is the largest HIV health care unit in the state. The 1917 Clinic participated in the Direct Care Prevention Collaborative, the CY 2012 Lead Agency-Provider meeting, and the AIDS Alabama's 2010 Consumer Needs Assessment Survey. A representative from this clinic actively participates in the Regional Quality Group (RQG) and the State ADAP Quality Group (AQG).

University of South Alabama HIV Early Intervention Clinic (USA)

Part D Grantee - Part B funding

The University Of South Alabama (USA) is Alabama's second largest research-oriented clinic. USA is located in Mobile in the southern tip of the state, and is affiliated with the University Of South Alabama School Of Medicine to serve women infants children and youth. USA participated in the Direct Care and Prevention Collaborative, the CY 2012 Lead Agency-Provider meeting and completed the Provider Needs Assessment Service Inventory. A representative from this clinic participates in the RQG and the State AQG.

Franklin Memorial Primary Care Center

Part C Grantee - Part B funding

Franklin Memorial Primary Care Center is a large full care clinic located in Mobile in the southern tip of Alabama. Franklin participated in the Direct Care and Prevention Collaborative and the CY 2012 Lead Agency- Provider meeting. A representative from this clinic participates in the RQG and the State AQG.

Mobile Early Intervention Clinic

Part - C Grantee - Part B funding

The Mobile Early Intervention Clinic is a third largest research-oriented clinic in Alabama. This clinic is affiliated with the University Of South Alabama School Of Medicine; and is located in the Mobile County Health Department in the extreme southern tip of Alabama. This clinic participated in the Direct Care and Prevention Collaborative and the CY 2012 Lead Agency-Provider. A representative from this clinic participates in the RQG and the State AQG.

Davis Clinic/AIDS Action Coalition (AAC)

Part C Grantee - Part B funding

AAC is a growing service clinic located in Huntsville in North Alabama. Huntsville is a large urban area that serves many surrounding rural counties. AAC participated in the Direct Care and Prevention Collaborative, the CY 2012 Lead Agency-Provider meeting and completed the Provider Needs Assessment Service Inventory. The clinic's Executive Director is an active participant in ASONA. A representative from this clinic actively participates in the RQG and the State AQG.

Health Services Center, Inc. (HSC)

Part C Grantee - Part B - Emerging Communities funding

HSC is located in Anniston in North East Alabama between Birmingham and Atlanta.

This clinic participated in the Direct Care Prevention Collaborative, the CY 2012 Lead Agency Provider meeting, completed a Provider Needs Assessment Inventory and participated in the AIDS Alabama 2010 Consumer Needs Assessment Survey. A representative from this clinic participates in the RQG and the State AQG.

Medical AIDS Outreach (MAO) (Formerly Montgomery AIDS Outreach (MAO))

Part C Grantee - Part B funding

MAO is located in Montgomery and serves 26 counties in South Central Alabama. MAO participated in the Direct Care and Prevention Collaborative, the CY 2012 Lead Agency Provider meeting, completed a Provider Needs Assessment Inventory and participated in the AIDS Alabama 2010 Consumer Needs Assessment Survey. A representative from this clinic actively participates in the RQG and the State AQG.

HOPE Clinic

Part C Grantee - Part B funding

HOPE Clinic is housed in Whatley Health Services which is a community health clinic serving Tuscaloosa and surrounding counties in Northwest Alabama. This clinic participated in the Direct Care and Prevention Collaborative, the CY 2012 Lead Agency-Provider meeting and completed a Provider Needs Assessment Inventory. A representative from this clinic participates in the RQG and the State AQG.

Cooper Green Hospital/St. George Clinic

Part C Grantee - Part B funding

The St George Clinic is located in the Cooper Green Hospital is located in Birmingham in North Central Alabama. This clinic participated in the Direct Care and Prevention Collaborative, the CY2012 Lead Agency- Provider meeting, participated in the Provider Needs Assessment Inventory and the AIDS Alabama 2010 Consumer Needs Assessment Survey. A representative from this clinic actively participates in the RQG and the State AQG.

UAB Family Clinic Birmingham and Montgomery

Part D Grantee - Part B funding

The UAB Family Clinic – Birmingham’s is located in North Central Alabama and in Montgomery in Central Alabama. UAB Family participated in the Direct Care and Prevention Collaborative, the CY2012 Lead Agency-Provider meeting and completed a Provider Needs Assessment Inventory. A representative from this clinic actively participates in the RQG and the State AQG.

AIDS Service Organizations (ASO)

ADPH through the HIV/AIDS Prevention and Control Division allocated Ryan White Part B funding in CY 2012 to six (6) AIDS Service Organizations (ASO) that participated in the SCSN. Each Part B funded ASO in Alabama is required to participate in the RQG beginning in CY2012. A brief description of each Part B funded agency and their participation in the 2012 SCSN is being provided below.

AIDS Alabama (AA)

Emerging communities Grantee - Part B

AA is located in Birmingham in the North Central Alabama. AA conducts the AIDS Alabama Consumer Needs Assessment Survey every three years in collaboration with the University of Alabama that is the primary resource used to ensure a large Consumer input in the SCSN and CP updating process. In addition, AA participated in the Direct Care and Prevention Collaborative and CY 2012 Lead Agency-Provider meeting. The Executive Director is an active participant in ASONA.

Birmingham AIDS Outreach (BAO)

Part B and Emerging Communities funding

BAO is located in Birmingham in North Central Alabama. BAO participated in the Direct Care Prevention Collaborative, the CY2012 Lead Agency-Provider meeting, participated in the Provider Needs Assessment Inventory and participated in the AIDS Alabama 2010 Consumer Needs Assessment Survey. The Executive Director participates in ASONA.

South Alabama Cares (CARES)

Part B

CARES is located in the southern tip of the state in Mobile Alabama; CARES participated in the Direct Care and Prevention Collaborative, the CY2012 Lead Agency-Provider meeting and completed a Provider Needs Assessment Survey.

Selma AIDS Information and Referral (AIR)

Part B

Selma AIR is a Part B funded service agency located in Selma in the West Central part of the state serving Public Health Area VII also known as Alabama's Black Belt. This agency participated in the Direct Care and Prevention Collaborative, the CY2012 Lead Agency Provider meeting and completed the Provider Needs Assessment Inventory.

Unity Wellness of East Alabama Medical Center (Formerly AIDS Outreach of EAMC)

Part B

Unity Wellness is located in Auburn Northeast Alabama in Opelika, and is affiliated with the local hospital (East Alabama Medical Center (EAMC)). Unity Wellness participated in the Direct Care and Prevention Collaborative, the CY2012 Lead Agency -Provider and completed the Provider Needs Assessment Inventory. The Executive Director participates in ASONA.

West Alabama AIDS Outreach (WAAO)

Part B

WAAO is located in Tuscaloosa and serves the counties in the Northwest portion of the state near the Alabama Mississippi state line. This agency participated in the Direct Care and Prevention Collaborative, the CY2012 Lead Agency-Provider meeting, and participated in the Provider Needs Assessment Inventory. The Executive Director participates in ASONA.

h. Collaboration with HIV/AIDS Specific Organizations

Alabama's MAI funded Peer Mentors

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. The Peer Mentors work with local medical clinics, ASOs and CBOs that provide HIV specific services to infected persons and high risk negative individuals. Because Peer Mentors are very knowledgeable about HIV care and services offered in their local areas, including identifying gaps in HIV care and services, they are valuable participants in updating Alabama's SCSN and Comprehensive Plan. Peer Mentors were represented at the Direct Care and Prevention Collaborative, Prevention Community Planning Groups (CPG), the AIDS Alabama 2010 Consumer Needs Assessment Survey, in the Alabama Consumer Advisory Board (ACAB) and in the AQQ.

Alabama Consumer Advisory Board (ACAB)

ACAB meetings provide an opportunity for Alabama's HIV Consumers to share their care and service needs from a personal and local perspective. Since most ACAB members and MAI funded Peer Mentors also attend the State ACAB meetings and participate in their local prevention network meetings, ACAB members as well as Peer Mentors are key participants in the SCSN updating process.

ADPH HIV Prevention and Control Division

Speakers at the Sixth Annual Direct Care and Prevention Collaborative included Ron Sparks, Director of Alabama's Office of Rural Development, Ann Jordan Reynolds Consultant Division of HIV/AIDS Prevention & Control, Nic Carlisle, Director Policy & Advocacy, AIDS Alabama Inc. *UAB South Central Public Health Training Center* Lisa McCormick, Assistant Professor, UAB Department of Health Care Organization & Policy. The 2011 Collaborative meeting was also an opportunity for participants to participate in plans for Alabama to address the President's National HIV/AIDS Strategy. (The 2011 DC and Prevention Collaborative Meeting Agenda is included in SCSN and CP in Attachment 2)

The HIV Surveillance Branch has always supported the State HIV/AIDS Direct Care and Prevention activities. The Surveillance staff provides an update of current state HIV/AIDS surveillance data and a comprehensive State Epidemiological Profile.

Southeast AIDS Training and Education Center – (SEATEC)

SEATEC assists health care providers in Alabama by identifying training opportunities and providing consultation services to enhance their capacity to offer HIV care. This service supports an increase access to care and improved health outcomes for PLWH/As in Alabama. SEATEC has always supported Alabama's Direct Care and Prevention program activities including the Direct Care and Prevention Collaborative each year.

Ryan White Part B Lead Agency

All RW Part B funded care and service providers must report service utilization data to the UWCA each CY. A service inventory was developed using service utilization data for CY 2011 to identify service needs and gaps in services presented in the 2012 SCSN. The UWCA is responsible for conducting Lead Agency-Provider meetings to bring all RW funded providers receiving Part B funding together to discuss program issues including care and service development based on identified unmet needs and barriers to care and service delivery with a focus on financial barriers.

The AIDS Service Organization Network of Alabama (ASONA)

Executive Directors of Ryan White Part B funded ASOs and the HIV/AIDS Division meet quarterly as a statewide network, the AIDS Service Organization Network of Alabama (ASONA). ADPH and ASONA collaborative meetings serve as a forum for sharing information, providing support, and receiving technical assistance.

Emerging Communities

The Central Alabama Ryan White Consortium meets monthly to oversee emerging communities funded care and services. All Emerging Communities providers attend, as well as peer educators (including youth representatives under the age of 19), HIV positive Peer Mentors, faith-based programs, including several representatives from large African-American churches, and community groups and representatives from education programs across the city that target specific populations, such as MSMs and homeless populations. Great care is taken to ensure the composition of the Central Alabama Consortium reflects the epidemic in Birmingham, which is the largest metropolitan area in Alabama, and where the largest HIV care and service centers are located. Alabama's SCSN updating process included EC needs assessment data. EC funded participants include AIDS Alabama, BAO, Health Services Center and the 1917 Clinic.

IV. SPECIAL CONSIDERATIONS

Part - A Alabama does not qualify to receive Part A funding.

Part - B

As previously mentioned, updating Alabama's SCSN every three-years is a collaborative process that includes HIV Consumers, Direct Care and Prevention participants and RW care and service providers funded through Part B, C and D as well as interested community partners. However, Alabama has always faced challenges in securing the participation of other state agencies such as Medicaid and Mental Health in the process until the Governor agreed to reinstate the State's HIV/AIDS Task Force. On World AIDS Day 2011, Alabama's governor signed an Executive Order creating the HIV/AIDS Prevention Task Force. 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 including Medicaid and Mental Health. 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.

B. DESCRIPTION of ALABAMA'S CONTINUUM of CARE

The Governor of Alabama has designated the Alabama Department of Public Health (ADPH) as grantee of the State's Ryan White (RW), Part B CARE grant. Unlike other State agency directors and commissioners, the Alabama State Health Officer, Dr. Williamson, is appointed by the State Board of Health and is not a member of the Governor's cabinet. However, Dr. Williamson does meet with the Cabinet. The Governor and the Alabama State Legislature approve and monitor the ADPH budget.

The Division of HIV/AIDS Prevention and Control operates under the auspices of the ADPH Bureau of Communicable Disease; and is responsible for administration of the funds for planning, organizing and implementing Alabama's Part B project activities and initiatives. Programmatic management of the Part B grant is the responsibility of the HIV Direct Care and Services Branch Director, fiscal management is the joint responsibility of the HIV Division Administrative Branch and the Part B Lead Agency, the United Way of Central Alabama (UWCA), with oversight by the HIV Division Director.

The HIV/AIDS Division Director, Jane Cheeks, J.D., M.P.H oversees program activities for the following six branches that make up the Division: Administration, Communications and Training, Prevention Planning and Development, Direct Care and Services, including the AIDS Drug Assistance Program (ADAP), HIV/AIDS Surveillance, and the Quality Management and Evaluation Branch.

The Alabama Department of Public Health (ADPH) divides the state into eleven Public Health Areas (PHAs) to facilitate coordination, supervision, and development of public health services. Ranging in size from one to eight counties, the areas are determined primarily by population. The most populous counties, Jefferson and Mobile, are the only single county PHAs. Each area has a regional office responsible for developing and managing local programs of public health services to meet the needs of that particular area. Each of Alabama's 67 counties has at least one county health department. Some health departments have multiple sites to be more accessible to their client populations.

Since 1988, all 67 county health departments in Alabama have offered voluntary and confidential HIV counseling/testing to individuals seeking STD, TB, Maternity, and Family Planning services. Counseling, testing, referral and partner notification (CTRPN) services are under the direction and administration of the Division of STD Control. Public Health nurses are trained to perform HIV pre-test counseling and post-test counseling. Disease Intervention Specialists (DIS) performs counseling, make referrals to social and medical services and perform partner notification activities for those who test positive. DIS also makes referrals and counsel clients who test negative for HIV, but have specific issues to be discussed.

Surveillance Branch

Data from the Surveillance Branch is shared on a regular basis with health department program components. These are directly involved with HIV/AIDS prevention, counseling and testing services, and patient education and risk reduction activities, with the State

Prevention Council and the Ryan White-funded ASO's and HIV clinics. Data interpretation and technical assistance from the Division staff are used for planning and evaluating prevention activities and targeting groups and geographic areas most in need.

Staff of the Surveillance Branch prepares an extensive epidemiologic report. The Division supplies state and statistical data from numerous sources, including the STD Division, the Center for Health Statistics, and the Center for Demographic Data and Cultural Research, Auburn University at Montgomery. To determine needs beyond the data in the epi-profiles, regions will continue to use various methods, including resource inventories, surveys, key informant interviews, community forums, and focus groups.

In November 1987, the Alabama Board of Health designated HIV as a reportable condition. Physicians are required to report diagnosed cases of AIDS. In order to retain a license, all laboratories performing HIV testing are required to report reactive tests including provider and patient identifiers.

HIV Prevention Branch

ADPH has monitored test results to detect newly discovered HIV-positive cases living in Alabama through the development of its "Enhanced Referral Tracking System" (ERTS) for over six years. Data analysis of laboratory HIV-positive test reports yields an "ERTS list" of unreported or previously unknown HIV-positive people whose home address is within Alabama's jurisdiction. Four of Alabama's eight Peer Mentors continually work with their HIV Area Coordinators to investigate HIV-IPs on their area ERTS lists. Four additional Peer Mentors regularly review client lists with clinic Case managers to identify and contact clients who have missed clinic appointments. One additional Peer Mentor is contacted by her HIV Area Coordinator for assistance with ERTS list clients on an as-needed basis. Peer Mentors document outreach, education, and referrals of each client. Beginning in January 2010, Peer Mentor data has been documented at the client level to facilitate cross-referencing of tracking individual clients across programs. Peer Mentors are funded by ADPH through the HRSA sponsored Minority AIDS Initiative (MAI) grant. In each of the eleven PHAs, the division employs an HIV Area Coordinator who works with ERTS. The Coordinator investigates unreported HIV-positive individuals to determine if they are "in-care" or to aid the referral process so they may gain entry into medical care for HIV and AIDS treatment.

State Peer Mentor Program

The Peer Mentor program is funded through the Minority AIDS Initiative grant and consists of peer mentors representing PHAs throughout the State of Alabama. The program aims to identify HIV positive persons in the community who are not receiving prevention and direct care services. 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. Peer Mentors work with local medical clinics, AIDS Service Organizations and community-based organizations that provide HIV specific services to infected persons and high risk negative individuals.

Alabama Consumer Advisory Board (ACAB)

The Alabama Consumer Advisory Board consists of Consumers throughout the state and represents various PHA. Each Consumer participates in their local consumer group to brainstorm ideas, discuss community needs, advocate for medical/dental and social services, and offer support to newly diagnosed persons. The ACAB participates in its local prevention network meetings, consortia meetings, patient advisory board meetings, and consumer advocacy meetings. The ACAB provides a voice for consumer issues to be expressed at the state level. This allows an opportunity for consumer participation and input in state level community planning, primary and secondary prevention activities and direct care services.

Alabama Prison Initiative

The Alabama Prison Initiative aims to provide primary and secondary education services to HIV positive inmates identified in the Alabama Department of Corrections. The Initiative is a collaborative partnership between the Alabama Department of Public Health-HIV/AIDS Division, the Alabama Department of Corrections, NaphCare Pharmacy, statewide AIDS service organizations and community-based organizations. ADPH has collaborated NMAC, and ADC to provide agencies that provide HIV trainings such as Prison Rape Elimination Act (PREA) and Discharge Planning. ASOs and CBOs regularly provide agency information to inmates.

Funded Prevention Projects

The HIV/AIDS Division provides HIV prevention funding to support primary and secondary education and outreach activities. Since 1997, the Division has funded projects that responded to the Request for Proposals. Funded agencies were those who presented unique and innovative strategies for responding to the prioritized risk populations in the eleven public health areas. Currently, there are 7 Community Based Organizations (CBOs), throughout the State, that receive CDC federal funding through the ADPH.

Enhanced Referral Tracking System

The Enhanced referral Tracking System has eleven HIV Coordinators divided by regions that track and link newly diagnosed HIV cases into care. ERTS has been fully implemented since January 2005 and has been presented at several national conferences as a model for other states to track, report, and link newly diagnosed HIV cases into care. For the past three consecutive years, Alabama has reported over 60% of newly diagnosed HIV cases have been linked into care. The ERTS program will continue follow up and verify clients have entered care. In addition, the Quality Assurance component of the program continues to enhance the information reported by coordinators. With the continued increase in new HIV cases, the coordinators maintain their strong collaborations with DIS, ASOs, and peer mentors.

FOCUS Program

The FOCUS program engages school systems statewide to incorporate the program as a class credit course, a core youth auxiliary, or other mechanism to teach HIV prevention/ community planning and risk behavior subjects to students. To date, sixty-two schools statewide are implementing this program. Both exceptional and marginal students are invited to participate in this peer learning/teaching model.

Communications/Public Information Branch

Public information and education continue to serve as effective preventive tools against HIV infection and against fear and resultant discrimination directed toward people who are infected. A public information campaign was one of the first tactics initiated by the ADPH in the early days of the epidemic. Thousands of Alabamians are reached through mass media, health fairs, printed materials/videos, music CDs, and other events throughout the year. Educational/informational efforts encourage individual risk assessment, testing, behavior modification, and early intervention through medical treatment. Education and training activities are designed for health care workers, caregivers, emergency medical service workers, educators, social workers, correctional facility staffs, law enforcement personnel and others working with HIV/AIDS.

The Alabama AIDS Hotline, established by ADPH in 1988, provides information and referrals to callers to a toll-free number. The one-to-one interactions between callers and trained hotline counselors provide opportunities for specific and personal exchange of information/education and referrals. The toll-free line also serves as a tool for providers to receive technical assistance from central office staff.

The HIV/AIDS Resource Directory for the state of Alabama, updated and published every other year by ADPH, lists national, state, and local HIV/AIDS services. Over the past ten years, more than 50,000 copies have been distributed. The Communications Branch coordinates a web page for the Division that provides current information about AIDS, HIV, and related issues and activities in Alabama. Additionally, thousands of culturally sensitive brochures promoting HIV Prevention were distributed.

Technical Assistance for Collaborative Partnerships

Technical assistance is offered throughout the state to collaborative partners upon request. Services offered includes grant writing, program monitoring and evaluation, board/committee development, program development and implementation, primary and secondary prevention planning, community and street outreach, developing partnerships and nontraditional organizations, and documentation and reporting.

Cross Program Collaboration

The HIV, STD and TB Programs of the Alabama Department of Public Health (ADPH) began an organized cooperative effort in 1994. Currently, the HIV/AIDS Division and the STD Division central office staff work together to assure continuity of services and achievement of goals and objectives for HIV/STD prevention and control. Representatives from all programs have been cross-trained in HIV, STD, TB issues and screening methods. Quarterly meetings occur to review activities, discuss progress and plan future collaborative efforts. Disease Intervention Specialists (DIS) participate in the State's Prevention program's community planning process.

The Divisions share responsibility for the collection and analysis of HIV counseling and testing data. Counseling Testing Referral Partner Notification (CTRPN) services are performed by the STD Program for clients who test positive for HIV in both public and private health care settings. Clients who test positive for HIV are referred for a tuberculin skin test. HIV/AIDS-related reports are forwarded from the STD Division to the HIV/AIDS

Surveillance Branch for data entry and analysis.

Additionally, the HIV/AIDS, STD and TB Programs work jointly with the Alabama Department of Mental Health and Mental Retardation (ADMH/MR), and Substance Abuse Treatment personnel to establish Qualified Service Organization Agreements (QSOA), allowing the exchange of patient information between ADPH and MHMR, primarily related to persons in drug rehabilitation. A joint training session on QSOA's was conducted for supervisory personnel from ADMHMR such as ADPH HIV/AIDS, STD and TB Programs.

HIV and STD prevention programs continue to work closely to plan and implement strategies for HIV prevention through early detection and treatment of STDs. Proposed strategies include refinement of counseling and testing, data gathering techniques for HIV/STD risk assessment, and inclusion of community-based AIDS Service Organizations (ASO's) in cross- educational training.

Collaboration of agencies and organizations involved in HIV/AIDS Prevention Services

Collaboration partnerships and community projects are established internal and external of the Health Department. Services includes: fostering linkages throughout the state between prevention programs, direct care services, consumer advisory groups, nontraditional community based organizations, and ASO.

Direct Care and Support Services Branch/ADAP

In November 1987, the Alabama Board of Health designated HIV as a reportable condition. Physicians are required to report diagnosed cases of AIDS. In order to retain a license, all laboratories performing HIV testing are required to report reactive tests including provider and patient identifiers. Until 1990, the ADPH had very limited participation in provision of direct care services to persons infected with HIV/AIDS.). In 1990, Congress enacted the Ryan White CARE Act to provide funding for states, territories, and EMAs to offer primary care and support services for people living with HIV/AIDS who lack health insurance and financial resources for their care.

With the receipt of RW funding in 1991, a Direct Care Services Branch was organized. The HIV/AIDS Direct Care and Services Branch oversees Alabama's RW Part B program activities that includes RW Part B medical and social services including funded Case Management and Alabama's ADAP.

In Alabama, there are a number of ways to receive care for HIV-positive individuals such as Alabama's ADAP and Medicare D cost Assistance Plan (MEDCAP). Alabama's ADAP provides medications for low income or no income residents living with HIV. Enrollment requirements include an HIV diagnosis by Western Blot, a documented permanent Alabama residence, a total gross income at or below 250% of the current Federal Poverty Level (FPL), and no third party payer sources to cover medication costs. Over 97% (1641) of active enrollees in 2011 reported an annual household income less than 200% of FPL. Over 64% (1091) of active and new enrollees were from Alabama's Black population, with Hispanics and other minorities under 5%. Over twice as many males were actively enrolled in the program during 2011 at 71% (1209), compared to females at 29% (487). The primary age

for enrollees for the same time period for the 25-44 age group was 55% (928) with the second highest in the 45-64 age group at 38% (639).

Medicare D Cost Assistance Plan (MEDCAP)

Alabama's ADAP sponsors a Medicare Part D cost assistance plan (MEDCAP) to assist ADAP enrollees eligible for Medicare, but do not qualify for Low Income Subsidy Assistance (LIS). MEDCAP pays for the cost of co-pays and premiums associated with the MEDCAP specific Medicare Part D plan. After nearly doubling in Enrollment in 2008 with 63 enrollees, MEDCAP continues to increase annually. MEDCAP enrollment for 2011 ended with 74. Medicare Part D continues to affect Alabama's ADAP enrollment through the transitioning of ADAP clients on to Medicare Part D plans for medication services.

Case Management

The HIV/AIDS Division funds a licensed Social worker through RW Part B to provide case management services to individuals who are not Medicaid-eligible in the higher-prevalence areas in PHAs 1 & 2 in counties across northern Alabama. Services are provided for non-Medicaid eligible clients. This Social worker is based out of the AIDS Action Coalition Part C funded clinic located in Huntsville in extreme North Alabama.

Clinical Trials Unit

The Center for AIDS Research at the University of Alabama at Birmingham (UAB) works in conjunction with the 1917 AIDS Outpatient Clinic, AIDS Clinical Trials Unit, and AIDS Vaccine Evaluation Unit.

VA Services

The Birmingham Veterans Administration Medical Center offers clinical HIV services to outpatient and inpatient veterans.

Women-Infants-Children and Youth

The Children's Hospital in Birmingham; and the University of South Alabama Women and Children Hospital in Mobile are the sites that provide care for the majority of HIV-infected women, infants, youth and children in the state. Education and counseling for family members of these children are also provided at both sites. Also clinical HIV expertise is provided through a contract with the University Of South Alabama Hospital (Infectious Disease Department). This service is provided at both sites in Mobile.

AIDS Service Organization Network of Alabama (ASONA)

Representatives of the AIDS Service Organizations and the HIV/AIDS Division meet quarterly as a statewide network, the AIDS Service Organization Network of Alabama (ASONA). Meetings serve as a forum for sharing information, providing support, and receiving technical assistance.

AIDS Alabama (AA) serves as fiscal agent for the network, subcontracting with the other organizations to provide prevention services, post-test education, case-management, and housing statewide funded by state and federal grants. This includes funding for prevention education from the state legislature through the Alabama Special Education Trust Fund.

ASO's and HIV clinics provide an accessible system of care and services for most people living with HIV in Alabama. Support services, including case-management, transportation and access to service/treatment are funded in areas where the need is documented and supported by results of surveillance data. Alabama epidemiological and surveillance data are used as criteria for funding Service Providers. Funding is awarded by a formula based on the number of persons living with HIV/AIDS in a defined service area, geographic area to be served, and number of clients served by provider.

The Evaluation and Quality Management Branch

The Division Director is responsible for the overall direction of the state QM/QI program in collaboration with the Division's Evaluation and QM Branch Director. Alabama's state quality program uses a network approach to implement the State's quality program that depends on local quality programs (Part B, C and D) and the state quality staff to implement CQI/QI activities. The Evaluation and Quality Management Branch and Direct Care Director attend the CQI group meetings to stay informed of Part C and D state CQI projects. The Division's QM and Evaluation Branch oversees the state's quality plan, and assumes a leadership role in collecting and analyzing local CQM project outcome data that guides state care and service improvement decisions. .

- **Ryan White funded HIV care and service inventory (by service category, organized by core and support services)**

Alabama's RW program moved from supporting local consortia beginning in 2006. Only two regional consortia continue to meet (Birmingham to manage Emerging Communities funding and Mobile consortium). HIV clinics and service organizations make application for RW funding through the State's Part B Lead Agency, the United Way of Central Alabama (UWCA), to provide HRSA defined core service priorities and support services with appropriate justification based on HRSA's minimum 75/25 funding requirement.

Alabama has allocated approximately 90% of funds for HRSA defined core services each year of the RW grant since 1990. This has been necessary because of the State's poor Medicaid system, and because there are few medical providers willing to provide care for HIV infected individuals. This has resulted in the creation of an HIV care and services system outside the private medical sector that is funded primarily through Alabama's RW grant. Funding decisions are made by ADPH as the State's RW Grantee using a formula based on the State's current HIV/AIDS Epidemiologic Profile, as well as unmet need data, service utilization reported by funded clinics and service organizations to the UWCA and in their annual RW Service Reports (RSR).

Beginning in CY 2002 RW funded HIV care clinics were designated as permanent active surveillance sites because of the large number of cases reported originating from these sites. Representatives from RW Part B, Part C and D funded clinics and ASOs continue to play an important role in Alabama's HIV/AIDS Direct Care and Services planning process; and in updating the SCSN and CP. Social workers/Case managers and Clinicians in RW funded HIV clinics and service organizations, are responsible for the coordination of care and service delivery. HIV care and services in Alabama are primarily located in the State's urban areas;

however, alternate care and services are offered at satellite clinics located in many rural areas across the State. Clinics and ASOs receiving RW Part B, C and D funding in Alabama for CY2012 are listed here.

AIDS Action Coalition (AAC)

AAC is a Part C grantee and receives Part B funding to provide HIV and primary medical care, education, social services and emergency financial assistance to individuals infected with or affected by HIV/AIDS in Public Health areas 1 & 2. The demography of the epidemic in this area is beginning to resemble that in South Alabama that includes an increase in heterosexual transmission and female representation.

AAC partners with MAO in the Alabama **e-Health Initiative** along with Whatley Health Services in Tuscaloosa to be able to extend medical care to serve 50 counties in the state. Services provided by AAC include outpatient ambulatory, local ADAP, oral health, early intervention, mental health, medical case management, non-medical case management, emergency financial assistance; health education and risk reduction, housing svcs., linguistic svcs., medical transportation svcs.; referral for health care and support svcs., and treatment adherence counseling.

AIDS Alabama (AA)

AA is located in Birmingham in the North Central Alabama. AA is the Emerging Communities grantee and receives Part B funding. AA serves as fiscal agent for the Emerging Communities service network, subcontracting with the other organizations to provide prevention services, post-test education, case-management, and housing statewide funded by state and federal grants. This includes funding for prevention education directly from the state legislature through the Alabama Special Education Trust.

AA oversees the State's HOPWA services as well as targeted case management services. AA provides support services including multiple apartment complexes that houses applicable individuals living with HIV, case management and transportation to medical and social service appointments. AIDS Alabama also has a Rectory Substance Abuse Treatment Program (transitional housing) offers eleven beds to HIV positive homeless persons seeking substance abuse treatment.

Since 1990, ADPH has used state funds to contract with community-based ASO's through AA to provide post-test education sessions for individuals infected with HIV. Health department clinics, private physicians, and other testing sites may refer individuals who have received initial post-test counseling to local ASOs for additional post-test education and support. ADPH reimburses for four sessions per individual during a two-year follow-up period.

Since April 1990, Targeted Case Management for HIV/AIDS has been available to Medicaid-eligible individuals under funding from the Health Care Financing Administration (HCFA). AA oversees the Medicaid Targeted Case Management program.

Alabama Department of Public Health Clinical Laboratories

The State Lab, located in Montgomery in Central Alabama, continues to perform in excess of 100,000 HIV tests for all clinics in the public health system. Additionally CD4 lymphocyte

testing is offered and performed free of charge for private providers and outpatient HIV clinics throughout the state.

Alabama Reference Laboratory in Montgomery serves a broad geographic area providing HIV-antibody testing and CD4 lymphocyte counts for private physicians and medical clinics throughout the southern region of the state.

Unity Wellness Center of EAMC (UWC)

Unity Wellness is located in Auburn Northeast Alabama in Opelika, and is affiliated with the local hospital (East Alabama Medical Center (EAMC)). UWC is a full-service HIV/AIDS specific agency serving Lee, Macon, Russell, Chambers and Tallapoosa Counties (in Public Health Areas 8 & 6). UWC receives Part B funding and subcontracts with MAO to provide medical case management services. Services provided include medical and non medical case management, oral health care, outpatient ambulatory health svcs., early intervention svcs., emergency financial assistance, medical transportation and housing.

Birmingham AIDS Outreach (BAO)

BAO is located in Birmingham in North Central Alabama. This ASO receives Part B and Emerging Communities (EC) funding. to provide client services and prevention education programs in the greater Birmingham and surrounding areas. Services provided include mental health services, non-medical case management, emergency financial assistance; food bank and home delivered meals, legal svcs., medical and transportation svcs. BAO oversees the ADPH funded intervention program, the Birmingham Mpowerment Project, that targets young African-American MSM's 18-40.

Birmingham VA Medical Center

The VA is located in Birmingham in North Central Alabama and serves as the primary medical provider for HIV- infected veteran population for the Southeast. The clinic's multidisciplinary team approach combines the efforts of five attending physicians, fellows, physician assistant, nurse coordinator, mental health provider, social worker, team associates, and support staff. This hospital and clinic generally report more than ten HIV/AIDS cases quarterly in Alabama. The clinic also has an effective collaborative relationship with Jefferson County Department of Health's disease intervention staff for new patients who need in care services.

Cooper Green Hospital/St. George Clinic

St. George Clinic is located in Birmingham in North Central Alabama; and is a Part C grantee and receives Part B funding. This clinic serves as the primary medical provider for the indigent HIV-infected population for Jefferson County (PHA IV). The clinic has an effective collaborative relationship with Jefferson County Department of Health's disease intervention staff for new patients who need in care services. This clinic collaborates extensively with UAB Family Clinic, Children's Hospital, which is the largest HIV clinic for follow-up of prenatal exposed children and families. Part B funded services include outpatient ambulatory, oral health and a local ADAP.

Franklin Memorial Primary Care Center

Franklin Memorial Primary Care Center is a large full care clinic located in Mobile in the southern tip of Alabama with numerous satellite clinics in counties across South Alabama. Franklin Memorial Primary Care Center is a Part C grantee, receives Part B funding and receives funding for prevention education activities. A full range of services is available to persons living with HIV through Franklin Primary Care Center which includes outpatient ambulatory , local ADAP, oral health care; insurance premium assistance, mental health svcs., medical nutrition therapy, medical case management and substance abuse outpatient services.

Health Services Center, Inc. (HSC)

HSC is a Part C grantee and receives Part B and Emerging Communities funding. HSC has five satellite clinics that are located throughout the coverage area, and serves a largely rural HIV Consumer population from Public Health Area IV (11 counties). HSC was nationally recognized as the first rural HIV/AIDS specific clinic, and was the first Ryan White, Title III grantee in Alabama. HSC provides oral health svcs., outpatient ambulatory health svcs., mental health svcs., and medical transportations svcs.

Maude Whatley Health Services (HOPE Clinic)

HOPE Clinic is housed in Whatley Health Services which is a community health clinic serving Tuscaloosa and surrounding counties in Northwest Alabama extending to the Alabama – Mississippi state line. HOPE Clinic is a Part C grantee and receives Part B funding. This full service clinic is based in Tuscaloosa with satellite offices in Walker County (Sipsey) and in Sumter County. Whatley Health Services provides family medicine at three different sites that includes a dental clinic.

Whatley partners with MAO and AIDS Action Coalition in Huntsville in the Alabama **e-Health Initiative** to be able to extend medical care to 50 counties in the state. Part B funded services include outpatient ambulatory, local ADAP, oral health care, mental health svcs., medical nutrition, health education and risk reduction and medical transportation.

Mobile Early Intervention Clinic in Mobile (MCHD)

The Mobile Early Intervention Clinic is a third largest research-oriented clinic in Alabama. This clinic is affiliated with the University Of South Alabama School Of Medicine; and is housed in the Mobile County Health Department in Mobile located in extreme southern tip of Alabama. This clinic is a Part C grantee Early Intervention Clinic and receives Part B funding. MCHD also houses a dental clinic. Services offered include, outpatient ambulatory, oral health care and medical nutrition.

Medical AIDS Outreach (MAO)/Copeland Clinic

MAO is a Ryan White Part C grantee and receives B and Emerging Communities (EC) funding. MAO is located in Montgomery in Central Alabama and in Dothan in Southeast Alabama. In addition, MAO has satellite clinics in five other counties (Selma, Clayton, Auburn, Greenville & Troy).

MAO partners with Whatley Health Services in Tuscaloosa and AIDS Action Coalition in Huntsville in the Alabama **e-Health Initiative** to be able to extend medical care to over 50

counties in the state. This clinic provides outpatient ambulatory, local ADAP, oral health care, mental health svcs., medical case management, non-medical case management and emergency financial assistance. MAO subcontracts with Selma AIR and Unity Wellness center to provide medical case management services to offer HIV care at these two sites.

Selma AIDS Information & Referral (Selma AIR)

Selma AIR receives Part B funding, and subcontracts with MAO to provide medical case management svcs. Selma AIR is located in Selma in west central Alabama and provides services to eight counties in PHA VII. The service area includes the poorest counties in Alabama in the heart of the Black Belt. Services offered by Selma AIR include oral health care, outpatient ambulatory, non-medical case management, food bank and home delivered meals, medical transportation svcs., psychosocial support svcs.; and referral for health care and support svcs. Selma AIRS subcontracts with MAO to provide medical case management services.

South Alabama Cares (CARES)

CARES is a Part B funded ASO located in Mobile in the southern tip of the state. CARES provides a wide range of support services for the HIV population in counties in the southern and Southwestern part of the state that is considered to be extremely rural; and in need of HIV care and services for PLWH/As in those counties near the Alabama-Mississippi state line. CARES offers oral health care referrals, health insurance premium and cost sharing; nonmedical case management, emergency financial assistance; food bank and home delivered meals; housing services and medical transportation svcs.

UAB 1917 Clinic (1917 Clinic)

The 1917 Clinic is an academically based clinic, and is the largest HIV health care unit in Alabama serving more than 1,500 patients annually. For more than 20 years, the UAB 1917 Clinic has primarily provided comprehensive core medical and social services to adult HIV infected patients. Medical specialty, dental and mental health services are available onsite through referral. The 1917 Clinic is a Part C grantee and receives Part B and EC funding. Since 1994 the Alabama HIV/AIDS Clinical Trials Unit (HVTU), has been housed in the UAB 1917 Clinic; and under the direction of the Principal Investigator, Michael S. Saag, MD, is responsible for HIV/AIDS vaccine, prevention and treatment research. The National Institute of Allergy and Infectious Diseases (NIAID) fund the Clinical Trials Unit. Services provided by the 1917 clinic includes: outpatient ambulatory svcs., local ADAP, oral health care, mental health svcs., medical nutrition therapy, medical case management, substance abuse outpatient svcs.; and home and community based health svcs.

UAB Immunology Laboratory

The UAB Lab is located in Birmingham in North Central Alabama. The UAB Lab provides HIV and CD4 testing for the University Hospital and many clinical providers in the Birmingham area.

UAB Family Clinic, Children's Hospital

UAB Family Clinic is a statewide referral source for infected children, adolescents and their families. This clinic is located in Birmingham in North Central Alabama and has regional extensions in Montgomery in Central Alabama. UAB Family Clinic is a Part D grantee and

receives Part B funding. The clinic provides medical and supportive services to an estimated 95% of the known infected children, adolescents, young adults, pregnant women/adult women in Alabama. Services offered include outpatient ambulatory health svcs., local ADAP, oral health care, early intervention svcs., health education and risk reduction; and referral for health care and support svcs.

The University of South Alabama Family Specialty Clinic (USA)

USA is Alabama’s second largest research-oriented clinic in the State. USA is located in Mobile in the southern tip of the state and is affiliated with the University Of South Alabama School Of Medicine to serve women, infants, children and youth. This clinic is a Part D grantee and receives Part B funding. Services provided include outpatient ambulatory health svcs., oral health care and medical transportation.

West Alabama AIDS Outreach (WAAO)

WAAO is located in Tuscaloosa and serves the counties in the Northwest portion of the state near the Alabama Mississippi state line. WAAO receives Part B funding and subcontracts with HOPE Clinic to provide medical case management svcs. WAAO operates at the main office in Tuscaloosa. Services offered include a local ADAP, medical and non-medical case management, emergency financial assistance; food bank and home delivered meals and psychosocial support svcs.

Service Inventory Summary CY 2011**		
Core Medical Services		
a.	**	Outpatient /Ambulatory health services
b.	**	AIDS Drug Assistance Program (ADAP) treatments (STATE ADAP)
c.	**	AIDS Pharmaceutical Assistance (local)
d.	**	Oral health care
e.	**	Early Intervention Services
f.	**	Health Insurance Premium & Cost Sharing Assistance
g.		Home health care
h.	**	Home and Community-based Health Services
i.		Hospice Services
j.	**	Mental health services
k.	**	Medical Nutrition Therapy
l.	**	Medical Case Management (including Treatment Adherence)
m.	**	Substance abuse services–outpatient
Support Services		
n.	**	Case Management (non-Medical)
o.		Child care services
p.	**	Emergency financial assistance
q.	**	Food bank/home-delivered meals
r.	**	Health education/risk reduction

s	**	Housing services
t	**	Legal services
u	**	Linguistics Services
v	**	Medical Transportation Services
w		Outreach services
x.	**	Psychosocial support services
y.	**	Referral for health care/supportive services
z		Rehabilitation services
aa.		Respite care
ab.	**	Treatment adherence counseling

NOTE: Part B RW grant funds may be to provide Support Services listed in the chart above. The Ryan White Program Service Category Definitions listed below include additional categories that are only funded through RW Part C; and or D and not B

Core Medical and Support Services Definitions

Part B grants fund core medical services and support services. Core medical services include outpatient and ambulatory health services, ADAP, Local AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost-sharing assistance, home health care, medical nutrition therapy, hospice care, home and community-based health services, mental health, outpatient substance abuse care, medical case management, and treatment adherence services.

Alabama’s RW Part B Program currently provides funding to 9 HIV specialty clinics that receive Part B and C to provide HIV medical care and services; 2 that receive Part D (Women and Children) and 6 ASOs receive Part B funding to provide case management and other essential support services for HIV positive Alabama residents. To update the State’s service inventory in the SCSN for 2012, services allowed through RW funding are described here along with funded care and service organizations that were funded to provide each service in CY 2012

- a. ***Outpatient/Ambulatory Services*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service’s guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **HSC – 1917**

Clinic – MAO – St. George – UAB Family – USA Specialty – AAC – MCHD – UWC – Franklin – HOPE Clinic

- b. ***AIDS Drug Assistance Program (ADAP treatments)*** is a State-administered program authorized under Part B of the Ryan White Program to provide FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare. **State AIDS Drug Assistance Program**
- c. ***AIDS Pharmaceutical Assistance (local)*** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. **1917 Clinic – MAO – St George –UAB Family- AAC – Franklin – WAAO – HOPE Clinic**
- d. ***Oral health care*** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers. **HSC – MAO – St. George – UAB Family –USA Specialty – AAC – MCHD – UWC – SAC – Selma AID – Franklin**
- e. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures. **UAB Family –AAC –UWC**
- f. **Health Insurance Premium & Cost Sharing Assistance** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles. **Franklin**
- g. ***Home Health Care*** includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parental feeding, diagnostic testing, and other medical therapies. **HIV Medicaid Waiver Program**
- h. ***Home and Community-based Health Services*** include skilled health services furnished to the individual in the individual’s home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long-term care facilities are NOT included. **1917 Clinic**
- i. ***Hospice services*** include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients. **No RW funded provider offering**

- j. ***Mental health services*** are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers. **BAO – HSC- AA – 1917 Clinic – MAO – AAC – Franklin – HOPE Clinic**
- k. ***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of primary care visits and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services. **1917 Clinic – MCHD – Franklin – HOPE Clinic**
- l. ***Medical Case management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. **1917 Clinic – MAO – AAC – UWC – Selma AIR – Franklin – WAAO**
- m. ***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel. **AA – 1917 Clinic – Franklin**

SUPPORT SERVICES

- n. ***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. **BAO – AA – MAO – AAC – UWC – Selma AID – WAAO**
- o. ***Childcare services*** are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training. NOTE: This does not include childcare while a client is at work. **No RW provider offering**
- p. ***Pediatric developmental assessment and early intervention services*** are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational

intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category. **USA Family UAB Family, Children's**

- q. **Emergency financial assistance** is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. **BAO – AA – MAO – AAC- -UWC – SAC**
- r. **Food bank/home-delivered meals** include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. **BAO – MAO (EC) – SAC – Selma AIR – WAAO**
- s. **Health education/risk reduction** is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status. **UAB Family – AAC HOPE Clinic**
- t. **Housing services** are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services. **AAC – SAC**
- u. **Legal services** are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver. **BAO**
- v. **Linguistics services** include the provision of interpretation and translation services. **AAC -**
- w. **Medical transportation services** include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services. **BAO-HSC – USA Specialty- AAC – UWC – SAC – Selma AIR – HOPE Clinic**
- x. **Outreach services** are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding). These services may target high-risk communities or individuals. Outreach services must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication, and services must target populations known through local epidemiologic data to be at disproportionate risk for HIV infection. Services must be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached and be

designed with quantified program reporting that will accommodate local effectiveness evaluation. **No RW provider offering**

- y. **Permanency planning** is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them. **No RW provider offering**
- z. **Psychosocial support services psychosocial support** are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements. **AA- Selma AIR – WAAO**
- aa. **Referral for health care/supportive services** is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program. **UAB Family – AAC – Selma AIR**
- ab. **Rehabilitation services** are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client’s quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training. **No RW provider offering**
- ac. **Respite care** is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS. **No RW provider offering**
- ad. **Treatment adherence counseling** is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting. **AAC**

RW Part B Service Utilization Review for CY2011-2012

All Part B funded care and service providers must report service utilization data to the Part B Lead Agency (UWCA) during the contract year. Service utilization data provides a comprehensive RW service inventory used to update the SCSN each planning cycle, as well as to support funding decisions and service planning prior to each RW contract year. (Figure1)

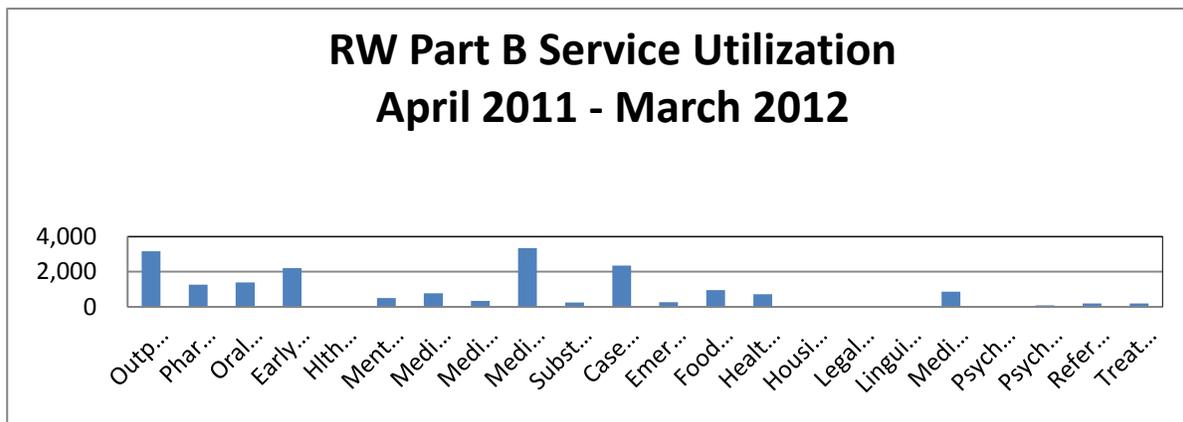
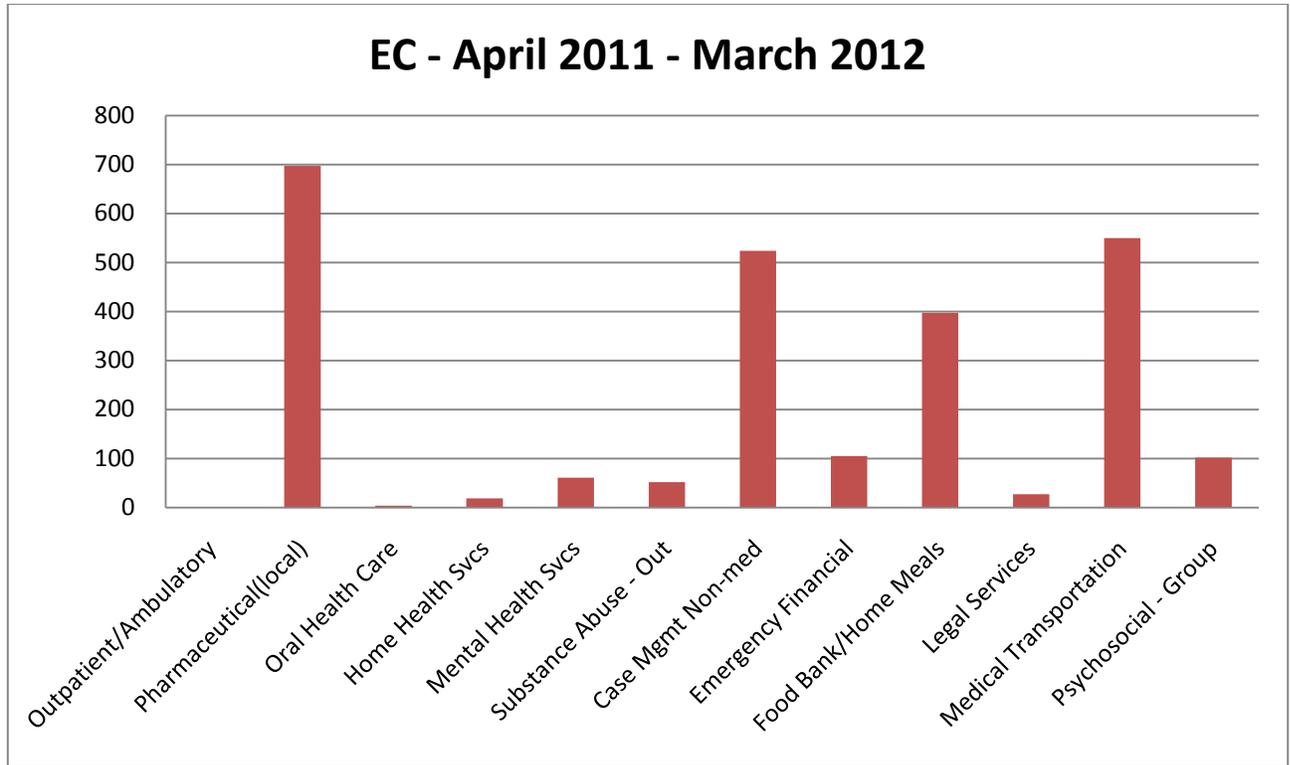


Figure 2



Alabama has a Jurisdiction that is classified as an Emerging Community (EC) – Birmingham-Hoover Alabama - making the state eligible to apply for EC funding for FY 2012. These funds are used to augment current state, privately raised, and federal funds in provision of medical and other support services to HIV-positive consumers. These funds are awarded to one HIV Care Consortium, the Central Alabama Ryan White Consortium, whose service areas are included in the BMSA. The actual recipients of funds are the following programs that operate in these counties: the University of Alabama at Birmingham 1917 Clinic (referred to as 1917) and six AIDS Service Organizations (ASOs) which are AIDS Alabama, Birmingham AIDS Outreach (BAO), Health Services Center (HSC), AIDS Action Coalition (AAC), West Alabama AIDS Outreach (WAAO), and Montgomery AIDS Outreach (MAO). The distribution methodology is based on the cumulative number of persons infected with HIV disease through October 2011 in the service area. The total number of infections was 5,613. Each county was assigned a percentage of the total with the funding designated proportionately. A summary of the services provided through EC funding, and the number of unduplicated clients accessing these services for CY 2011 is presented in Figure 2.

- **Non Ryan White funded – HIV care and service inventory (Organizations and Services)**

Primary and Rural Health Center Partners

The Historically Black Colleges and Universities (HBCU) component of the ETI will span 15 college campuses with a program goal to test 10% of the student enrollment at each campus. These partnerships create new HIV rapid testing sites, and provide the latest education, information, and experiences in the field.

The Division and the University of Alabama Family Health Clinic outreach services for pregnant women will collaborate through a new strategy called *The Pregnancy Improvement Project (PIP)* to create a web page provides perinatal updates, statistics, CDC recommendations, and treatment guidelines. A 1-800 number is located on the web page with HIV perinatal experts answering the calls five days per week. Private providers have access to web resources and brief needs and cultural competency to more effectively work with pregnant women.

The Division and the University of Alabama (UAB) Emergency Department (ED)

The UAB Emergency Department (UED) testing initiative is located in the busiest hospital center in the state. Any pregnant woman who presents for services will be offered testing in all venues. Clients with positive results are linked to the UAB 1917 Specialty Clinic and/or Family Medicine program.

Historically Black Colleges and Universities (HBCUs) in Alabama

The HBCU component of the ETI will span 15 college campuses with a program goal to test 10% of the student enrollment at each campus. These partnerships create new HIV rapid testing sites, and provide the latest education, information, and experiences in the field.

Medicaid Waiver Program

Centers for Medicare & Medicaid Services (CMS) approved the ADPH plan to extend home- and community-based services to persons with HIV/AIDS in 2003. The 1915(c) waiver of Medicaid rules allows the state to provide services to individuals in their homes, keeping many out of nursing homes and other institutions. The State enrolls persons with HIV/AIDS and related diseases with incomes of up to 300 percent of the Supplemental Security Income federal benefit level. This brings in a group of individuals who would not normally be eligible for Medicaid unless they were in an institution.

Laboratories

Alabama Reference Laboratory (ARL)

ARL is located in Montgomery in south central Alabama, and serves a broad geographic area providing HIV-antibody testing and CD4 lymphocyte counts for private physicians and medical clinics throughout the southern region of the state. The site plays a vital role in Alabama's Surveillance Branch to evaluate the completeness of HIV reporting.

UAB Immunology Laboratory

The UAB Lab is located in Birmingham in north central Alabama; and provides HIV and CD4 testing for the University Hospital and many clinical providers in the Birmingham Area.

- **How RW funded care/services interact with Non-RW funded services to ensure continuity of care**

The Division supports coordinated opportunities for integrative activities. Since 1982, all HIV test providers have been required to refer all HIV positive cases for TB and STD services. The STD Division staff provides Partner Services (PS) to HIV positives.

The Division and the STD Division central office staff work closely to assure continuity of services and achievement of the goals and objectives of the HIV program. These programs share responsibility for the collection and analysis of HIV counseling and testing data. In addition to CTRPN services in the county health department, the STD Program also provides follow-up to individuals testing positive for HIV-Abs reported to the HIV/AIDS Surveillance Branch by facilities other than ADPH clinics. This requires close daily coordination between the HIV/AIDS and STD Programs.

Historically Black Colleges and Universities (HBCUs)

Through the Early Testing Initiative (ETI), the Division in collaboration with the STD Division and ASOs offer joint HIV testing events at the Historically Black Colleges and Universities (HBCUs), rapid and acute HIV as well as testing for syphilis, gonorrhea and Chlamydia testing.

The HBCU component of the ETI will span 15 college campuses with a program goal to test 10% of the student enrollment at each campus. These partnerships create new HIV rapid testing sites, and provide the latest education, information, and experiences in the field.

New Primary and Rural Health Center Partners

The ETI also offers an opportunity to collaborate with new primary and rural health center partners to promote routine early HIV testing.

Medical HIV Testing Sites

The UAB Emergency Department (UED) testing initiative is located in the busiest hospital center in the state. Any pregnant woman who presents for services is offered testing in all venues. Clients with positive test results are linked to the UAB 1917 Specialty Clinic and/or Family Medicine program to begin care and services.

Patient Assistance Programs (PAP) and educational programs, providing continuing education and capacity building for providers

The Magic City Choral Society of Birmingham has instituted an annual choral benefit performance called the Red Ribbon Concert that raises funds for Birmingham AIDS Outreach, AIDS Alabama, West Alabama AIDS Outreach and the University of Alabama at Birmingham 1917 Clinic. Each of these agencies holds numerous fund raising events that help generate funding for services.

AIDS United provides funding to AIDS Alabama for advocacy and outreach to youth and Latino communities.

Substance Abuse and Mental Health Services Administration (SAMHSA) funding for the Living in Balance Chemical Addiction Program (LIBCAP), first awarded in 2008. This program serves PLWH/As in Alabama in need of substance abuse treatment.

The Centers for Disease Control (CDC) funding of \$1.7 million for a five-year project providing HIV prevention services to the target population in Birmingham of Young Men who have Sex with Men of Color. They have collaborated with Birmingham AIDS Outreach (BAO) in the project that began 10/1/2011.

Community Foundation of Greater Birmingham

Aids Alabama and Birmingham AIDS Outreach (BAO) receive funding from the Community Foundation of Greater Birmingham and BAO has an established endowment fund with the Foundation

Hundreds of volunteers in all of the State's ASO's clinics annually provide many hours of critical services and support to PLWH/As in Alabama.

All providers utilize mainstream resources such as SSI/SSDI, food stamps, and Red Cross and U.S. Department of Agriculture utility and food funds as well.

McKinney –Vento funding to provide services for consumers to fight homelessness comes to AIDS Alabama annually that is in excess of \$600,000.00. In 2011, new funding from this source provided more than \$245,000 for two-year renewable grants for permanent supportive housing programs for those with chronic homelessness.

HUD programs

AIDS Alabama links consumers to mainstream HUD programs such as public housing, Shelter plus Care Housing assistance vouchers and Section Eight vouchers. The U.S. Department of Housing and Urban Development (HUD) offers HOPWA Formula funding for a number of housing programs in the BMSA as well as in the entire state.

HUD's Housing Opportunities for Persons with AIDS (HOPWA) also renewed the Alabama Rural AIDS Project for another three years beginning January of 2011 for an additional \$875,000 for housing and supportive services in 32 rural counties. JASPER House, another HOPWA program remains funded and is in its final year of a three grant of \$937,000.00.

Alabama Prison Initiative

The Alabama Prison Initiative provides primary and secondary prevention education services to HIV positive inmates identified in the Alabama Department of Corrections (ADC). The Initiative is a collaborative partnership between the ADPH and the HIV/AIDS Division, the ADC, NaphCare Pharmacy, ASOs and CBOs. ADPH has collaborated with NMAC and ADC to provide HIV service trainings such as Prison Rape Elimination Act (PREA) and Discharge Planning. ASOs and CBOs also provide agency information to inmates regularly.

The FOCUS Program was designed to promote school and community partnerships for the prevention of HIV/AIDS and other adolescent risky health behaviors. The FOCUS program's reputation is far-reaching among teachers, officials, students, and parents who experience the

culturally relevant innovative approaches for adolescents. As of June 2011, 3,575 students were enrolled in the FOCUS structured curriculum-based program in the northern region of Alabama where 3,789 adults, teachers and parents representing 190 schools support the program. Social media analyses include 173 Facebook members and 312 monthly student produced e-Newsletter recipients. The consultant markets the FOCUS Program at national conferences and statewide meetings.

- **Affect of Budget Cuts on Alabama's Service System and Continuum of Care**

Shrinking dollars from federal funding sources creates a reduction in services with an increase in the numbers of patients testing positive. The shortfall of general funds in Alabama that began in CY2012 may severely affect HIV direct care and prevention services in CY2013. Further funding cuts will result in employee lay-offs, employees functioning in multiple roles, and services eliminated or reduced. In addition, cuts may be necessary in prevention, direct care, and program support due to salary adjustments and other expenses presenting major barriers to maintaining linkages between the community planning process, prevention priorities and direct care and services. The need for funding for prevention and direct care services to address the public health problem of HIV/AIDS infection was recognized as an ongoing issue that needs attention on the local, state and federal levels.

Base Part B grants are awarded to States and Territories using a formula based on reported living cases of HIV/AIDS. States with more than one percent of total HIV/AIDS cases reported in the United States during the previous two (2) years must provide matching funds with their own resources using a formula outlined in the legislation. Alabama's Part B program receives funding through the following sources

- RW Part B base grant,
- AIDS Drug Assistance Program (ADAP) award,
- ADAP supplemental award,
- Minority AIDS Initiative (MAI) award
- Alabama Matching Funds

In 2011, the Alabama State legislature appropriated state funds for matching the RW grant. The amount has increased from \$600,000 in 2001 to \$5,000,000 in 2006. The amount of state funding has remained at \$5,000,000 until the current year when, due to shortfalls in all state funding, 10% was retained by the Governor's budget until funds become available.

Alabama's Part B program has allocated approximately 90% of funds for the now identified "core" services each year of the RW grant. This has been necessary because Alabama has a poor Medicaid system and few medical providers who have been willing to provide care for HIV infected individuals. This has resulted in creation of an HIV care and services system outside the private medical sector that is funded primarily through Alabama's RW grant.

Alabama's RW program is finding it more difficult to keep up with the growing need for HIV/AIDS care and services including life saving medications at the same time that available state and federal funding resources are decreasing. This is especially the case in the current

economic climate that is creating increased needs for the State's HIV/AIDS population at the same time that available funding resources are decreasing. Alabama experienced an \$861 million dollar or a 12.3% funding shortfall in the State's general fund budget in CY2011 with an increase in the gap in funding in CY2012.

A major challenge for both the State's ADAP, as well as RW funded care and service providers, is determining the impact of the Early Identification of People with HIV/AIDS (EIIHA) on the potential increase in the State's newly identified HIV positive population. HIV testing services have increased, however, treatment providers are not increasing at the same rates creating larger patient loads for clinics whose numbers of staff has remained unchanged. Shrinking dollars from federal funding sources creates a reduction in services with an increase in the numbers of patients testing positive. Alabama is a rural state that requires a great deal of travel to notify individuals of their test results. The geographic locations may also hinder how soon an individual can be notified about confirmatory test results for preliminary positive tests.

With increasing utilization and limited funding, Alabama's ADAP formulary had to be reduced in 2011 from 102 medications to 73 by eliminating the majority of complimentary drugs. The reduced formulary presented a challenge for Social workers/Case managers in RW funded clinics having to apply to Pharmaceutical Assistance Programs (PAPs) and other drug resources for their Clients to access eliminated medications from the ADAP formulary. The current formulary continues to offer at least one medication from the core classes of FDA approved antiviral drugs for the State's ADAP to remain in compliance with HRSA funding requirements. To avoid having to remove enrollees from Alabama's ADAP beginning in 2011, enrollment was decreased from 1900 to 1600 through natural attrition. A major challenge was sustaining this decrease due to the large number of new applicants and Clients re-enrolling. Consequently, the program experienced increased enrollment resulting in having to reinstate enrollment restrictions and the waiting list by the end of October 2011.

- **N/A to Alabama – Jurisdictions that lost a TGA**

C. A Description of Needs

- **Care Needs**

To meet CARE Act legislative requirements and expectations of HRSA/HAB, Alabama uses the unmet need framework to plan and develop HIV care and services in the state. Data generated through Alabama's Epi Profile, as well as special studies to include provider and consumer surveys, HIV/Direct Care and Prevention's annual state collaborative meeting, and RW funded service reports (RSRs) are also utilized to determine service needs and to support funding allocation decisions.

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 identified 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.

The HIV/AIDS epidemic in Alabama has affected persons in all gender, age, race/ethnicity, and socioeconomic groups in all 67 counties. However, the effect has not been the same for all groups. In 1998, Alabama's State Health Officer declared a state of emergency in the African-American community based on the disproportionate HIV infection rate among Alabama's Black population. In recognition of this critical health issue, the ADPH, the Legislative Black Caucus, the AIDS Service Organizations Network (ASONA), and the Governor declared HIV/AIDS in Alabama's Black population an ongoing public health crisis. Alabama is experiencing a widening disparity of HIV infection in the State's Black population, and a potentially deepening health disparity crisis in the rapidly increasing Hispanic population.

The impact of the HIV/AIDS epidemic on the Black population and other minority populations living in the state also reflects important issues related to extreme poverty, lack of education, lack of consistent support systems, and lack of access to care and housing. The majority of primary HIV medical care clinics and services are located in the four major metropolitan areas in the state (Mobile, Montgomery, Birmingham and Huntsville). Social workers/Case managers and Clinicians in the State face ongoing challenges locating health care and service resources as well as transportation resources for HIV residents to access medical care and services. These important issues offer formidable challenges for Alabama to be able to reduce new HIV infections. In addition, identifying infections early providing adequate HIV treatment and support services, and designing effective prevention messages for the multiple at risk populations living in Alabama are major challenges that need to be addressed.

The disproportionate impact of the HIV/AIDS epidemic in the State's Black population and Hispanic/Latinos also reflects important challenges for the state related socio-economic factors such as extreme poverty, lack of education, lack of consistent support systems, and adequate access to care and housing.

Alabama's HIV/AIDS population has aged over the past five years, and they are living longer as a result of effective use of drug treatment and therapies. This has affected Alabama's ability to provide adequate medical and social services (i.e. RW and Medicare) for the State's growing aging HIV/AIDS population. Increased longevity due primarily to positive HIV/AIDS treatment outcomes has significantly impacted the State's public health care system and HIV care and service resources to keep up with the care and service needs of Alabama's population living with HIV disease and their family members.

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 for Alabama especially in the current economic climate as funding resources are decreasing.

Because Alabama is a predominantly a 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 RW 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.

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.

- **Capacity Development Needs Resulting From Disparities in the availability of HIV Related Services in Historically Underserved Communities and Rural Areas**

Alabama's RW program is committed to HRSA's goal to ensure 100% access to care with 0% disparity in delivery of HIV care and services. Information gathered at the November 2011 Direct Care and Prevention Collaborative highlights the needs identified by Consumers, State Prevention and Direct Care participants and concerned citizen's from across the State is provided here.

Goal 1: Reduce new HIV infections

Group 1

Promote the message treatment as prevention
Expand community partners to implement EBIS in all communities.
Get age appropriate HIV prevention in grades 5 – 12.

Group 2

Stigma reduction
Educate community and faith-based leaders
Promote testing and linkage of services especially among primary care.
Collaborate and communicate better with other agencies
Create access online with a "calendar of events" for ADPH, ASOs, & CBOs.
Education among youth, MSMs, LGBT, etc.,
Partner with Board of Education and school leaders to promote HIV education
Public education through alternative media

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

Group 1

One stop shop
Promoting tele-medical,
Educating providers, nurse practitioners, physician
Case Management, access to programs (HOPWA, ARAP, transportation)

Group 2

Increase/improve communication with health care providers (e.g., ASO's local hospitals and community health centers)
Standardized enrollment process for all testing sites.
Recruitment of students in Infectious Disease field
Use of e-Health (telemed) statewide to provide more access to HIV care and mental health.
Collaborate staffing among Direct Care providers (team based approach)
More Peer Mentors (females, Hispanics, etc.) to offer supportive services, diverse Peer Mentors.

Goal 3: Reduce HIV related health disparities and health inequities

Group 1

Reduce HIV-related mortality in communities at high risk for HIV infection

Provide more satellite testing and provider access
The number of HIV/ID providers
Provide incentive programs for Infectious Disease providers
Access to acute HIV testing

Adopt community level approaches to reduce HIV infection in high risk communities

Collaboration with local community groups, including public housing directors
Education in different facets of the community, taking it outside the medical field
Access to the local school system
Buy-in of the high risk populations

Reduce stigma and discrimination against people living with HIV

Normalize the words "HIV & AIDS"
Provide constant discussion
Increase the number of Peer Mentors who are willing to share their stories
Billboards and commercials, providing more HIV education to the public

Group 2

Step 1

More oral & free testing opportunities in high risk areas
Accessibility to treatment through expanded clinics & telemedicine
Partnerships with universities for specialty emphasis on HIV/AIDS for providers
Work on reciprocity for doctors outside Alabama through legislation

Step 2

More oral & free testing opportunities in high risk/rural areas

Network opportunities to support treatment ensuring access to care.

Develop community partners with churches, universities, businesses and primary care for education and advocacy.

Step 3

Develop community partners with churches, universities, businesses, and primary health for education & advocacy.

Educate primary health care providers as a target to help disseminate accurate materials, information & referral.

Develop faith based programs to impact advocacy & stigma

Goal 4: Achieve a more coordinated national response to the HIV epidemic

Group 1

Mandated education programs across the board, federal, state and local government.

Group 2

Step 1

Better communication across the board to know what programs are working or not working

Step 2

Database that gives basic information (every group knows)

Networking

Technical Assistance for Collaborative Partnerships

Technical assistance is offered throughout the state to collaborative partners upon request.

Services offered includes grant writing, program monitoring and evaluation, board/committee development, program development and implementation, primary and secondary prevention planning, community and street outreach, developing partnerships and nontraditional organizations, and documentation and reporting.

D. Description of Priorities for the Allocation of funds based on the following

• Size and demographics of the HIV/AIDS Population

Alabama's care and service implementation plan reflects a 93% allocation of the State's RW funding for core medical services to meet the 75/25 core medical service requirement in CY 2012. Alabama's latest unmet need calculations show that greater than 70% of persons not receiving care are AF/AM. Outreach programs such as the MAI funded Peer Mentor program, focus activities to reach out to the State's HIV positive minority population specifically to refer them into care including enrolling eligible clients in the State's ADAP to begin medication services.

ADPH provides funding to service providers in all areas of the state based on a formula that relies in part on surveillance and service utilization data to ensure RW Part B resource allocations are in proportion to the percentage of the State's HIV disease cases by each population. The Part B funding formula also ensures geographic parity for PLWH/As in Alabama to be able to access HIV care and services in all areas of the state. Through contract requirements with service providers, Alabama requires that all RW funded care and service

agencies ensure that resource allocations are in proportion to the percentage of the State's HIV disease cases by each population.

To assure access to ADAP and medical care for the state's minority communities, Non-medical and Medical case management, and transportation services will be funded to connect HIV positive individuals with medical care and support services focusing efforts on the State's minority population living in rural areas where access to care and services requires traveling long distances. Each service provider must document a detailed plan regarding the provision of services to women, infants, and children affected by HIV. The plan must show what portion of funds is allocated to provide services to women, infants, and children in their service area. The two RW Part D funded clinics work with all Part C funded clinics and Part B funded service agencies statewide to provide services targeted to HIV-infected women, infants, children and youth and their families

E. Description of Gaps in Care

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. 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 RW 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. 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.

F. Description of Prevention and Service Needs

The *AIDS Alabama's 2010 Consumer HIV Needs Assessment Survey* is an important resource used each three-year planning cycle to guide the development of HIV care and service goals presented in the SCSN, and to guide improvements in HIV care and services presented in the CP. A description of HIV prevention and service needs of over 500 HIV Consumers who participated in AIDS Alabama's needs assessment survey is provided here. A copy of the summary data from the *AIDS Alabama 2010 Consumer HIV Needs Assessment Survey* is attached to Alabama's SCSN and CP. (Attachment 3)

Medications

In the 2010 AIDS Alabama Needs Assessment, 29% of participants said they had no medical insurance of any kind, and 38% say they have medications prescribed that they did not take due to having no resources to purchase. Concerning assistance for paying for medications, there was a significant reduction in the number of individuals who indicated that they needed assistance paying for medications in the 2010 survey compared to responses in the 2007 survey (Figure 2.31). However, there was more dependence on the State's ADAP and Pharmaceutical Assistance Programs (PAPs) in 2010 compared to 2007. There was an increase in participants in 2010 who did not know the source of their medication assistance.

	2010		2007	
Private insurance	29	6.2%	31	6.3%
Medicare/Medicaid	194	41.4%	192	38.7%
Service organization	11	2.3%	5	1.0%
State ADAP	173	36.9%	170	34.3%
PAP	11	2.3%	3	.6%
Clinic assistance	16	3.4%	38	7.7%
Other	23	4.9%	48	9.7%
Don't know	12	2.6%	9	1.8%

Clinical Trials

From a statewide perspective, access to clinical drug and vaccine trials is a critical need. Participants in AIDS Alabama's 2010 survey reported that in the 6 months prior to the survey, 3% (17) of the sample had taken part in a clinical trial to test new HIV medications while 54% (288) reported that they would like more information about clinical trials. The AIDS Clinical Trial Unit is located in Birmingham in North Central Alabama and is located in the 1917 Clinic that is the largest HIV care unit in the state. Consumers will travel for care from other areas located outside of the metropolitan area.

Case Management Services

There is an increased need for licensed Social Workers employed in all RW funded care and service agencies in Alabama. Eighty-seven percent (454) of the over 500 participants in AIDS Alabama's 2010 Consumer Needs Assessment Survey reported having a case manager or social worker. Participants reported going from one to 15 times within the month and they had spoken on the phone with their caseworker ranged from 1 to 25 phone calls within the month. HIV Consumers in Alabama must make application to the state's AIDS Drug Assistance Program (ADAP) and Medicare Part D Assistance Program (MEDCAP) through case management services or a private clinician. Medical and non-medical case management services are a critical need for the majority of HIV Consumers in Alabama. Most RW Part C and D funded clinics applied for Part B funding in CY2012 to add case management services to meet increasing consumer needs.

Mental Health and Substance Services

There is an increased need for inpatient and outpatient mental health and substance abuse treatment centers in the state. There is also an identified need for qualified mental health and

substance abuse professionals to provide treatment services in the urban and rural areas in Alabama. The AIDS Alabama 2010 survey reported that 52.4% of the participants reported having psychological difficulties in the last six months that was an increase over 43% of participants reported in 2007. Within the same period, 30% (157) had received help for an emotional or psychological problem compared to 24% receiving services in the 2007 survey. In the six months prior, 52.4% (279) reported having some kind of emotional or psychological problem.

Psychosocial Support Services: The AIDS Alabama 2010 survey found that 14% (75) of participants expressed that they would like assistance finding a support group. AIDS Alabama reported serving 85 individuals in provision of psychosocial skills training to help consumers learn skills in ordinary skills of daily living in CY2011.

Dental Services

There are a decreasing number of dentists in Alabama to provide dental care to residents. Sixty percent of participants in the AIDS Alabama 2010 needs assessment survey reported receiving dental care in public funded community health centers or HIV clinics. If the local HIV clinic does not offer dental care or there is not a local referral source to provide dental care, clients may decide not to access dental care especially if they need to travel outside of their local area for a dental appointment.

Transportation

AIDS Alabama's 2010 Needs Assessment showed that only 41% of participants reported having reliable transportation while 39% reported depending on others for transportation to access medical appointments. Thirty-five percent (184) said that in the past 6 months they have had problems and/or needed assistance with transportation. Thirty-two percent (169) said that they would like assistance with transportation needs Table 2.32. African American participants requested a slightly higher need for assistance with transportation issues when compared to their white counterparts (Figure 2.36).

Housing

In 2010, the majority of the participants (53%) are stably housed which is a significant difference when compared to 2007 (66%). Participants reporting to be homeless in the last six months of the 2010 survey were at 27% (146) with 47% determined to be in an unstable housing situation. Along with non-RW resources, AIDS Alabama reported that more than 200 clients were assisted in the previous year with some type of housing or housing stability assistance. Similar to reported housing needs in 2007, African American males and White females appeared to be less stably housed in 2010 (Figure 2.18). Over all the need for housing assistance was down over the previous AIDS Alabama Consumer Needs Assessment Survey in 2007 however, the number of participants in the 2010 survey reported to have had to sleep in a car an emergency shelter, streets drug treatment jail and halfway house had increased over the 2007 Survey results.

Food, Groceries, Meals

The downward turn in the American economy affects the average funds available for food for Consumers as jobs and money become increasingly in short supply. AIDS Alabama's 2010

Needs Assessment reported 40% (215) of the participants said that at times they did not have enough money for food for themselves and/or their families' needs. In the past 6 months, 27% (141) of the survey participants experienced problems or needed assistance with food meals and/or nutrition while 36% (190) would like assistance with food, meals and/or nutrition Table 2.31. At least half of the participants have requested assistance with food needs however; the black participants in the survey appear to have a greater need in this area (Figure 2.35). In CY2011, BAO provided 1,941 food contributions (Food voucher or boxes) and 251 nutritional supplement episodes. AIDS Alabama spends more than \$35,000 a year of non-EC funds on providing food to residential consumers.

Emergency Financial Assistance

The AIDS Alabama Needs Assessment survey found 11% (61) participants reported an average income from all financial sources at \$500-\$800 a month with 10% (53) reporting no income. In the past 6 months, 35% (189) of the participants reported receiving financial assistance (e.g. SSI, Medicaid) with only 13% (72) receiving financial assistance at the time of the survey. Forty-two percent (223) participants requested financial assistance in the 2010 AIDS Alabama Consumer Needs Assessment Survey. AIDS Alabama reported assisting over 50 households with emergency financial assistance in the last grant year. The need for emergency financial assistance by HIV Consumers in Alabama is expected to increase with the current US economy that is seeing increased cost of living including increased utility rates, shortage of jobs, and loss of jobs and loss of housing.

Health Insurance

Alabama does not provide a state sponsored health insurance continuation plan consequently health care can be difficult to access for individuals living in Alabama who are uninsured or underinsured. According to AIDS Alabama 2010 needs assessment survey, 26% (136) participants reported having no medical insurance while 27% reported enrolled in Medicaid and 27% (141) received care through an emergency room (Table 2.26). As previously mentioned, Alabama has a poor Medicaid system. As a result, few medical providers are accepting new Medicaid patients creating a barrier to accessing medical care and services.

Child Care

Two percent (10) of participants said that they had problems and needed assistance with childcare issues in the past 6 months. Three percent (15) would like assistance with childcare.

Legal Services

In 2010, 50% (269) of the participants reported having spent time in jail, lockup or prison, however, only 13% (65) reported that in the past 6 months they had problems or needed assistance with legal issues such as wills, discrimination, child custody, eviction or criminal issues, etc. Since becoming HIV positive, 16% (84) survey participants thought that they experienced discrimination because of their HIV status. Six percent (30) said that they would like assistance with discrimination issues.

Training and Employment

Overall requests for education and employment assistance increased or stayed the same in 2010 when compared with the 2007 data. (Figure 2.37) However, 16% (88) of participants reported that they had problems or needed assistance with education, job training, and/or

employment in the past 6 months. Twenty-three percent said that they would like assistance with education, job training and/or employment.

HIV Prevention Education and Outreach Activities

Significant knowledge gaps remain at multiple levels within the state with regard to HIV disease, its prevention and its treatment that hinders the implementation of effective HIV care and service programs. HIV prevention funding supports primary and secondary education and outreach activities and direct HIV care and services. Since 1997, the Division has funded projects that respond to the Request for Proposals. Funded agencies present unique and innovative strategies for responding to the prioritized risk populations in the eleven public health areas.

Currently, there are seven CBOs in Alabama receiving CDC federal funding through ADPH. As mandated by the CDC, Alabama will continue to intensify its efforts begun in 1998 to reach HIV positives, their high-risk partners and other high-risk negatives.

PLWAs living in rural Alabama may have limited access to prevention and care services. The Alabama HIV Prevention Council believes its prioritization process further complements the current focus resulting in the following prioritized populations in Alabama for 2012-2015.

- 1. Men Who Have Sex with Men**
- 2. Women Who Have Sex with Men**
- 3. Men Who Have Sex with Women**

Interventions included strategies to prevent HIV infection and to provide education, support and resources to those already infected. All prevention activities affiliated with the ADPH encourage abstinence, postponing sexual activity, and reducing risks of exposure to HIV.

G. Description of Barriers to HIV Care

Routine Testing

Programmatic, systemic, and logistical barriers to routine testing making individuals aware of their status include some of the following: Disenfranchised individuals who may not be citizens of the United States may have a fear of all institutions and resist testing and treatment. Access to testing services may present barriers for young men living in rural areas of the state.

A recent change in Alabama's immigration laws has created an institutional barrier that may prove difficult for providers of services as well as undocumented minority clients in need of services.

The Alabama law allows a person to seek STD testing without parental consent at the age or 12. There are county health departments in all 67 counties in the state and HIV testing is free, however, lack of factual HIV information also presents as a barrier to HIV testing. From a program perspective, lack of valid information has always presented challenges for the DIS whose job is to locate new positives and their partners.

HIV testing services have increased but treatment providers are not increasing at the same rates creating larger patient loads for clinics whose numbers of staff has remained unchanged.

Alabama is a rural state that requires a great deal of travel to notify individuals of their test results. The geographic locations may also hinder how soon an individual can be notified about confirmatory test results for preliminary positive tests.

Program and Geographical Barriers

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 RW 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.

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.

Funding and resources for provision of transportation to clinical and other support services is woefully inadequate across all regions. This is apparently a problem whether area is urban and covers only one county or is rural including multiple counties and large geographic areas.

Access to new and appropriate medications, that includes adequate funding levels, must be maximized and appropriate monitoring markers (i.e., viral load testing, resistance testing) and programs for assessing and promoting adherence to treatment regimens must be made available to all persons in need. From the statewide perspective, access to clinical drug and vaccine trials is a critical need.

Improved coordination of case management activities among agencies and marketing of available programs and services to increase client awareness of available resources

There is need for statewide collaboration of agencies to increase awareness of services and to improve the referral process to these services.

The provision of basic living needs, such as housing, utilities, and food were identified as inadequately met in most areas. There is a need for long-term management of HIV disease, as it becomes more and more a chronic management issue.

Home health care and nursing home care are critical needs as are support services such as dependent care, respite and caregiver services, vocational rehabilitation, and psychosocial

support services to facilitate the transition from acute crisis to living with chronic HIV disease.

In Alabama most of the school systems still support abstinence only education which creates additional constraints on students exploring their sexuality.

Stigma around HIV/AIDS and risk behaviors related to HIV transmission (i.e. IVDU, MSMs). Stigma – fear of being HIV positive and gay especially in rural areas in Alabama. Young gay men have also become the victims of bullying in school settings. Cultural challenges include working with individuals and testing systems that still judge MSM.

Lack of transportation to access testing and HIV care and services

Lack of knowledge about HIV/AIDS prevention and treatment - There is no urgency to test for HIV infection. MSM, ages 13 – 29, do not feel HIV is a real threat.

Fear of loss of confidentiality

HIV is viewed by younger generations as a disease one can live with.

Minority population – fear of deportation – language and cultural barriers –

Talking openly about sexual matters is still taboo in the south.

Provider Related Barriers

(* tied for 3rd place needs listed in order of importance by providers)

- 1) Lack of funding
- 2) Lack of transportation services for clients to access care and services
- 3) Lack of Case Management staff*
- 4) Lack of Physicians to provide care*
- 5) Distances for Consumers to travel to access care and services
- 6) Poor adherence
- 7) Stigma related to HIV/AIDS diagnosis
- 8) Lack of Insurance
- 9) Lack of housing and shelter resources
- 10) Poor communication between providers in local areas and across the state

Consumer Related Barriers

Service needs and gaps in services consistently identified across all regions in the state include 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.

H. Evaluation of 2009 Comprehensive Plan - Successes

- **Recommendation 1-1:** The development of an HIV/AIDS Task Force to develop a master plan for state HIV prevention and direct care and services. The Task Force will include representatives of public health, community-based organizations, experts in behavioral marketing, and prevention research and consumers. The plan will identify appropriate state and local actions to address all affected individuals, and will provide a blue print for future funding decisions. **Progress:** Alabama's Governor signed a proclamation on World AIDS Day 2011 to organize the Governor's Task Force on HIV/AIDS to move the state toward implementation of the National HIV/AIDS Strategy in 2012. Efforts are ongoing to gain the involvement of a diverse group of individuals from local and state government, members of Alabama's business community, faith communities, as well as representatives from the medical and education communities.
- **Recommendation 1-2:** The Commission asked the Governor to write the Chairperson of the School Boards and the Principals of all the schools in the 127 school districts to support immediate and ongoing implementation of the HIV prevention education program as already approved in the Department of Education's curriculum by August 1, 2001. **Progress:** This recommendation was accomplished in 2005 that has allowed Alabama's HIV Prevention activities to include HIV prevention education programs available to school systems across the state.
- **Recommendation 1-3:** The Commission asked the Governor to create an Expert Research Panel as a component of the HIV Commission by July 31, 2001. This expert panel should include individuals with expertise in public health research to provide scientifically sound advice for:
 - a) identification of target populations and intervention priorities that are based on statewide surveillance and epidemiological data;
 - b) Use primary and secondary interventions targeting the high-risk populations;
 - c) Identification of proven intervention and evaluation methodologies that are applicable to at-risk populations within the state of Alabama;
 - d) Development of HIV prevention partnerships among state, community, and academic entities, and
 - e) Dissemination of technical assistance and scientific knowledge statewide**Progress:** Alabama elected a new state Governor and Legislature in January 2011. The new Governor agreed to reorganize the Governor's State HIV Prevention Task Force as the State's expert panel to address HIV/AIDS in Alabama. The Task Force will offer an opportunity for individuals representing state and local government as well as representatives from the business, health and faith communities to work together to address HIV/AIDS in Alabama and to implement the National HIV/AIDS Strategy.
- **Recommendation 2-3:** Expedite current and future efforts to create Medicaid AIDS Waivers for medical coverage for low-income people living with HIV/AIDS. The Commission urges the Governor to set timelines for the Alabama Medicaid Agency and the Health Care Finance Authority to have the 1915 (c) Home, Community Based AIDS Waiver completed and approved by October 1, 2001, and the 1115 Demonstration Waiver completed and approved by December 1, 2002. **Progress:** The Medicaid HIV waiver became operable in 2004. The waiver program is a well-established program that serves over 100 PLWAs across the state that are nursing home eligible to remain in their home to receive care. With the State's budget

shortfall in 2011, program changes were necessary as well as reduction in staff that could jeopardize the State's HIV Waiver services in CY 2012.

- **Recommendation 2-4:** Implement the current federal guidelines for HIV/ AIDS standards of care for the entire state of Alabama, including adults, children, pregnant women, and prisoners by January 1, 2002.
- **Recommendation 2-5:** Authorize the HIV Commission to study and report on ways to achieve 100% access and 0% disparity in HIV care, with a report to the Governor by February 1, 2002. **Problem statement and resolution:** People who are living with HIV are faced with multiple challenges that affect their well-being, their quality of life, and their ability to enter care or fully engage in care. Barriers to care still exist, but the Divisions' Evaluation and Quality Management Branch are assessing them.
- **Recommendation 3-1:** Appoint an interagency council of the Department of Mental Health/Mental Retardation, Department of Corrections, and Department of Education, Department of Public Health and the Alabama Medicaid Agency, as a component of the HIV Commission by March 31, 2002. This Council will work with the Commission's Care Committee to find solutions to barriers identified by the Care Committee.
- **Recommendation 3-2:** Identify and document numbers of HIV+ persons are engaged in care and address barriers to their care by November 1, 2001. **Progress:** The Division has developed a process to measure unmet need as required by HRSA. The Division has also designed and implemented a program for identifying and referring persons into early care and treatment services. See references to Alabama's ERTS program in this document.
- **Recommendation 4-1:** Initiate a competitive, statewide, pilot research program that can address problems and needs that are specific to the state. This program will fund pilot grants that would be awarded in collaboration with academic centers throughout the state to investigate novel prevention interventions or evaluation approaches that will specifically address state needs.
- **Recommendation 5-1:** Extend the period of the Governor of Alabama's HIV Commission for Children, Youth, and Adults in an effort to address the many complex challenges to delivery of statewide medical and supportive services for the infected and affected population. **Progress:** The Commission is still recognized by the current Governor, but is inactive at the current time. s previously stated, the State's new Governor is supportive of re-organizing the Governor's Task Force and signing a new declaration to resume activities of the Task Force in 2012 to address the State's HIV/AIDS epidemic and to implement the National HIV/AIDS Strategy in Alabama.
- **Recommendation 5-2** HIV disease often results in complex dental disorders, conditions, and diseases. Oral disease is exacerbated in persons with HIV infection because of their compromised immune systems and medication side effects. Oral disease increases the nutritional requirements and causes other associated health problems in those infected. Many dentists across the state are not willing to treat persons with HIV disease. Further study is needed to document appropriate interventions. **Progress:** Even with decreasing financial resources, Alabama's RW funded providers included funding in their CY2011 budgets to support preventive and treatment for dental services, and plans to continue to allocate funding in CY2012 for dental treatment
- **Recommendation 5-3:** The Alabama Department of Corrections' (ADOC) policy of excluding all prisoners with HIV from the educational, vocational and rehabilitative programs available to other inmates results in HIV positive inmates serving longer sentences, under

much harsher conditions than their HIV negative peers. It also deprives HIV positive inmates of opportunities for rehabilitation afforded to other prisoners. There is no scientific basis for the claim that this policy is necessary to prevent HIV transmission. The outcome desired by the Care Committee is equal access to all programs and standard of medical care afforded to any other inmate regardless of their HIV status. Whether or not prison segregation is an appropriate intervention will require further research. **Progress:** The ADOC changed policies and now does not exclude HIV positive inmates from activities as in the past. This change is a direct result of the HIV/AIDS Division's Alabama Prison Initiative.

- **Recommendation 5-4:** The indigent HIV positive population in Alabama needs to ensure inpatient care is available to them when needed. Presently, outpatient services are typically available and accessible by indigent persons living with HIV. The same level of access to inpatient care needs to be available to this population in both urban and rural areas. The Care Committee needs further study to quantify the inpatient services needed and payment mechanisms for those services. **Progress:** The Division created and funded an Evaluation and Quality Management Branch to monitor level of access to care for all clients in Alabama. The Division has funded a Peer Mentor program to identify HIV positive clients and refer them into early care and services.
- **Recommendation 5-5:** Thousands of HIV positive Alabamians are not receiving medical care. Fifty percent of Alabamians reside in non-urban areas. This demographic creates a natural barrier to service that compounds the challenges to engaging rural HIV positive persons in care. The barriers to accessing medical care and supportive services for these persons must be documented and a plan of action created to engage this population in care. **Progress:** Alabama's Part B funded service organizations make application for funding to include transportation services to ensure that clients can access care and services.
- **Recommendation 5-6:** Assess and monitor to ensure HIV care and service delivery across the state meet current PHS guidelines. Access to training opportunities need to be available to ensure that Alabama's private and public health care providers deliver HIV care and services that meet current PHS care and service guidelines. There is a need for state resources to initiate research to address the scientific soundness of statewide HIV/AIDS prevention and care programs, and to evaluate program effectiveness. **Progress:** The HIV/AIDS Division created and funded an Evaluation and Quality Management Branch to monitor level of access to care for all clients in Alabama. All RW funded care and service providers, as a funding requirement must submit a copy of their updated quality plan to the State's RW Lead Agency. In addition, each funded clinic and ASO must report on a quality project at the beginning of the grant year and provide outcome data each quarter to the Lead Agency. All RW funded care and service organizations complied with these funding requirements at the beginning of CY 2011.
- **Recommendation 5-7:** There is a tremendous lack of adequate end-of-life care facilities in Alabama for persons with HIV disease. Even with the medical interventions prolonging life, a number of persons cannot tolerate the medications and/or have reached the end of their effective care options. Nursing homes in Alabama routinely refuse to accept persons living with HIV disease. Discrimination based on disability and disease status is unacceptable. The state is responsible for nursing home licensure and inspection and should use that authority to end any discrimination based on HIV disease. Few options are available to achieve required supportive services in long-term care. **Progress:** This issue continues to be a challenge in Alabama. However, the Division collaborated with Medicaid and the ADPH Home and

Community Base Waiver Program to offer the HIV Medicaid Waiver Program to allow eligible Clients an alternative to nursing home care that allows the Client to remain in their home and receive home health and hospice care. The HIV Medicaid Waiver Program offered home health care to well over 100 Alabama residents living with HIV disease in Alabama in CY2011.

On-Going Challenges for 2012-2015

- **Recommendation 2-1:** To increase state funding for HIV medications for the AIDS Drug Assistance Program (ADAP) to \$6 million this year to meet the current needs of people living with HIV through the adoption of the fiscal year 2012 State of Alabama budget.
Progress: In 2011, the Alabama State legislature appropriated state funds for matching the Ryan White grant. The amount of state funding has remained at \$5,000,000 until the current year when, due to shortfalls in all state funding, 10% was retained by the Governor's budget until funds become available.
Recommendation 2-2: Provide state funds to eliminate the waiting list for eligible recipients of the AIDS Drug Assistance Program, effective October 1, 2001, and each year thereafter.
Progress: Increase in federal funding and implementation of Medicare Part D were instrumental in Alabama being able to retire the waiting list in CY 2006. In CY2011 with increasing program utilization, funding was not adequate for Alabama's ADAP to continue to operate without restricting enrollment resulting in reinstating a waiting list beginning in May 2011 with capped enrollment at 1700.
- **Recommendation 3.3:** To assess: a) Mental health needs and chemical dependency needs of PLWH/As, and create action items to address these needs. **Progress:** Several programs were refunded in 2012 from funding sources outside of RW funding to help meet mental health and substance abuse service needs of PLWH/As in Alabama. However, there are still gaps in mental health and substance abuse treatment services identified by PLWH/As and RW funded providers statewide that need to be addressed during the next three year planning cycle (2012-2015).
Recommendation: 3.3 (b) Eliminate transportation barriers for PLWH/As to access care and services; and identify required action items. **Progress:** Even though more RW funded care and service providers in Alabama include transportation services as a budget item for their agency to provide, lack of transportation to access care and services remains a formidable challenge. Need for transportation continues to be an identified need by PLWH/As, as well as providers, as a critical barrier second only to stigma to accessing HIV care and services especially for individuals living in the State's rural areas where there is no public transportation system.
- **Recommendation:** To develop a statewide housing plan to meet the needs of PLWH/As in Alabama. **Progress:** HUD's Housing Opportunities for Persons with AIDS (HOPWA) renewed the Alabama Rural AIDS Project for another three years beginning January of 2011 for an additional \$875,000 for housing and supportive services in 32 rural counties – two of these counties are in the Emerging Communities (EC) portfolio. JASPER House, another HOPWA program, remains funded and is in its final year of a three grant of \$937,000.00 U.S. Department of Housing and Urban Development (HUD) HOPWA Formula funding for a number of housing programs in the BMSA as well as in the entire state. Even with these housing resources funded outside of RW funding sources, PLWH/As and providers reported a

need for additional housing for PLWH/As and their families as well as for PLWH/As and substance abuse across the state.

- **Recommendation:** To document and identify links between existing social, demographic, and economic problems such as domestic violence, rural vs. urban and poverty with PLWH/As accessing HIV care and prevention services. **Progress:** Progress was made in 2011 with the revival of the HIV/AIDS Task Force by Alabama's Governor, and with the renewed commitment of participants named to the Task Force to work together to meet these challenges going forward.

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II. Where Do We Need To Go?

The purpose of this section is to provide an opportunity to discuss Alabama's vision for an ideal, high quality, comprehensive continuum of care and the elements that shape this ideal system. The Early Identification of Individuals with HIV/AIDS (EIIHA) initiative supports all three of the National HIV/AIDS Strategy (NHAS) goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

A. Alabama's plan to meet challenges identified in the evaluation of the 2009 CP

The 2012 CP will provide a guide for the maintenance and improvement of Alabama's system of HIV care and services that is responsive to the changing epidemic and unmet health care needs PLWH/A. Challenges identified in the evaluation of the 2009 Comprehensive Plan are addressed in the CP for the next three-years (2012-2015) to include:

- 1) Increased need for funding for Direct Care and Prevention activities including funding for the state's ASAP for the State to keep up with the increasing demand for services and increased HIV testing efforts through the EIIHA project.
- 2) Continued need for additional housing services across the state for PLWH/As and their families as well as transitional housing for PLWH/As with a substance abuse diagnosis from both Consumer's and service providers surveyed to update Alabama's SCSN and CP this planning cycle.
- 3) To improve collaboration and coordination across all RW funded care and prevention service providers, HIV Consumers and community partners who are committed to HIV efforts. In addition, the maximum effect of prevention efforts must include collaboration of all RW Part B funded HIV care and service providers. The Governor's HIV/AIDS Prevention Task Force is a positive step, but the state faces challenges to address existing social, demographic, and economic barriers, such as domestic violence, rural vs. urban and poverty, for PLWH/As to access HIV care and prevention services.

B. 2012 Proposed care goals

Alabama's Division of HIV/AIDS Prevention and Control Mission Statement:

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 following proposed goals were identified through the SCSN process for this three-year planning cycle (2012-2015) that also allows Alabama to begin to implement the National HIV/AIDS Strategy to address the State's HIV/AIDS epidemic. The activities identified to address these goals are either ongoing or will have specific time lines.

- 1) **Reduce new HIV infections**
- 2) **Increase access to care and improve health outcomes for people living with HIV**
- 3) **Reduce HIV related disparities and health inequities**
- 4) **Achieve a more coordinated response to Alabama's HIV/AIDS epidemic**

C. Goal regarding individuals *Aware* of their status, but are not in care (Unmet Need)

Goals:—To increase access to care and improve health outcomes for PLWH/As.

To reduce HIV transmission

D. Goals Regarding Individuals *Unaware* of Their HIV Status EIIHA

Goals: - (1) To reduce HIV incidence; (2) To increase access to care (3) To optimize health outcomes, and (3) To reduce HIV-related health disparities.

Proposed solutions to close gaps in care:

E. ACTION PLAN:

1. Increase coordination of HIV programs in the state
2. Develop and improve monitoring of care and services and progress toward meeting goals and objectives,
3. Expand testing sites
4. Test results provided at point of care
5. Linkage to care as quickly as possible

F. Proposed solutions to address overlaps in care:

1. To increase coordination of HIV care and service programs in the state
2. To develop and improve monitoring of HIV care and services and progress toward meeting goals and objectives

G. Provide a description detailing the proposed coordinating efforts with the following programs to ensure optimal access to care:

- **Part A Services – Alabama does not qualify to receive Part A funding**
- **Alabama's RW Part B Services**

Since the early years in the HIV epidemic, the Division has nurtured its relationships with state and community partners to gain acceptance as a recognized leader and partner in reducing the spread of HIV disease in Alabama. The system of HIV/AIDS programs is supported through a network of services statewide under the direction of the ADPH, through the Division, as Alabama's RW Part B grantee to set program policy; and provide guidance,

technical assistance and financial support to HIV care and service organizations across the state.

Other care and service organizations contributing to the State's HIV/AIDS efforts include the University of Alabama medical and hospital systems, the University of South Alabama medical and hospital systems, Alabama's Primary Care Clinics, fifteen Historically Black Colleges and Universities, the STD program of the ADPH, numerous other public and private partnerships and the eleven regional ADPH offices.

- **Part B –C and D**

The Division's Direct Care and Services Branch in collaboration with the Part B Lead Agency (United Way of Central Alabama-UWCA) is responsible for overseeing Alabama's RW Part B funded care and services delivered at multiple Part B – C – and D funded sites in the state to delay onset of symptoms and to prevent and treat complications of HIV infection.

Alabama's RW Part B Program currently provides funding to 11 HIV specialty clinics that receive Part B and C Outpatient/Ambulatory (HIV Medical Care), two Part D (Women and Children) grantees, and five ASOs located across the state to provide case management and other essential support services. A list of specific clinic names and services provided is available in the SCSN included in the CP for 2012-2015.

- **The AIDS Drug Assistance Program (ADAP)**

ADAP in collaboration with community health care providers is committed to providing HIV medications to low income and uninsured Alabama residents diagnosed with HIV in an effort to increase their life expectancy and to improve their quality of life.

- **Medicare Part D**

Alabama's ADAP sponsors a Medicare Part D cost assistance plan (MEDCAP) that assists HIV positive individuals with Medicare Part D who do not qualify low-income subsidy assistance to pay for the cost of co-pays or monthly premiums and would otherwise qualify for enrollment in ADAP for medications. Alabama does not offer a State Health Insurance Continuation Program (HICP) or HIV Care Consortia to cover Medicare Part D out-of-pocket expenses.

- **Medicaid and Department of Industrial Relations**

Agreements between the ADPH, Alabama's Medicaid and the Department of Industrial Relations allows for regular cross matching of the ADAP database to verify a client's monthly Medicaid status and quarterly earned income. Coordination of efforts between these agencies continues to strengthen the centralized ADAP eligibility determination process to ensure that only clients eligible participate in the program.

- **Medicaid – Targeted Care Management**

The ADPH has an established network of public health social workers. Since April 1990, "Targeted Case Management" for HIV/AIDS has been available to Medicaid-eligible individuals through funding from the Health Care Financing Administration (HCFA). Case management activities are provided by licensed social workers or certified caseworkers. In addition, the Division funds social workers to provide case management services to

individuals who are not Medicaid-eligible in the following higher-prevalence areas: Public Health Area 1 & 2 including counties across northern Alabama; the southeastern counties of PHA's 8 & 10; PHA 11 (Mobile County); and PHA 4 (Jefferson County). In other areas, funding for case management services is available for Medicaid-eligible individuals. Services are provided for non-Medicaid eligible through Ryan White Part B funds. Advanced clinical services for management of HIV disease have been available in two areas of the state, Birmingham and Mobile.

- **Medicaid Waiver Program**

Centers for Medicare & Medicaid Services approved the ADPH plan to extend home-and community-based services to persons with HIV/AIDS in 2003. The 1915(c) waiver of Medicaid rules allows the state to provide services to individuals in their homes, keeping many out of nursing homes and other institutions. The state enrolls persons with HIV/AIDS and related diseases with incomes of up to 300 percent of the Supplemental Security Income federal benefit level. This brings in a group of individuals who would not normally be eligible for Medicaid unless they were in an institution.

- **RW Part B Case Management**

Case management continues to play a major role in Alabama's efforts to increase access to care for underserved minority and hard-to-reach populations. Many Part B funded service agencies receive funding to provide transportation services for clients who live in rural areas to access HIV clinic appointments and medications. ADAP clients living in outlying or rural areas access ADAP services through referrals made by caseworkers in RW Part C and D funded HIV care clinics located statewide. ADAP utilization data consistently shows that (95%) of clients enrolled in Alabama's ADAP are referred to the program by primary care physicians from RW funded Part C and D clinics. In addition to ADAP referrals, caseworkers will refer eligible Clients and family members to the State's Child Health Insurance Program (CHIP). When an individual does not qualify for enrollment in Medicaid or CHIP, the caseworker will complete the ADAP application process on behalf of the individual to begin medication services.

- **Children's Health Insurance Program**

CHIP is a low-cost, comprehensive healthcare coverage program for children under age 19. Benefits include regular check-ups and immunizations, sick child doctor visits, prescriptions, vision and dental care, hospitalization, mental health and substance abuse services, and much more. CHIP covers eligible children that live in Alabama. Children must also:

- be under age 19
- be a U.S. citizen or an eligible immigrant
- not be covered under any health insurance
- not be a resident in an institution
- not be covered by or eligible for Medicaid
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- Center for AIDS Research University of Alabama at Birmingham (UAB)**
 The Center for AIDS Research at the University of Alabama at Birmingham (UAB) works in conjunction with the 1917 AIDS Outpatient Clinic, AIDS Clinical Trials Unit and AIDS Vaccine Evaluation Unit. Physicians associated with Alabama's AIDS Clinical Trials Unit at UAB work with Part C and D funded clinics and ASOs to recruit eligible patients for clinical trials. Clients actively receiving ADAP HIV medications who decide to participate in clinical trials are placed on inactive ADAP status and medication assistance is discontinued while the client is enrolled in the clinical trial. When the Client's participation in the clinical trial is completed, the physician refers the client to ADAP for eligibility review to resume ADAP medication services. Welvista was approved to provide pharmaceutical assistance in Alabama for applicants to receive medication assistance while waiting to be moved to active enrollment.
- Peer Mentoring Program – Minority AIDS Initiative (MAI) Grant**
 The Peer Mentor Program is a consumer-driven prevention and care related service offered by the Division in 2005 focuses on connecting PLWH/As and their partners, and high-risk negatives to care, as well as, retaining and reclaiming clients for services. Peer Mentors are HIV-positive individuals whose mature handling of their own disease is a model for others. Newly diagnosed and stigmatized individuals identify with and trust Peer Mentors more readily than other workers, allowing the mentor to address personal concerns and barriers to care. 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. Peer Mentors work with local medical clinics, ASOs and CBOs that provide HIV specific services to infected persons and high risk negative individuals.
- Consumer Advisory Board (ACAB)**
 The Division not only involves consumers through the CPG process but also continues to support the Alabama Consumer Advisory Board (ACAB) that sponsors an annual conference targeting HIV consumers and other participants statewide. The ACAB consists of consumers throughout the state and represents various Public Health Areas. ACAB members participate in local prevention network meetings, consortia meetings, patient advisory board meetings, and consumer advocacy meetings. ACAB also provides a forum for consumer participation and input in state level community planning, primary and secondary prevention activities and direct care services.
- STD Control Branch**
 The Division and the STD Division central office staff work closely to assure continuity of services and achievement of the goals and objectives of the HIV program. The programs share responsibility for the collection and analysis of HIV counseling and testing data. In addition to CTRPN services in the county health department, the STD Program also provides follow-up to individuals testing positive for HIV-Abs and reported to the HIV/AIDS Surveillance Branch by facilities other than ADPH clinics. This requires close daily coordination between the HIV/AIDS and STD Programs. Since 1988, pre-and posttest counseling and testing services have been available at all county health departments. Voluntary and confidential

testing and counseling is offered to individuals seeking STD, TB, Maternity, and Family Planning services. Public health nurses are trained to perform pretest counseling and posttest counseling of persons who test negative for HIV-Abs. Disease intervention specialists (DISs) perform counseling, referral to social and medical services, and partner notification activities for those who test positive and for those who test negative, but have specific issues to be discussed, such as referral and/or preventive measures.

- **Alabama’s HIV Surveillance Branch**

HIV/AIDS reporting in Alabama is reportable, by name and patient identifiers. The Division’s Surveillance Branch operates an active surveillance program for both AIDS and HIV infection reporting. Surveillance staff provides extensive area specific epidemiological data for each CPG, funded care and service agencies and planning groups upon request. The Surveillance Branch is the clearing house for state and county statistical data from numerous sources, including the STD Division, the Center for Health Statistics, and the Center for Demographic Data and Cultural Research (Auburn University at Montgomery) to include in local and area service plans. A state-level epidemiologist is available to provide technical assistance in the analysis surveillance data. Alabama’s Surveillance Branch staff provides the state’s updated HIV/AIDS epidemiology profile annually to track trends in the state’s HIV/AIDS epidemic. The Division utilizes surveillance data as a primary resource to guide planning for statewide HIV care and service delivery; to justify and obtain funding for needed services programs; and to improve and evaluate Alabama’s Ryan White funded care and services.

- **Prevention**

The CDC mandated HIV Prevention Planning process under the direction of the Division has provided a solid foundation for the state’s prevention efforts since 1992. The participation of “community” representing a wide range of those affected/infected, agency representatives and other interested lay individuals along with the state health department through the HIV Prevention Community Planning Group (CPG) has evolved and continues to evolve into the recognized infrastructure for the direction of prevention program activities statewide. In 2003, the eleven area CPGs merged into one statewide group of 33 elected members. HIV consumers have been a vital part of the HIV prevention planning community.

- **Prevention Community Planning Groups**

The Community Planning Groups work with the State’s HIV Surveillance Branch to identify and analyze data to prioritize at risk populations. The national program’s shift to HIV positive persons and their partners, and other high-risk individuals will increase planning efforts to link prevention and care. Despite less emphasis on primary prevention, the Division will continue to provide capacity building assistance for specialized programs demonstrating the potential for the greatest impact on individuals, groups, institutional systems or communities.

- **Enhanced Referral Tracking System**

The Enhanced referral Tracking System has eleven HIV Coordinators divided by regions that track and link newly diagnosed HIV cases into care. ERTS was fully in place beginning in January 2005, and has been presented at several national conferences as a model for other states to track, report, and link newly diagnosed HIV cases into care. For the past three

consecutive years, Alabama has reported over 70% of newly diagnosed HIV cases linked into care. The ERTS program will continue follow up and verify clients have entered care. In addition, the Quality Assurance component of the program continues to enhance the information reported by coordinators. With the continued increase in new HIV cases, the coordinators maintain their strong collaborations with the State's STD Branch, Disease Intervention Specialist (DIS), ASOs, and Peer Mentors.

- **Expanded HIV Testing Initiative**

Under the Expanded HIV Testing Initiative, the University of Alabama at Birmingham Hospital Emergency Department (UAB-ED) has begun offering "opt out" HIV rapid test during all three shifts of the emergency department. This expansion in testing exposes individuals from all socio-economic, educational, and racial backgrounds to HIV testing. Individuals who do not have health insurance and use the ED for ongoing treatment and care will now be able to test for HIV on a routine basis. The UAB-ED will link all HIV positive patients to the 1917 Clinic specializing in HIV services. The UED and 1917 Clinic share a common computerized record system allowing the 1917 linkage coordinator to have results for a Western Blot test performed at the ED prior to the linkage visit. The initial 1917 referral visit will confirm and explain the HIV results, respond to initial emotional and social concerns, review modes of transmission/prevention measures, and discuss options for care.

As part of Alabama's Expanded HIV Testing Initiative, the ADPH implemented rapid HIV testing in Historically Black Colleges and Universities (HBCU) within the state. These non health-care venues have been chosen as sites with a high-risk demographic within the rural and metropolitan south based on age (18-24) and race (AF-AM) in addition to high-risk behaviors (heterosexual, MSM, and MSM/W). Alabama targeted 15 HBCUs as testing venues during the first year for the expanded testing initiative. HBCUs located in counties with the highest HIV incidence based on 2009 statistics were targeted the first year. These included Montgomery County (41/100,000/yr), Mobile County (28/100,000/yr), Jefferson County (30/100,000/yr), and Macon County (45/100,000/yr).

- **Funded Prevention Projects**

The HIV/AIDS Division provides HIV prevention funding to support primary and secondary education and outreach activities. Since 1997, the Division has funded projects that responded to the Request for Proposals. Funded agencies were those who presented unique and innovative strategies for responding to the prioritized risk populations in the eleven public health areas. Currently, five community-based organizations throughout the State receive CDC federal funding through the Alabama Department of Public Health.

- **FOCUS Program**

The FOCUS program engages school systems statewide to incorporate the program as a class credit course, a core youth auxiliary, or other mechanism to teach HIV prevention/ community planning and risk behavior subjects to students. To date, sixty-two schools statewide are implementing this program. Both exceptional and marginal students are invited to participate in this peer learning/teaching model.

- **Alabama Prison Initiative**

The Alabama Prison Initiative aims to provide primary and secondary education services to HIV positive inmates identified in the ADC. The Initiative is a collaborative partnership between the Alabama Department of Public Health-HIV/AIDS Division, the Alabama Department of Corrections, NaphCare Pharmacy, state ASOs and CBOs. ADC collaborates with other agencies in the state that provide HIV services, trainings such as to inmates. Prison Rape Elimination Act (PREA) and Discharge Planning. ASOs and CBOs also regularly provide agency information.

- **Community Health Centers**

The Division in collaboration with Community Health Clinics (CHC) in Alabama will improve access to HIV/AIDS care and services through an integrated service model. CHCs are located across the state to expand access to care for PLWH/A in Alabama. In addition, CHCs will collaborate with various ASOs in the state to integrate the preventive and care models in Alabama.

Veteran’s Services

- The Birmingham Veterans Administration Medical Center offers clinical HIV services to outpatient and inpatient veterans.

I. Metropolitan Statistical Area Emerging Communities Funds for the Birmingham Metropolitan Statistical Area (BMSA)

The Central Alabama Ryan White Consortium meets monthly to oversee emerging communities funded care and services. All Emerging Communities providers attend, as well as peer educators (including youth representatives under the age of 19), HIV-positive Peer Mentors, faith-based programs, including several representatives from large African-American churches, and community groups and representatives from education programs across the city that target specific populations, such as men who have sex with men and homeless populations. There has been great care taken to ensure that the composition of the Central Alabama Consortium reflects the epidemic in Birmingham, which is the largest metropolitan area in Alabama, and where the largest HIV care and service centers are located.

III. HOW WILL WE GET THERE?

Summary:

The purpose of this section is to describe the specific Strategy, Plan, Activities and Timeline associated with achieving specified goals and meeting identified challenges.

A. Strategy, plan, activities (including responsible parties), and timeline to close gaps in care

Alabama’s strategy to close gaps in care is to address disparities in access and services among affected and historically underserved populations is to expand testing sites throughout the state, informing clients of their test results at the point of care and referring clients to treatment and support services as expeditiously as possible. Several programs are in place to

reach out to underserved communities, and new programs are being considered for future funding.

Action Plan

- Continue to provide HIV test kits to approved providers;
- Implement a legislatively mandated reporting requirement for viral loads and CD4 counts to identify HIV positive individuals;
- Continue to expand linkage services to further track clients beyond the first “kept” appointment; enhancing post-test education of HIV positive clients and their partners;
- Continue to expand HIV awareness, education and testing to populations living in high-risk environments to prevent new infections;
- Continue to improve access to services in rural areas of the state and,
- Continue to support more coordination of services such as transportation, housing, and other daily living needs of HIV positive clients

Activities and Project Participants

Time Line on-going over the next 1-3 years

An ETI work plan was completed in collaboration with the University of Alabama in Birmingham (UAB), Alabama Primary Health Care Association (APHCA), health department representatives from STD, TB, and Immunization, as well as, ASO representatives, college officials, and student leaders of the Historically Black Colleges & Universities (HBCUs).

- 1) Expand HIV awareness, testing and care services will continue to be supported by HIV Surveillance data to select geographic regions with increased incidence of HIV and other STDs, limited or underutilized prevention and care services and/or areas with a large percentage of minorities.
- 2) Provide rapid test kits to different venues across the state. – The Division
- 3) Offer testing for syphilis, gonorrhea and Chlamydia testing at scheduled events. - Through the ETI, the Division, in collaboration with the STD Division
- 4) Target students by identify testing venues that may include health fairs, sporting events, mixers, and dormitory educational forums; and support promotional strategies and incentives to encourage student participation. HBCU’s- ASOs – ERTS Prevention Nurse Coordinators
- 5) Continue to engage communities through partnerships with the Division’s ten HIV Program Coordinators and local ASOs in the Public Health Areas (PHAs).
- 6) Continue to promote routine early HIV testing to engage new primary and rural health center partners. UAB Emergency Department (UED) Testing Initiative

The UAB Emergency Department (UED) testing initiative is located in the busiest hospital center in the state. Any pregnant woman who presents for services will be offered testing in

all venues. Clients with positive results will be linked to the UAB 1917 Specialty Clinic and/or Family Medicine program.

- 7) Continue to provide negative and positive results at the point of care.
- 8) Continue to provide HIV confirmatory tests through the Bureau of Clinical Laboratory (BCL) The BCL will continue to participate in proficiency testing for all analytes
- 9) Continue to assign lab tests to Disease Intervention Specialists (DIS) the same day received from the lab.
- 10) Continue to initiate fieldwork on each case within two days. The standard is 30 days to close a case; however, partner identification and notification may be extended beyond 30 days.
- 11) Continue to contact individuals testing positive who do not return for their results through the Enhanced Referral Tracking System (ERTS).
- 12) Continue to provide fact cards to Students to explain test results, and to encourage them to contact our HIV 1-800 Hotline for general information about HIV and locations where further testing is available in their area.
- 13) Continue to promote school and community partnerships for the prevention of HIV/AIDS and other adolescent risky behaviors through the **FOCUS Program**

The Focus program was designed to promote school and community partnerships for the prevention of HIV/AIDS and other adolescent risky health behaviors. Alabama HIV/AIDS Surveillance 2010 data shows youth (aged 13-24) comprise 25% of newly reported cases and 31% of all reported new Black belt HIV cases are within three of eleven Public Health Areas.

The FOCUS program's reputation is far-reaching among teachers, officials, students, and parents who experience the culturally relevant innovative approaches for adolescents. As of June 2011, 3,575 students were enrolled in the FOCUS structured curriculum-based program in the northern region of Alabama. Support for the FOCUS program is currently provided by 3789 individuals representing 190 schools made up of adults, teachers and parents.

AF/AM Minority Population

Alabama's care and service implementation plan reflects a 93% allocation of the State's RW funding for core medical services to meet the 75/25 core medical service requirement for 2012-2015. Alabama's latest unmet need calculations show that greater than 70% of persons not receiving care are AF/AM.

- 1) Continue to focus efforts on the state's minority population living in rural areas to assure access to ADAP and medical care for the state's minority communities: - Division – Part B and C funded ASOs and Clinics

2) Continue to fund non-medical and medical case management, and transportation services to help connect HIV positive individuals with medical care and support services. – Division – Part B – C and D funded ASOs and Clinics

3) Continue to support outreach programs such as the MAI funded Peer Mentor program, to reach out to the State’s HIV positive minority population specifically to refer them into care including enrolling in the State’s ADAP. - Division

4) Continue to ensure geographic parity to access HIV care and services in Alabama by relying in part on surveillance and service utilization data to allocate RW funding to offer HIV care and services in all areas of the state. - Division

5) Continue to require all RW funded care and service agencies ensure that resource allocations are in proportion to the percentage of the State’s HIV disease cases by each population through contract requirements with service providers. – Division

Data Resources

1) The Enhanced HIV/AIDS Reporting System (e-HARS)

2) The HIV Incidence Surveillance Program utilizes data from the Testing and Treatment History (TTH), Incidence and Viral Resistance Surveillance (IVR) database, and

3) The HIV/AIDS Data Information System (HADIS), a relational data collection and management system, includes data entry and access to CTS testing within the state.

4) Set priorities through the direct care and prevention planning process,

5) Consult with the community networks for grass root observations and ideas, and

B. Strategy, plan, activities to address the needs of individuals *Aware* of their HIV status, but are not in care, with emphasis on retention in care

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 include the following:

Action Plan

- **Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.**
- **Increase the number and diversity of available providers of clinical care and related services for PLWH/As**
- **Support PLWH/A with co-morbidities**
- **Support PLWH/A who have challenges meeting basic service needs**

Activities and Project Participants

Time Line On-going over the next 1-3 years

Project activities to meet the goals and objectives began in CY 2009 and are projected to extend through 2015.

- 1) Continue to identify HIV positive individuals and refer them into primary care through the ERTS program - Enhanced Referral and Tracking System (ERTS)
- 2) Continue to refer newly diagnosed HIV positive individuals into care. HIV Coordinators located statewide utilize strong relationships with ASOs; state and county STD staff, traditional and university-based hospitals and institutions
- 3) Continue to link newly HIV positive persons through referral and follow-up activities Alabama's Peer Mentors and ERTS Prevention Nurse Coordinators
- 4) Complete linking to care activities. - Peer Mentors who are HIV positive persons contracted by the ADPH to work in collaboration with HIV care and service agencies and ERTS Coordinators

Data Sources

- 1) Alabama's unmet need framework
- 2) State HIV/AIDS Surveillance Alabama's Epi Profile,
- 3) Special studies including HIV care and service provider and consumer surveys,
- 4) HIV/Direct Care and Prevention's annual state collaborative meeting, and
- 5) RW service reports (RSR)

C. To Identify Individuals Who are Unaware of Their Status.

The Division of HIV/AIDS Prevention and Control's (Divisions) strategy for ensuring that individuals who are unaware of their HIV status supports the three main goals of the National HIV/AIDS Strategy, (1) reducing HIV incidence; (2) increasing access to care and optimizing health outcomes, and (3) reducing HIV-related health disparities.

The Division has increased the number of HIV tests performed by increasing and locating testing sites in areas identified through surveillance data that are experiencing an increase in HIV and other STDS.

Increased testing sites will lead to the early identification of new positive cases. The newly infected will be linked to clinics that provide treatment and support services as close to their homes as possible.

The Division will continue to adopt community level approaches for HIV prevention and awareness; and the reduction of stigma and discrimination through on-going collaboration with the HIV Prevention Planning Group, statewide community network groups, Peer Mentors, the Alabama Consumer Advisory Board (ACAB), AIDS Service Organizations (ASO), Focus Project and many other community partners across the state.

Action Plan:

- **To intensify HIV prevention efforts in communities where HIV is most heavily**
- **To expand targeted efforts to prevent HIV infection using combination of effective evidenced-based approaches**
- **To educate Alabama residents about HIV and how to prevent becoming infected**

Activities and Project Participants Time Line 1-3 years

- 1) Increase the number of HIV tests performed by increasing and locating testing sites in areas experiencing an increase in HIV and other STDS. The Division and State HIV/AIDS Surveillance – STD Division - DIS
- 2) Increase early identification of new positive cases efforts by increasing testing sites. The Division
- 3) Linking newly infected to clinics that provide treatment and support services as close to their homes as possible. ERTS Prevention Nurse Coordinators– Peer Mentors -STD DIS
- 4) Adopt community level approaches for HIV prevention and awareness by the Division.
- 5) Reduction of stigma and discrimination through on-going collaboration by the Division with multiple care and service agencies and community partners.-- HIV Prevention Planning Group, statewide community network groups, Peer Mentors, the Alabama Consumer Advisory Board (ACAB), AIDS Service Organizations (ASO), Focus Project and other community partners across the state.
- 6) Incorporate EIIHA activities and strategies into the RFP process by the Division. During early fall 2012, the Division will offer a new competitive RFP process to allocate Prevention funds for new behavioral, structural and/or biomedical interventions in 2013.
- 7) Additional capacity building for the Division staff and the HPPG members to become more familiar with the newest medical interventions to better prepare potential applicants to compete for prevention funding – Division – State Prevention Staff – State Direct Care Staff - SEATEC

Data Sources:

State HIV/AIDS Surveillance data eHARS
ERTS Program data
State STD data

D. Strategy, plan, activities for addressing the needs of special populations:

Alabama’s strategy is to address disparities in access and services among affected and historically underserved populations.

Action Plan

- **Continue to expand testing sites throughout the state,**
- **Continue to inform clients of their test results at the point of care and**
- **Continuing to refer clients to treatment and support services as quickly as possible**

Activities and Project Participants

Time Line 1-3 Years

The Division has written a letter of support and attended a CDC site visit for AIDS Alabama Inc, who will be implementing the plan. Collaborating with AIDS Alabama will be the Jefferson County Health Department and University of Alabama at Birmingham HIV Acute Testing Program. The project will be funded for 5 years. AIDS Alabama in Birmingham located in North central Alabama.

At the time of the CP 2012 update, Health Services Center in Anniston Alabama located in Anniston in East Alabama and AIDS Action Coalition located in Huntsville in North Alabama have received funding to begin to implement plans to address needs of special populations in their service areas. AIDS Alabama project is being highlighted in the CP.

Target Group – Data Resource

AF-AM and Latino MSM, ages 13 – 29. Surveillance data supports a growth in the number of individuals in this category.

AIDS Alabama submitted a proposal in May 2011 to provide Category A: HIV prevention services for high-risk Young Men of Color Who Have Sex with Men (MSM of Color) and their partners, regardless of age, gender, race, or ethnicity.

The project will have a focus on:

- Recruitment
- Enhanced Testing to include STIs and TB
- Comprehensive Counseling
- Condom Distribution
- Focus on Sexual Health Education

- 1) Recruit MSM to participate in this project. The intervention will be Many Men, Many Voices.
- 2) Provide intervention opportunities consisting of 6 consecutive 2-3 hour sessions delivered during a weekend retreat using a curriculum and group guide based on behavioral change
- 3) Assist participants identify their risk behaviors,
- 4) Assess social/cultural barriers for needed change,
- 5) Identify options for HIV prevention and safer sexual practices in the midst of a supportive environment of their peers.

Cultural challenges include working with individuals and testing systems that still judge MSM. Consequently, access to testing services may present barriers for young men living in

rural areas of the state as well as lack of factual HIV information also presents as a barrier to being tested.

Women and Children

In Alabama, perinatal transmission rates remain low (<1%). Alabama had four HIV-positive perinatal cases reported in 2010.

Action Plan and Project Participants

Time Line On-going 1-3 years

1) Provide quality HIV care and services for women and children by continuing to strengthen partnerships with the Division and the 2 Part D funded clinics in Alabama. UAB Family Clinic and USA Specialty Clinic

2) Provide perinatal updates to OB-GYNs, midwives, and nurses through a variety of methods over the years, including workshops in major cities, satellite presentations, and mailed information. - The Division

3) Collaborate through a new strategy called *The Pregnancy Improvement Project (PIP)* web page that provides perinatal updates, statistics, CDC recommendations, and treatment guidelines. The Division and the University of Alabama Family Health Clinic

A 1-800 number is available on the web page with HIV perinatal experts answering calls five days per week. Private providers will have access to web resources and brief needs and cultural competency to more effectively work with pregnant women. The project included a direct mail out to announce the web page and answer any related questions. The new web page was launched May 2012.

E. Description detailing the activities to implement the proposed coordinating efforts with the following programs at a minimum to ensure optimal access to care:

The Division supports coordinated opportunities for integrative activities. Since 1982 all HIV test providers have been required to refer all HIV positive cases for TB and STD services. The STD Division staff provides Partner Services (PS) to HIV positives. The ETI is another example of cross program collaboration. During early fall 2012, the DHPC will offer a new competitive RFP process to allocate Prevention funds for new behavioral, structural and/or biomedical interventions in 2013.

Direct Care and Services

The Division's Direct Care and Services Branch has developed a comprehensive and coordinated plan for clinical services at multiple sites in the state to delay onset of symptoms and to prevent and treat complications of HIV infection. Alabama's Ryan White Part B Program currently provides funding to 11 HIV specialty clinics that receive Part B and C Outpatient Ambulatory, two that receive Part D (Women and Children), and five ASOs located across the state to provide case management and other essential support services.

AIDS Service Organizations – RW Part B Funded

ASOs provide post-test counseling sessions for individuals infected with HIV. Health departments, clinics, private physicians, and other testing sites may refer clients who have received initial post-test counseling to local ASOs for additional post-test education and support.

Representatives of ASOs, and the Division meet quarterly as a statewide network, called ASONA. This group serves as a forum for sharing information, providing support, and receiving technical assistance. AIDS Alabama serves as fiscal agent for the network, subcontracting with the other organizations to provide prevention services, post-test education, case-management, and housing statewide funded by state and federal grants. This includes funding for prevention education directly from the state legislature through the Alabama Special Education Trust Fund.

The state supports the State CARE Network to plan for an accessible system of HIV care and services for persons living with HIV disease in Alabama. Key participants in this group include representatives from HIV clinics and service agencies, Peer Mentors, Consumer Advisory Board (CAB) members, ADPH as the state's RW grantee, ERTS Nurse Coordinators, other state and local agencies, and interested HIV Consumers.

State AIDS Drug Assistance Program (ADAP)

The state ADAP accepts referrals from physicians, primary care centers, university associated clinics and hospitals, area/local social workers, and community-based organizations (CBOs) and ASOs.

State Laboratory

Laboratories provide HIV-antibody testing and CD4 lymphocyte counts for private physicians and medical clinics. The ADPH Clinical Laboratories central lab also performs HIV tests for all clinics in the public health system and viral load testing for ADAP participants.

RW Part C and B Funded Clinics

Case managers provide assessments of client needs and link clients with resources for medical care and treatment, mental health care and treatment, transportation, food and housing. These case management services are available through HIV clinics and ASOs located across the state. Funding for case management services is available for Medicaid-eligible and non-Medicaid eligible clients.

RW Part D Funded Clinics

The State's two Part D funded specialized perinatal programs ensure access to quality medical care from well trained professionals who are able to provide the most current HIV/AIDS specific treatment and prevention information, testing and treatment regimens, training, and technical assistance services for the State's women infants and children with HIV/AIDS or affected by the disease.

Prevention Programs

The Alabama HIV Prevention Council, comprised of community and public health representatives, develops the statewide HIV prevention plan. The council uses current

epidemiological data to identify high-risk populations. For each of those populations, the council identifies unmet prevention needs, priorities and interventions. Some individuals who are HIV positive Consumers participate in the Alabama HIV Prevention Council to provide crucial input into the statewide prevention plan. Consumers work with community-based ASOs on a paid or volunteer basis.

Enhanced Referral and Tracking Program (ERTS)

ERTS provides an opportunity for HIV-positive Alabamians to make an initial medical appointment and be linked into medical care through a systematic way of identifying and documenting linkages to care, and through further tracking by the HIV Program Coordinator. Currently, ERTS data shows 70% of newly reported cases are “in care.” This program is a joint collaboration that strengthens relationships between HIV/AIDS, STD, CBOs, consumers, mental health and substance abuse treatment facilities, and other agencies. ERTS provides baseline and benchmark data to establish the “unmet need” and to improve access to care regionally and statewide for persons newly diagnosed with HIV.

University of Alabama at Birmingham Emergency Department

Under the Expanded HIV Testing Initiative the University of Alabama at Birmingham Hospital Emergency Department (UAB-ED) has begun offering “opt out” HIV rapid test during all three shifts of the emergency department. This expansion in testing exposes individuals from all socio-economic, educational, and racial backgrounds to HIV testing. Individuals who do not have health insurance and use the ED for ongoing treatment and care will now be able to test for HIV on a routine basis.

Historically Black Colleges and Universities (HBCUs)

As part of Alabama’s Expanded HIV Testing Initiative, the ADPH implemented rapid HIV testing in Historically Black Colleges and Universities (HBCU) within the state. These non health-care venues have been chosen as sites with a high-risk demographic within the rural and

Alabama Prison Initiative

The Alabama Prison Initiative aims to provide primary and secondary education services to HIV positive inmates identified in the ADC. The Initiative is a collaborative partnership between the Alabama Department of Public Health-HIV/AIDS Division, the Alabama Department of Corrections, NaphCare Pharmacy, state ASOs and CBOs. ADC collaborates with other agencies in the state that provide HIV services, trainings such as to inmates. Prison Rape Elimination Act (PREA) and Discharge Planning. ASOs and CBOs also regularly provide agency information.

Community Health Centers

The Division in collaboration with Community Health Clinics (CHC) in Alabama will improve access to HIV/AIDS care and services through an integrated service model. CHCs are located across the state to expand access to care for PLWH/A in Alabama. In addition, CHCs will collaborate with various ASOs in the state to integrate the preventive and care models in Alabama.

Minority AIDS Initiative Funded Peer Mentor

Efforts to find people not in care are supported by several programs. The Peer Mentor Program is a consumer-driven prevention and care related service offered by DHPC since 2005 focuses on connecting PLWHA (person living with HIV/AIDS) and their partners, and high-risk negatives to care, as well as, retaining and reclaiming clients for services. Seven contracted Peer Mentors work closely with regional HIV Program Coordinators and AIDS Service Organizations (ASO) statewide. Peer Mentors are HIV-positive individuals whose mature handling of their own disease is a model for others. Newly diagnosed and stigmatized individuals identify with and trust Peer Mentors more readily than other workers, allowing the mentor to address personal concerns and barriers to care.

Alabama's Consumer Advisory Board

Consumers who participate in local CABs conduct local awareness and education events and provide input into local care and service policy. The Statewide Consumer Advisory Board (ACAB) provides those valuable functions at the state level. Some consumers who are long-term survivors serve as Peer Mentors to find out-of-care HIV positive persons and link them to needed medical and dental care and social services.

F. How Alabama's Comprehensive Plan addresses "Healthy People 2020 Objectives for Improving Health-HIV"

Objective: In the 21st century, strategies for reducing HIV transmission will continue to evolve and will require shifts from current efforts. Future strategies should focus on continuing to address the disproportionate impact of HIV/AIDS among certain racial and ethnic groups. **Response:** Alabama's HIV prevention and direct care programs target AF/AM as the priority population for intervention.

Objective: To enhance prevention strategies for populations that are particularly at high risk, such as injection drug users, homeless persons, runaway youth, mentally ill persons, and incarcerated persons. Some of these populations are difficult to reach. **Response:** Prevention programs funded in Alabama address all the above listed populations.

Objective: To increase the number of people who learn their HIV status to detect HIV infection when the potential for transmission is greatest, and the need for prevention, care and treatment, including HAART, is greatest. **Response:** MAI funds support the Statewide Peer Mentoring Program. The program consists of HIV positive Peer Mentors representing nine Public Health areas throughout the State of Alabama. Program goals include identifying high-risk individuals in the community and providing education and outreach to encourage individuals to be tested, and to learn their HIV status. Peer Mentors offer education and outreach services to infected persons; and make referrals to medical/dental care, consumer advocacy, inpatient and outpatient substance abuse treatment, emergency and transitional housing, case management, secondary prevention counseling and food distribution programs. Peer mentors work closely with their local medical clinics, and ASOs that provide HIV specific services to infected persons and high risk negative individuals.

Objective: To reach high-risk sero-negative individuals to help them remain uninfected. **Response:** ADPH recently received CDC funding to conduct an Expanded HIV Testing Initiative. Testing partners include Historic Black Colleges and Universities, rural health

clinics and The University of Alabama at Birmingham Emergency Department. The efficiency of Peer Mentor program's outreach and education activities has increased via cross-referencing surveillance, ERTS and ADAP data so Peer Mentors do not spend time looking for individuals already in care. This allows program outreach and education activities that focus on individuals who are not in care.

Objective: To improve access to HAART to reduce deaths and HIV associated illness and possible infection of others. **Response:** At the time of this CP writing, ADAP has capped enrollment at 1700 and has nearly 80 Clients on the program's waiting list. The average cost per ADAP client is approximately \$11,000 to \$12,000 per client per year. The ADAP formulary, at the time of this CP writing, offers 74 medications with no limit placed on the number of anti-retroviral medications available per client. Alabama's ADAP restricted enrollment and implemented a waiting list in CY2011 as cost saving measures. Utilization and funding projections will continue to guide decisions made by the ADAP Advisory Group to continue to restrict program enrollment as necessary in CY2012. The ADAP Quality Group will continue to meet at a minimum of four times per contract year to ensure the delivery of quality ADAP services.

Objective: To increase efforts and opportunities to provide counseling to prevent transmission and re-infection for all HIV-infected individuals who are receiving medical and supportive care. **Response:** The MAI funded Peer Mentor Program supports HIV positive peers in providing supportive counseling, community referrals, linkages, risk reduction and advocacy to newly diagnosed persons and high-risk negative persons strengthen secondary prevention activities. HIV positive individuals receive referral services through the Enhanced Referral Tracking System (ERTS) Program. Regional HIV Coordinators collaborate with HIV clinics and service agencies to provide counseling and testing services. All ADPH funded HIV prevention programs are required to include an HIV counseling and testing component and referral to medical services for clients testing HIV positive.

G. How Alabama's CP for 2012-2015 reflects the SCSN

Alabama's Strategy to Meet Critical HIV Care and Service Needs for 2012-2015

Alabama's care and service implementation plan reflects a 93% allocation of the State's RW funding for core medical services to meet the 75/25 core medical service requirement for 2012-2015. Alabama's latest unmet need calculations show that greater than 70% of persons not receiving care are AF/AM.

- 1) Continue to focus efforts on the state's minority population living in rural areas to assure access to ADAP and medical care for the state's minority communities:
- 2) Continue to fund non-medical and medical case management, and transportation services to help connect HIV positive individuals with medical care and support services
- 3) Continue to support outreach programs such as the MAI funded Peer Mentor program, to reach out to the State's HIV positive minority population specifically to refer them into care including enrolling in the State's ADAP.

- 4) Continue to ensure geographic parity to access HIV care and services in Alabama by relying in part on surveillance and service utilization data to allocate RW funding to offer HIV care and services in all areas of the state
- 5) Continue to require all RW funded care and service agencies ensure that resource allocations are in proportion to the percentage of the State's HIV disease cases by each population through contract requirements with service providers.
- 6) Continue to fund medical case management services to provide treatment and medication adherence activities.
- 7) Each service provider will continue to document a detailed plan regarding the provision of services to women, infants, and children affected by HIV. The plan must show what portion of funds is allocated to provide services to women, infants, and children in their service area.
- 8) Alabama's two RW Part D funded clinics will continue to work with all Part C funded clinics and Part B funded service agencies to provide services targeted to HIV-infected women, infants, children and youth and their families.
- 9) The state ADAP staff will continue to monitor medication adherence and work in collaboration with the medical case managers to ensure clients remain compliant with medications to remain enrolled in the program.
- 10) Each service provider will continue to be required to report service data quarterly to the UWCA each CY as a RW Part B funding requirement.

Action Plan: To Continue to Offer Quality State AIDS Drug Assistance (ADAP) Services Activities and Project Participants
Time Line- Ongoing 2012-2015

Project 1) Quality Measure: ADAP enrollees with recorded CD4 in the last six months- 100% compliance with the Client Eligibility Review (CER) twice a year requirement to ensure CD4 and VL updated with each CER. **Measurement:** Percent of active ADAP enrollees meeting CER enrollment requirements to receive an HIV medical visit including a medical case management service for each enrollee in the measurement year. **Data Element:** Tracking Outcomes – ADAP data-base EPI Info- **Goal** 95% compliance rate for ADAP enrollees to have a medical visit with an updated CD4 and VL once during the 12-month measurement year.

Project 2) Quality Measure: Medical Case Management and Medical Visits
Goal: To ensure that ADAP enrollees have a minimum of two medical visits in 12 months
Measurement: Percent of ADAP enrollees with two or more medical visits in an HIV care setting during the measurement year. **Data Element:** Tracking Outcomes -ADAP Data Base – EPI-6 **Project Outcome Goal** 90% have a medical case management visit twice during the 12-month project.

Project 3) Performance Measure: ADAP - Centralized ADAP Eligibility Determination Process

Goal: To decrease the length of time to process ADAP applications and Client Eligibility

Measurement: Percent of ADAP applications approved or denied within two weeks of receiving in the ADAP Eligibility.

Data Element: (1).Date of receiving a new application or CER in the ADAP Eligibility Office (2).Final date of approval or denial of an ADAP application or CER

Data Sources: Eligibility Tracking Outcomes -ADAP Data Base –EPI-6 **Goal** 95% completed within 2 weeks of receiving

Project 4) Performance Measure: ADAP Client Eligibility Review Process (CER)

Goal: To ensure all active ADAP enrollees complete CER at a minimum of twice a year.

Measurement: Percent of active ADAP enrollees reviewed for eligibility at least twice during the contract year.

Data Element: (1).ADAP enrollees meeting Client Eligibility Review (CER) requirement

Data Sources: ADAP Data Collection System – EPI- 6 and New Integrated Data Collection System Project **Goal** 100% compliance with CER requirement

The ADAP Adherence Project will continue an active approach to cost containment over the next three years, and will include the following activities:

Monitoring monthly drug utilization;

(1) Monitor monthly drug costs to ensure ADAP consistently receives accurate drug pricing;

(2) Monitor monthly medication pickups to improve medication adherence;

(3) Completing regular ADAP medication inventories at all clinics to decrease program costs by decreasing medication waste:

(4) Improving the current Client Satisfaction Survey to collect significant client data to base improvement decisions;

(5) Implementing the data collection system (DM/DI) to integrate data systems across programs by 2012 and,

(6) Implementing 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 CER and application process.

Action Plan: To Continue to Ensure Quality Ryan White Services to Meet HRSA/HAB Monitoring Standards

Activities and Project Participants

Time Line On-going 2012 – 2015

Integrating data and information systems

Goal 2.1: Access Alabama's HIV Surveillance e-HARS data collection system to improve collection of updated CD4 counts and Viral Load values to ensure all active ADAP enrollees received at least one clinical visit per year.

Goal 2.2: Continue to access statewide aggregate service utilization data from quarterly provider service reports collected and submitted through UWCA web based system.

Goal 2.3: ADAP central pharmacy e-prescribing system to submit medication orders directly to the ADAP central pharmacy.

Goal 2.4: Implement CAREWare in the ADAP central office to begin collection Client Level Data (CLD) to report October 1, 2012.

Optimizing the management of resources

Goal 3.1: Continue to conduct site visits to measure compliance with state case management standards.

Goal 3.2: Continue to monitor Medicaid enrollment of ADAP clients through MSIQ access in the eligibility office.

Goal 3.3: Continue to conduct site visits to monitor program and fiscal activities of all funded providers during the grant year.

Aligning jurisdictions and services across the entire continuum of care

Goal 4.1: Continue to include Part B representation in Alabama's Part C and D state Quality Management Group

Goal 4.2: Share QM plans and assessment system-wide outcome measures and evaluating client engagement in medical care.

Goal 4.3: Develop statewide, cross-parts goals, measurements and a statewide, cross-parts Quality Management Plan.

Goal 4.4: Continue to promote participation by all RW funded clinics in the ADAP Quality Group.

Goal 4.4 Continue to require all Part B funded providers to submit a quality care plan each contract year as a funding requirement.

Goal 4.5 Continue to require all Part B funded providers to work on a quality project during the grant year and submit outcome data quarterly report during each contract year.

H. How Alabama's Comprehensive Plan Coordinates With and Adapts to Changes That Will Occur With the Implementation of the Affordable Care Act (ACA)

An on-line introduction to the ACA stated that, "the health of people living with HIV and AIDS is influenced not only by their ability to get coverage but also economic, social, and physical factors." Alabama's CP addresses the identified critical needs of PLWH/As who are aware of their HIV status and those who are unaware of their status by incorporating the goals and objects stated in the ACA in this updated CP for 2012-2015 which includes:

- **Quality comprehensive care:** ACA proposes to meet the health care needs of Americans, including prescription drugs, preventive care, chronic disease management, and substance abuse and mental health treatment to help people living with HIV/AIDS stay healthy.
- **Coordinated care:** The Affordable Care Act calls for new investments to help providers manage chronic disease. The law also recognizes the value of patient-centered as a way to strengthen the quality of care, especially for people with complex chronic conditions such as HIV. Medical homes provide a way to offer coordinated, integrated, and comprehensive care that has proven to be particularly effective for treating people living with HIV.
- **Diversity and cultural competency** The Affordable Care Act expands initiatives to strengthen cultural competency training for all health care providers and ensure all

populations are treated equitably. It also bolsters the federal commitment *to reducing health disparities*.

- **Prevention and wellness.** The law makes critical investments in prevention, wellness, and public health activities to improve public health surveillance, community-based programs, and outreach efforts. The law requires many insurance plans to offer HIV screening tests for at-risk people at no additional cost to them making it more likely they will get tested and, if necessary, get access to life-saving treatment more quickly. And starting in 2012, the law also requires many plans to provide coverage without cost-sharing of HIV and other STI counseling for all sexually active women.

I The Division shares the values and vision set forth in the *National HIV/AIDS Strategy and The Health People 2020* and is committed to reducing HIV incidence increasing access to care and optimize health outcomes and reduce HIV-related health disparities in Alabama. Alabama's Comprehensive Plan for 2012-2015 incorporates the goals stated in *the National HIV/AIDS Strategy* into the State's strategy to address the HIV/AIDS epidemic over the next three year planning cycle.

Reducing new HIV infections by intensifying HIV prevention efforts in the communities where HIV is most likely concentrated; expand targeted efforts to prevent HIV infection using a combination of effective evidenced-based approaches, and prevention education.

Increasing access to care and improving health outcomes for people living with HIV by establishing a system to link them to care when they learn they are positive; increase the number and diversity of available providers of clinical care and related services, and ensure support for people living with co-occurring conditions, and those who have challenges meeting their basic needs.

Reducing HIV-related disparities and health inequities by reducing HIV-related mortality in communities at high risk for HIV infections; adopt community level approaches to reduce HIV infection in high risk for HIV infection, and work to reduce stigma and discrimination against people living with HIV.

Achieving a more coordinated response to the HIV epidemic by increasing the coordination of HIV programs, and by developing an improved mechanism to monitor and report on progress toward achieving state and national goals.

MAI goals and objectives will implement the National HIV/AIDS Strategy of the United States.

Goal 1 To reduce new HIV infections

Objective 1.1 By April 1, 2012, the ACAB and each Peer Mentor will define at least 2 long-term goals and 5 objectives that target population groups most at risk for infection based upon surveillance and community data.

Objective 1.2 By December 31, 2012, ACAB members and Peer Mentors will each participate in at least 5 prevention activities such as testing events and making presentations.

Goal 2 To increase access to care and improve health outcomes for people living with HIV

Objective 2.1 By March 31, 2013, 85% of newly diagnosed minority persons will be enrolled in medical care within 3 months of diagnosis.

Objective 2.2 By March 31, 2012, 85% of newly diagnosed minority persons will be referred to a social worker, and to support groups or mental health counselors if needed.

Goal 3 To reduce HIV-related disparities and health inequities

Objective 3.1 By March 31, 2013, provide education and referrals for viral load and CD4 counts to 85% of HIV-positive minority persons living in Alabama.

Objective 3.2 By March 31, 2013, 90% of HIV-positive eligible minority persons living in Alabama will be receiving medications via ADAP.

Goal 4 To achieve a coordinated response to the HIV epidemic

Objective 4.1 By March 31, 2012, compile and analyze PHA-specific Peer Mentor data to measure progress toward the achievement of each Peer Mentor's goals and objectives.

Objective 4.2 By June 30, 2012, track clients through Peer Mentor, ERTS and ADAP data on a quarterly basis and document progress toward achievement of MAI goals and objectives.

J. Discuss the strategy to respond to any additional or unanticipated changes in the continuum of care as a result of state or local budget cuts

Projected continued growth in rural Alabama through 2025, will present continued challenges for the state's health care system to assure delivery and access to quality health care and social services for residents living in both rural and urban areas in the state. Shrinking dollars from federal funding sources will mean a reduction in services with an increase in the numbers of patients testing positive. The shortfall of general funds in Alabama that began in CY2012 may severely affect HIV direct care and prevention services in CY2013 and beyond.

Further state funding cuts could result in employee lay-offs, employees functioning in multiple roles, and services eliminated or reduced. In addition, cuts may be necessary in prevention, direct care, and program support due to salary adjustments and other expenses presenting major barriers to maintaining linkages between the community planning process, prevention priorities and direct care and services. The need for funding for prevention and direct care services to address the public health problem of HIV/AIDS infection is and will be an ongoing issue that needs attention on the local, state and federal levels.

Base Part B grants are awarded to States and Territories using a formula based on reported living cases of HIV/AIDS. States with more than one percent of total HIV/AIDS cases reported in the United States during the previous two (2) years must provide matching funds with their own resources using a formula outlined in the legislation. Alabama's Part B program receives funding through the following sources

- RW Part B base grant,
- AIDS Drug Assistance Program (ADAP) award,
- ADAP supplemental award,
- Minority AIDS Initiative (MAI) award
- Alabama Matching Funds

In 2011, the Alabama State legislature appropriated state funds for matching the RW grant. The amount has increased from \$600,000 in 2001 to \$5,000,000 in 2006. The amount of state funding has remained at \$5,000,000 until the current year when, due to shortfalls in all state funding, 10% was retained by the Governor's budget until funds become available.

Alabama's Part B program has allocated approximately 90% of funds for the now identified "core" services each year of the RW grant. This has been necessary because Alabama has a poor Medicaid system and few medical providers who have been willing to provide care for HIV infected individuals. This has resulted in creation of an HIV care and services system outside the private medical sector that is funded primarily through Alabama's RW grant.

Alabama's RW program is finding it more difficult to keep up with the growing need for HIV/AIDS care and services including life saving medications at the same time that available state and federal funding resources are decreasing. This is especially the case in the current economic climate that is creating increased needs for the State's HIV/AIDS population at the same time that available funding resources are decreasing. Alabama experienced an \$861 million dollar or a 12.3% funding shortfall in the State's general fund budget in CY2011 with an increase in the gap in funding in CY2012.

A major challenge for both the State's ADAP, as well as RW funded care and service providers, is determining the impact of the Early Identification of People with HIV/AIDS (EIIHA) on the potential increase in the State's newly identified HIV positive population. HIV testing services have increased, however, treatment providers are not increasing at the same rates creating larger patient loads for clinics whose numbers of staff has remained unchanged. Shrinking dollars from federal funding sources creates a reduction in services with an increase in the numbers of patients testing positive. Alabama is a rural state that requires a great deal of travel to notify individuals of their test results. The geographic locations may also hinder how soon an individual can be notified about confirmatory test results for preliminary positive tests.

With increasing utilization and limited funding, Alabama's ADAP formulary had to be reduced in 2011 from 102 medications to 73 by eliminating the majority of complimentary drugs. The reduced formulary presented a challenge for Social workers/Case managers in RW funded clinics having to apply to Pharmaceutical Assistance Programs (PAPs) and other drug resources for their Clients to access eliminated medications from the ADAP formulary. The current formulary continues to offer at least one medication from the core classes of FDA approved antiviral drugs for the State's ADAP to remain in compliance with HRSA funding requirements. To avoid having to remove enrollees from Alabama's ADAP beginning in 2011, enrollment was decreased from 1900 to 1600 through natural attrition. A major challenge was sustaining this decrease due to the large number of new applicants and Clients re-enrolling. Consequently, the program experienced increased enrollment resulting in having to reinstate enrollment restrictions and the waiting list by the end of October 2011.

IV. How will we monitor progress?

Summary: The purpose of this section is to describe the methods and/or means by which progress in achieving goals and meeting challenges will be monitored

Ryan White HIV/AIDS Program and Legislative Quality Requirements

The Health Resources and Services Administration under the Ryan White HIV/AIDS Treatment Modernization Act of 2006 require Grantees to have a Clinical Quality Management (CQM) program in place as a condition of grant award. Legislative requirements stated in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 direct Grantees to develop, implement, and monitor clinical quality management programs to ensure the following:

- Funded service providers adhere to established clinical practices;
- Quality improvement strategies include support services that help people access appropriate HIV health care (e.g., transportation assistance, case management) and improve treatment adherence and;
- Demographic, clinical and health care utilization information is used to monitor trends in HIV-related illnesses and the local epidemic.

Quality defined in relation to the Ryan White (RW) HIV/AIDS Program

The HIV/AIDS Bureau (HAB) defines ‘quality’ as the degree to which health or social services meet or exceeds established professional standards and user expectations.

Quality expectations for Alabama’s Ryan White (RW) Part B funded providers

HAB’s *Monitoring Expectations for Part A and B Grantees: Part B Program Monitoring Standards*, guided the development of Alabama’s RW Part B CQM expectations for the State’s Part B funded providers that are the following:

The Part B Quality Plan is included with this document (Attachment 4)

1. Implementation of a CQM Program to assess the provision of HIV health services funded through the RW CARE Act to assure that services provided under the grant are consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV/AIDS and related opportunistic (OI) infections.
2. Develop a quality management plan that states expectations of providers and for the delivery of HIV care services provided under the grant.
3. Develop quality improvement strategies to include vital health related support services to ensure access to quality HIV health services and to improve treatment adherence.
4. Develop a method to track and report CQM project outcome data

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 that meet Public Health Services (PHS) and state guidelines.

The Division Director is responsible for the overall direction of the state QM/QI program in collaboration with the Division's QM and Evaluation Branch Director. Alabama's state quality program uses a network approach to implement the State's quality program that depends on local quality programs (Part B, C and D) and the state quality staff to implement CQI/QI activities. The Evaluation and Quality Management Branch and Direct Care Director attend the CQI group meetings to stay informed of Part C and D state CQI projects. The Division's QM and Evaluation Branch oversees the state's quality plan, and assumes a leadership role in collecting and analyzing local CQM project outcome data that guides state care and service improvement decisions. .

The ADAP Coordinator and the Direct Care Director work in collaboration with the Evaluation and Quality Branch, the Regional Quality Group (RQG) and the ADAP Quality Group (AQG) to meet ADAP goals and objectives. The Direct Care Director, the ADAP Coordinator and the Central Pharmacy staff are directly responsible for implementing medication services. ADPH contracts with one Central Pharmacy (NaphCare) to provide pharmacy and medication distribution services. NaphCare monitors medications and pharmacy dispensing services. The Direct Care and ADAP staff conducts on-going ADAP quality improvement activities and monitors project outcome data to support ADAP improvement decisions.

Method to Monitor Progress of the State ADAP in Providing Quality Services

- The ADAP Advisory Group meets to discuss ADAP financial issues and does not operate under the direction of by-laws. ADAP uses this process to ensure that the program continues to provide medication services to meet current standards and best practices.
- The ADAP Quality Group meets four times a year to discuss program issues and to monitor the quality of ADAP services.
- Ongoing Consumer ADAP Satisfaction Survey outcomes

Each Part B contractor must submit to the UWCA a written quality plan as a condition of award to ensure the funding of quality HIV care and services that meet PHS treatment guidelines and standards set by the state's RW program. All Part B funded providers must submit a quality project(s) along with any data collected with the first their first quarter progress report. Project updates are to be reported each quarter with final out-comes reported with the final progress report. The Direct Care Director reviews quality plans and monitors quality activities of Part B funded contractors. All Part C and D funded care providers must assess and monitor the quality of their HIV care as required by the Part C and D quality program - HIV-Qual.

The UWCA completes program and fiscal monitoring activities for the State's Part B program. Monitoring activities include, monitoring service utilization and expenditures to identify service needs, gaps in services and to guide funding allocation decisions. Contractors report quarterly service utilization and monthly billing to the UWCA using unique client identifiers. The UWCA monitors service utilization and expenditure data to eliminate duplication of services and billing by multiple contractors. The UWCA Social worker completes site visits to assess the quality of Part B funded case management service delivery and to provide technical assistance to improve Part B funded case management services.

Monitoring activities include collection of site visit out-come data, monitoring service utilization and expenditures to identify service needs, gaps in services and to guide funding allocation decisions. Regularly scheduled Part B Lead Agency/Provider meetings provide an opportunity to provide updates and technical assistance related to QI activities for Part B funded care and service providers.

Continuous quality assurance activities include the collection of out-come data used to evaluate the effectiveness of the State's RW program infrastructure and to decide on how quality improvement activities are accomplished, and to evaluate the state's quality activities to ensure the delivery of quality HIV care and services.

Over Sight of the Prevention Projects

Incidence and prevalence data is supplied upon request. The data is placed on the web site quarterly. The HIV Prevention Planning Group (HPPG) meets quarterly. The plan prioritizes risk populations based on the trends of the epidemic and the needs of the most affected populations. The State's HIV/AIDS Division uses this plan to guide programs and resource allocations for HIV prevention activities. The national program's shift to HIV positive persons and their partners and other high risk individuals will increase planning efforts to link prevention and care. The new strategy will further encourage improved service delivery among all providers. Despite less emphasis on primary prevention, the Division will continue to provide capacity building assistance for specialized programs demonstrating the potential for the greatest impact on individuals, groups, institutional systems or communities. Because HIV Prevention Planning is an ongoing process, the plan continues to evolve. The Community Networks groups meet monthly. HIV Program Coordinators set the scheduled meetings for 2012 in January. A staff member of the Division manages each program's activity and timelines.

Measure Progress of HIV testing efforts in Alabama

The expected outcomes of the Division's HIV testing program include:

- 1) Increasing the number of people who know they are infected; Division's, Data and Quality Management Director estimates that the expanded testing initiative will increase testing in Alabama by 30%.
- 2) Linking HIV positives to care;
- 3) Reducing the number of persons testing positive for HIV and other STD infections;
- 4) Increasing testing by 25% annually; and
- 5) Linking >85% of those with newly diagnosed infections into health care over the five-year period of this funding opportunity

Measure of Progress in decreasing HIV health disparities and stigma through:

- HIV/AIDS Care and Service Consumer Surveys
- HIV care and service Provider Surveys
- Input from Peer Mentors through participation in the State Quality Group and ADAP Quality Group
- Input from Alabama's Consumer Board through participation in the State Quality Group and ADAP Quality Group

- Outcome Data from the AIDS Alabama Consumer Needs Assessment Survey

Measure Progress: Healthy life expectancy of PLWH/As in Alabama

- Monitor Surveillance data related to decrease in deaths
- Monitor self-assessed health status of Alabama's HIV/AIDS Consumers through Consumer Surveys
- Monitor Chronic disease and co-infection prevalence

Data Resources

1) Integrated Data Collection System and Document Imaging system (DM/DI) that when fully implemented will link the Division's databases to improve client-level-data collection at the state level. Projected date of completion to have the system fully implemented in late 2012.

2) EPI 6 ADAP database to collect CD4 and VL data on all ADAP enrollees and to monitor compliance with twice a year CER

3) ERTS program data to monitor and evaluate effectiveness of the program to link newly diagnosed HIV positive residents to HIV care and services.

4) MAI funded Peer Mentor program data to monitor the number of HIV positive residents linked to HIV care and services by Peer Mentors across the state.

5) Prevention and intervention data to monitor state Counseling, Testing and Referral (CTR) activities to monitor trends in HIV testing to anticipate a need for increased in funding to establish additional services in the state.

6) State HIV/AIDS Surveillance data to monitor trends in the epidemic,

7) RSR data to monitor specific client demographics, clinical and service utilization and expenditures to manage duplication of services and billing, as well as to make service and funding priority decisions each grant year.

8) The UWCA hosts a web-based CareWare data collection system used by RW contractors to collect CLD or for contractors whose systems do not convert internal systems to upload CLD to complete the RW Service Report RSR.

9) Other Part B contractors collect CLD to report outpatient/ambulatory and medical and non-medical case management services through their clinic reporting systems or through the HRSA sponsored CAREWare.

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