**Indianapolis Transitional Grant Area**

**Comprehensive Plan**

**FY 2015 – 2017**

**Prepared for the**

**Health Resources and Services Administration**

**by the**

**Ryan White Services Program**

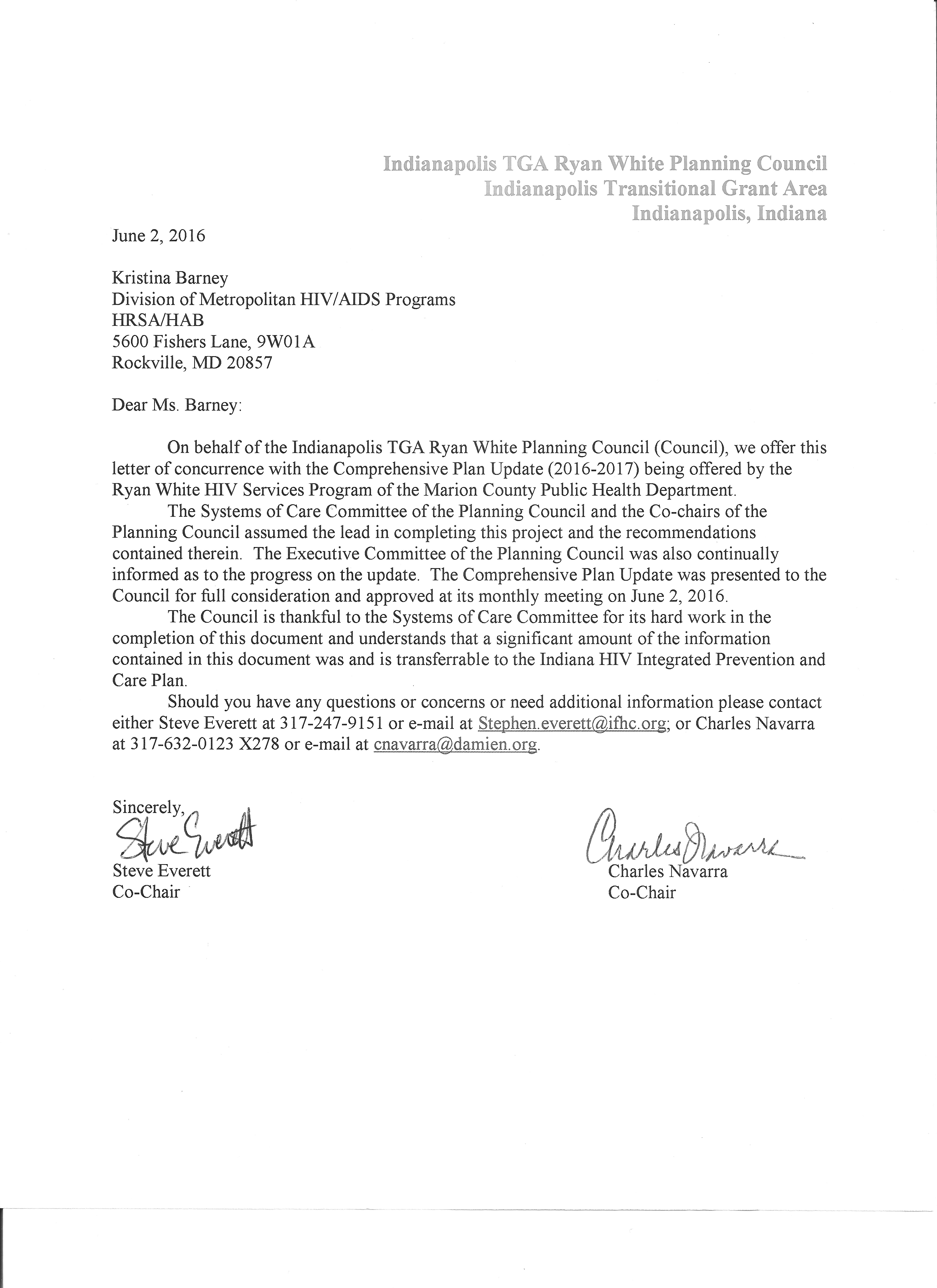
**Health and Hospital Corporation of Marion County, Inc.**

**Marion County Public Health Department**

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|  |  |  |
| --- | --- | --- |
| **LETTER OF CONCURRANCE** | |  |
| *Signed by the Ryan White Part A Planning Council Co-Chairs* | | [5](#Concurrence) |
| **CONTRIBUTORS** | |  |
| *Acknowledgements* | | [7](#Contributors) |
| **GLOSSARY** | |  |
| *Common acronyms, abbreviations, and definitions* | | [9](#Glossary) |
| **ALLOWABLE SERVICE EXPENSE CATEGORIES** | |  |
| *List of all services allowed under Ryan White Part A* | | [11](#ExpenseCat) |
| **EXECUTIVE SUMMARY** | |  |
| *Brief synopsis of the Indianapolis Transitional Grant Area Comprehensive Plan* | | [13](#ExecSummary) |
| **INTRODUCTION** | |  |
| Purpose | | [15](#Purpose) |
| Process | | [15](#Process) |
| Context and Revisions | | [15](#Context) |
| **SECTION I: WHERE ARE WE NOW?** | |  |
| **A.** | **Description of the Local HIV Epidemic** | [**17**](#Sect1A) |
|  | 1. CY 2013 Epidemiological Profile Summary | [17](#Sect1A1) |
|  | 1. Unmet Need Estimate for 2013 | [23](#Sect1A2) |
|  | 1. EIIHA Estimate of Status-Unaware Individuals | [24](#Sect1A3) |
| **B.** | **Description of the Current Continuum Of Care** | [**25**](#Sect1B) |
|  | 1. Overview | [25](#Sect1B1) |
|  | 1. Ryan White Care and Service Inventory | [26](#Sect1B2) |
|  | 1. Non-Ryan White Care and Service Inventory | [31](#Sect1B3) |
|  | 1. Interaction between Ryan White and Non-Ryan White Services | [32](#Sect1B4) |
|  | 1. Effect of and Response to State and Local Budget Reductions | [32](#Sect1B5) |
| **C.** | **Description of Need** | [**33**](#Sect1C) |
|  | 1. Previous Assessments | [33](#Sect1C1) |
|  | 1. Care Needs | [37](#Sect1C2) |
|  | 1. Capacity Development Needs | [42](#Sect1C3) |
| **D.** | **Description of Priorities for the Allocation of Funds** | [**43**](#Sect1D) |
|  | 1. Size and Demographics of the Population with HIV | [43](#Sect1D1) |
|  | 1. Needs of Individuals with HIV | [43](#Sect1D2) |
| **E.** | **Description of Gaps in Care** | [**45**](#Sect1E) |
|  | 1. Co-Morbidities | [45](#Sect1E1) |
|  | 1. Societal Issues | [48](#Sect1E2) |
| **F.** | **Description of Prevention and Service Needs** | [**50**](#Sect1F) |
| **G.** | **Description of Barriers to Care** | [**51**](#Sect1G) |
|  | 1. Service Barriers | [51](#Sect1G1) |
|  | 1. Barriers to Routine Testing | [57](#Sect1G2) |
| **H.** | **Evaluation of the 2012-2015 Comprehensive Plan** | [**57**](#Sect1H) |
|  | 1. Successes | [58](#Sect1H1) |
|  | 1. Challenges | [58](#Sect1H2) |
| **SECTION II: WHERE DO WE NEED TO GO?** | |  |
| **A.** | **Plan To Meet Identified Challenges** | [**59**](#Sect2A) |
| **B.** | **Proposed Care Goals** | [**59**](#Sect2B) |
|  | 1. Recommendations to Address Identified Service Barriers | [59](#Sect2B1) |
|  | 1. Recommendations to Address Identified Barriers to Routine Testing | [67](#Sect2B2) |
| **C.** | **Unmet Need Goals for Status-Aware Individuals** | [**67**](#Sect2C) |
|  | 1. Unmet Need Targets | [67](#Sect2C1) |
|  | 1. Identification and Engagement Goals | [68](#Sect2C2) |
| **D.** | **EIIHA Goals for Status-Unaware Individuals** | [**68**](#Sect2D) |
|  | 1. EIIHA Targets | [68](#Sect2D1) |
|  | 1. Identification and Engagement Goals | [68](#Sect2D2) |
| **E** | **Proposed Solutions To Close Care Gaps** | [**69**](#Sect2E) |
|  | 1. Co-Morbidities | [69](#Sect2E1) |
|  | 1. Societal Issues | [70](#Sect2E2) |
| **F.** | **Proposed Solutions To Address Care Overlaps** | [**70**](#Sect2F) |
|  | 1. Ryan White Program Grantees | [71](#Sect2F1) |
|  | 1. Planning Council | [71](#Sect2F2) |
| **G.** | **Proposed Coordinating Efforts** | [**71**](#Sect2G) |
|  | 1. Part B and ADAP | [71](#Sect2G1) |
|  | 1. Part C | [71](#Sect2G2) |
|  | 1. Part D | [72](#Sect2G3) |
|  | 1. Part F | [72](#Sect2G4) |
|  | 1. Non-Ryan White Private Providers | [72](#Sect2G5) |
|  | 1. Prevention Programs | [72](#Sect2G6) |
|  | 1. Substance Abuse Treatment Programs | [73](#Sect2G7) |
|  | 1. STD Programs and HIV Surveillance | [73](#Sect2G8) |
|  | 1. Medicare | [74](#Sect2G9) |
|  | 1. Medicaid | [74](#Sect2G10) |
|  | 1. Children’s Health Insurance Programs | [74](#Sect2G11) |
|  | 1. Community Health Centers | [74](#Sect2G12) |
| **SECTION III : HOW WILL WE GET THERE?** | |  |
| **A.** | **Closing Care Gaps** | [**75**](#Sect3A) |
|  | 1. Co-Morbidities | [75](#Sect3A1) |
|  | 1. Societal Issues | [76](#Sect3A2) |
| **B.** | **Addressing the Status-Aware** | [**77**](#Sect3B) |
|  | 1. Strategy | [77](#Sect3B1) |
|  | 1. Plan | [77](#Sect3B2) |
|  | 1. Activities | [78](#Sect3B3) |
|  | 1. Timeline | [78](#Sect3B4) |
| **C.** | **Addressing the Status-Unaware** | [**78**](#Sect3C) |
|  | 1. Strategy | [79](#Sect3C1) |
|  | 1. Plan | [79](#Sect3C2) |
|  | 1. Activities | [79](#Sect3C3) |
|  | 1. Timeline | [80](#Sect3C4) |
| **D.** | **Addressing Special Populations** | [**80**](#Sect3D) |
|  | 1. Strategy | [80](#Sect3D1) |
|  | 1. Plan | [80](#Sect3D2) |
|  | 1. Activities | [81](#Sect3D3) |
|  | 1. Timeline | [81](#Sect3D4) |
| **E.** | **Activities to Implement Coordinating Efforts** | [**81**](#Sect3E) |
|  | 1. Part B and ADAP | [81](#Sect3E1) |
|  | 1. Part C | [81](#Sect3E2) |
|  | 1. Part D | [81](#Sect3E3) |
|  | 1. Part F | [81](#Sect3E4) |
|  | 1. Non-Ryan White Private Providers | [81](#Sect3E5) |
|  | 1. Prevention Programs | [82](#Sect3E6) |
|  | 1. Substance Abuse Treatment Programs | [82](#Sect3E7) |
|  | 1. STD Programs and HIV Surveillance | [82](#Sect3E8) |
|  | 1. Medicare | [82](#Sect3E9) |
|  | 1. Medicaid | [82](#Sect3E10) |
|  | 1. Children’s Health Insurance Programs | [82](#Sect3E11) |
|  | 1. Community Health Centers | [82](#Sect3E12) |
| **F.** | **Health People 2020** | [**82**](#Sect3F) |
| **G.** | **Statewide Coordinated Statement of Need** | [**82**](#Sect3G) |
| **H.** | **Affordable Care Act** | [**83**](#Sect3H) |
| **I.** | **National HIV/AIDS Strategy** | [**83**](#Sect3I) |
|  | 1. Reducing New HIV Infections | [83](#Sect3I1) |
|  | 1. Increasing Access to Care and Improving Health Outcomes for People Living with HIV | [83](#Sect3I2) |
|  | 1. Reducing HIV-Related Disparities and Health Inequities | [83](#Sect3I3) |
|  | 1. Achieving a More Coordinated National Response to the HIV Epidemic | [84](#Sect3I4) |
| **J.** | **Budgetary Concerns** | [**84**](#Sect3J) |
| **SECTION IV: HOW WILL WE MONITOR PROGRESS?** | |  |
| **A.** | **Progress Monitoring** | [**85**](#Sect4A) |
|  | 1. Impact of the EIIHA Initiative | [85](#Sect4A1) |
|  | 1. Improved Use of Client-Level Data | [86](#Sect4A2) |
|  | 1. Use of Data to Monitor Service Utilization | [86](#Sect4A3) |
|  | 1. Measurement of Clinical Outcomes | [86](#Sect4A4) |
| **CONCLUSION** | |  |
| Limitations | | [89](#Limitations) |
| Future Plans | | [89](#FuturePlans) |
| **APPENDICES** | |  |
| 1. Epidemiological Profile | | [91](#Append1) |
| 1. Ryan White Services Program: Part A Allocations And Priorities | | [95](#Append2) |
| 1. Ryan White Services Program: Part A Goals and Objectives | | [99](#Append3) |

**LETTER OF CONCURRENCE**



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**GLOSSARY**

|  |  |
| --- | --- |
| **COMMON ACROYNMS AND ABBREVIATIONS** | |
| **ADAP** | AIDS Drug Assistance Plan |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ASO** | AIDS Service Organization |
| **CDC** | Centers for Disease Control and Prevention |
| **DEFA** | Direct Emergency Financial Assistance |
| **DMHA** | Department of Mental Health and Addictions |
| **EIP** | Early Intervention Plan |
| **EIS** | Early Intervention Services |
| **GLBT** | Gay, Lesbian, Bisexual, and Transgender |
| **HAB** | HIV/AIDS Bureau |
| **HARS** | HIV/AIDS Reporting System |
| **HE/RR** | Health Education/Risk Reduction |
| **HHC** | Health and Hospital Corporation of Marion County |
| **HIAP** | Health Insurance Assistance Plan |
| **HIV** | Human Immunodeficiency Virus |
| **HOPWA** | Housing Opportunities for People With AIDS |
| **HRSA** | Health Resources and Services Administration |
| **ISDH** | Indiana State Department of Health |
| **MAI** | Minority AIDS Initiative |
| **MCPHD** | Marion County Public Health Department |
| **MDAP** | Medicare Part D Assistance Plan |
| **QM** | Quality Management |
| **TGA** | Transitional Grant Area |

|  |  |
| --- | --- |
| **DEFINITIONS** | |
| **Fiscal Year** | The fiscal year is the twelve-month grant cycle. Federal fiscal years are often represented as “FY” + the year in which the period begins. For example, FY2015 for the Ryan White Part A grant begins on 1 March 2015 and ends on 28 February 2016. |
| **Incidence** | Incidence refers to the number of new infections within a time period. |
| **Prevalence** | Prevalence refers to the total number of all infections (often limited to living cases) within a geographic area. |
| **Rate** | A rate is a statistically derived number used to describe the proportion of cases within a population. |
| **Surveillance** | Surveillance is a public health discipline that counts and reports the number of cases and the trends of a particular disease. |
| **Unmet Need Estimate** | This estimate is a calculation of the number of HIV-positive people who know their status but are not receiving HIV-related primary medical care. |

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|  |  |  |
| --- | --- | --- |
| **CORE SERVICES** | | |
| **1** | Outpatient and Ambulatory Medical Care (including laboratory tests) | **X** |
| **2** | AIDS Drug Assistance Program (ADAP) |  |
| **3** | Local AIDS Pharmaceutical Assistance Program (LPAP) | **X** |
| **4** | Oral Health Services | **X** |
| **5** | Early Intervention Services (EIS) | **X** |
| **6** | Health Insurance Premium and Cost-Sharing Assistance | **X** |
| **7** | Home Health Care |  |
| **8** | Home and Community-Based Health Services |  |
| **9** | Hospice Care |  |
| **10** | Mental Health Services | **X** |
| **11** | Medical Nutrition Therapy |  |
| **12** | Medical Case Management Services (including treatment adherence) | **X** |
| **13** | Substance Abuse Treatment Services – Outpatient | **X** |
|  | | |
| **SUPPORT SERVICES** | | |
| **1** | Case Management (non-medical) | **X** |
| **2** | Child Care Services |  |
| **3** | Emergency Financial Assistance (EFA) | **X** |
| **4** | Food Bank and Home-Delivered Meals |  |
| **5** | Health Education and Risk Reduction |  |
| **6** | Housing Services | **X** |
| **7** | Legal Services (including permanency planning) | **X** |
| **8** | Linguistic Services | **X** |
| **9** | Medical Transportation Services | **X** |
| **10** | Outreach Services | **X** |
| **11** | Psychosocial Support Services (including pastoral care and counseling) | **X** |
| **12** | Referral to Health Care and Supportive Services |  |
| **13** | Rehabilitation Services |  |
| **14** | Respite Care |  |
| **15** | Substance Abuse Treatment – Residential |  |
| **16** | Treatment Adherence Counseling |  |
|  |  |  |
| **--** | Developmental Services for HIV Positive Children (generally limited to Part D) |  |

*This page has been left blank intentionally.***EXECUTIVE SUMMARY**

The Indianapolis Transitional Grant Area is substantially equivalent to the Indianapolis-Carmel Metropolitan Statistical Area, which is the 33rd most populous MSA in the country.[[2]](#footnote-2) In 2013, the TGA reported 223 new and 5351 living cases of HIV disease. Of the living cases, more than 52.6% (2817) have received an AIDS diagnosis. White males from 35 to 64 years of age accounted for the largest proportion of cases (33.1%), though Blacks were still more disproportionately affected by the disease than any other demographic group.[[3]](#footnote-3) In a year with only a small (2.3%) increase in total new case reports, Blacks experienced a 6.5% increase in new reports, and new cases for Hispanics increased by 25.0% compared to 2012.

Of the known living cases of HIV, the Ryan White Part A grantee has estimated that 26.3% are not currently in care.[[4]](#footnote-4) To address this population, the service delivery system in the area has been designed to minimize barriers and optimize access to HIV-related medical and social services. Its success is evidenced by the continual decrease in the estimated percentage of persons disengaged from care over the last several years. The service delivery system in the TGA benefits greatly from the resources of the state’s four Ryan White Program grantees which have been coordinated in an attempt to impact a number of priority service needs in an effective and efficient manner.

Based on the results of various instruments to assess the needs of people with HIV, the Ryan White Part A Planning Council has prioritized eight of the core services and eight of the support services allowed by the Health Resources and Services Administration. These include Outpatient and Ambulatory Medical Care (including laboratory tests); Local AIDS Pharmaceutical Assistance Program (LPAP); Oral Health Services; Early Intervention Services (EIS); Health Insurance Premium and Cost-Sharing Assistance; Medical Case Management Services (including treatment adherence); Mental Health Services; Substance Abuse Treatment Services – Outpatient; Case Management (non-medical); Emergency Financial Assistance (EFA); Housing Services; Legal Services (including permanency planning); Linguistic Services; Medical Transportation Services; Outreach Services; and Psychosocial Support Services (including pastoral care and counseling). Together, these 16 categories comprise the Part A grantee’s priority service needs.

Indiana is the proud home of four Ryan White grants representing Parts A, B, C, and F of the legislation. Each of these grants impacts the TGA to a varying degree. While the services offered under the Part A grant are geographically limited to the TGA’s physical boundaries, Part B grant services can be offered statewide. Ryan White Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a base grant, the AIDS Drug Assistance Program award, and special supplemental awards (as funds are available). Part C provides grants directly to service providers, such as ambulatory medical clinics, to support early HIV intervention services and ambulatory care. Part F provides support for the AIDS Education and Training Centers Program which is a network of 11 regional centers (and more than 130 local associated sites) that conduct targeted, multidisciplinary education and training programs for healthcare providers treating people living with HIV. As the clinical training component of the Ryan White Program, these centers seek to increase the number of healthcare providers who are effectively educated and motivated to counsel, diagnose, treat, and medically manage people with HIV disease, and to help prevent high-risk behaviors that lead to HIV transmission.

Nevertheless, despite the coordinated efforts of the various Ryan White Program grantees and other providers, challenges remain for the TGA. To address them, the Part A grantee has compiled a number of suggestions for service delivery improvement. Many of these are incorporated into this Comprehensive Plan and its goals and objectives for 2015-2017. Evaluation of the progress towards these goals – and of the continuum of care itself – will be accomplished through the monitoring efforts of the four Ryan White Program grantees and the Part A Planning Council.

*This page has been left blank intentionally.***INTRODUCTION**

**Purpose**

The Comprehensive Plan is a thorough description of the HIV service delivery system as implemented in the Indianapolis Transitional Grant Area (TGA). The plan documents the service priorities and funding allocation of the Ryan White Part A grantee, its efforts to provide services to those not currently receiving care, its collaborations with other service providers, and its goals and objectives for the maintenance and improvement of the system of care.

Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009[[5]](#footnote-5) provides assistance to Eligible Metropolitan Areas (EMAs) and TGAs that have been most severely affected by the HIV epidemic. To be eligible for TGA status, an area must have reported between 1,000 and 1,999 AIDS cases in the most recent five years and must have a population of at least 50,000. Grants are awarded to the chief elected official of the city or county that provides healthcare services to the greatest number of people living with AIDS in the TGA. In Indianapolis, the grant is awarded to the Mayor of Indianapolis who delegates its management to the Marion County Public Health Department (MCPHD) and the Health and Hospital Corporation of Marion County (HHC).

**Process**

In response to the legislative mandates of the Ryan White Program, HHC regularly revises its HIV service delivery plan based on the changing demands of the epidemic. The current plan was prepared by HHC based on current utilization and epidemiological trends and is informed by the results of numerous consumer and provider surveys.

Members of the Ryan White Part A Planning Council – which is composed of Ryan White Parts A, B, C, and F grantees, service providers, persons living with HIV, and other community members – provided valuable additional information regarding changes in the service delivery landscape, gaps in and barriers to care, and potential areas of system improvements. The Planning Council’s Systems of Care subcommittee then conducted a series of meetings to craft new goals and objectives and to update the appropriate sections. The final draft was reviewed by the Part A Planning Council and approved for submission to the Health Resources and Services Administration (HRSA) in June 2016.

**Context and Revisions**

This Comprehensive Plan was originally drafted in 2014 and early 2015 for the three-year period of March 2015 through February 2018 while awaiting official preparation guidance from HRSA. However, such instructions were never distributed. Instead, HRSA issued a joint statement with the Centers for Disease Control and Prevention (CDC) on 19 June 2015 announcing their guidance for a new *Integrated HIV Prevention and Care Plan*. This new plan is to be created collaboratively by the Part A, B, C, and F grantees, and its content is to pertain to the five full calendar years of 2017-2021. The integrated plan will be due to HRSA and the CDC on 30 September 2016.

In reaction to the announcement, this Comprehensive Plan underwent additional revisions to reflect a shortened coverage period (now only two fiscal years: FY2015 and FY2016). The final draft was completed in December 2015.

Relevant sections of this document may be updated in 2016 to create a subsequent revision reflecting current trends and developments. Thereafter, it is expected that the Indianapolis Transitional Grant Area Comprehensive Plan will be subsumed by the state’s *Integrated HIV Prevention and Care Plan* for 2017-2021.

*This page has been left blank intentionally.***SECTION I: WHERE ARE WE NOW?**

1. **Description of the Local HIV Epidemic**

The information that follows is a brief overview of the region’s significant epidemiology. (A complete epidemiological profile for HIV disease in the TGA is available from the Part A grantee upon request.)

* 1. **CY 2013 Epidemiological Profile Summary**

The Indianapolis TGA is equivalent to the Indianapolis-Carmel MSA.[[6]](#footnote-6) It is composed of ten counties: Brown, Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam, and Shelby.[[7]](#footnote-7) Of these, Marion and Hamilton are urban, while the majority of the other counties are suburban and rural. Based on U.S. Census Bureau estimates for 2013, it has a population of 1,822,776[[8]](#footnote-8) people with 46.3% (or 843,375) of the residents living in the City of Indianapolis.[[9]](#footnote-9)

The majority of the population is non-Hispanic White (73.5%). The largest minority group is non-Hispanic Black (15.2%), followed by persons who identify as Hispanic of any race (6.5%). Asians, Native Hawaiians, and Other Pacific Islanders comprise the third largest minority group (2.7%), and the remainder of the population is composed of persons belonging to other races or more than one race (2.1%).[[10]](#footnote-10) The most substantial growth has been seen in the Hispanic population which has increased 174.1% since 2000 when this group accounted for only 2.7%[[11]](#footnote-11) of the MSA.

Marion County is home to the City of Indianapolis and is easily the most urban area within the TGA. Unsurprisingly, its population here is much more diverse than that of the TGA overall. While Whites still comprise the majority of the population (58.3%), the percentages of Blacks and Hispanics are much larger (27.0% and 9.7%, respectively) in this urban county.[[12]](#footnote-12)

* 1. **Data Sources**

The TGA’s surveillance data are derived from the HIV and AIDS reports submitted by providers and laboratories to Indiana’s Office of Clinical Data and Research (OCDR) and to the HIV/AIDS Surveillance Department at MCPHD. Physicians and hospitals diagnosing or treating persons with HIV infection are required by law to submit confidential case reports to the county health departments which, in turn, submit the information to the OCDR at the Indiana State Department of Health (ISDH). Laboratories are similarly required by law to report any test results for Indiana residents that indicate the presence of HIV infection; this includes tests to measure the amount of CD4 T lymphocyte cells (the CD4 count) and the amount of virus particles (the viral load) present in a milliliter of blood.

The AIDS prevalence data presented below are based on the total number of AIDS diagnoses reported to OCDR, less those known to have moved from the state or to have died, as of 31 December 2013. Likewise, HIV prevalence data are derived from reports submitted to OCDR. Also accurate as of 31 December 2013, these figures exclude those known to have progressed to an AIDS diagnosis, moved from the state, or died. For purposes of HIV services planning, decisions are made primarily on the basis of total living cases of HIV disease (HIV and AIDS reports). This combination provides the most accurate total number of known HIV-infected persons who may require care and services.

The HIV incidence data which follows the prevalence information captures the new cases of HIV and AIDS as reported between 1 January 2013 and 31 December 2013. The trends in this data are most commonly used to inform HIV identification efforts.

* 1. **HIV Disease Prevalence[[13]](#footnote-13)**

Between 2011 and 2013, the total number of persons living with HIV disease in the TGA increased by 7.7%, from 4970 to 5351. By 31 December 2013, 2534 living HIV and 2817 living AIDS cases had been confirmed, compared to 2289 and 2681 at the end of 2011. However, while the prevalence population continued to grow, the proportion of AIDS cases showed signed of shrinking. At the end of 2011, 53.9% of all reported cases had received an AIDS diagnosis but, by the end of 2013, that percentage had improved slightly to 52.6%. During this time period, Marion County continued to be the epicenter of the HIV epidemic in the TGA with 86.6% of the prevalent cases in 2013. No other counties in the TGA had more than 5% individually.

Table A in Appendix 1 indicates that the vast majority (81.2%) of the TGA’s living cases are men. In 2013, Whites continued to be the most infected racial group (with 45.4% of the total cases). Compared to their presence in the population at large, Blacks were still the most disproportionately affected (with 42.6%). Hispanics accounted for 7.1% of all cases. The overall distribution of disease among racial categories has shown a steady shift from White to non-White since 2011. In that year, the prevalence population was 52.3% non-White; at the end of 2013, it was 54.6%.

The largest risk group continued to be composed of men who have sex with men (MSM), accounting for 63.2%[[14]](#footnote-14) of all cases. The exact size of this and the injection drug use risk groups remain in question, however, due to the high number reported in the “Other/No Known Risk” category (11.5% of all reports). The disease concentration across age groups remained consistent with the exception of the 15-24 and the 25-34 age groups. The former increased from 2.3% of the prevalence population in 2011 to 4.5% in 2013. The latter increased from 13.8% to nearly 16.2% in the same period. Taken together, these groups grew from 800 cases in 2011 to 1105 in 2013, an alarming increase of 38.1%.

For males from 15 to 24 years of age, the greatest risk of exposure has been sexual contact with another male; for all women over the age of 14, it has been heterosexual contact. Infection due to the use of injection drugs – to the extent it had been accurately measured given the concern noted above – has remained stable among all groups.

Considering foreign-born persons independently, the demographic profile is quite different. Among this group, male cases account for only 68.9%, and White cases represent just 13.1%. The most commonly reported modes of HIV exposure were heterosexual and MSM contact (36.4% and 28.0%, respectively). The continents of original for most of the HIV-positive foreign-born persons living in the TGA are Africa and Asia.

Overall, this epidemiological data reinforce some familiar trends. First, regardless of gender, Blacks continue to be the most disproportionately represented in the data. Black persons account for 43.9% of the living cases of HIV and 41.5% of the living cases of AIDS, yet they comprise only 15.2% of the general population in the TGA. Second, the 2013 data show that more than half of the prevalence population is over the age of 44 and a full 20% of the population is 55 or older.

The prevalence figure noted above describe the HIV-positive population that is status-aware. The Centers for Disease Control and Prevention (CDC) currently estimate that about 14% of HIV-infected individuals in the U.S. are undiagnosed and unaware of their HIV-positive status.[[15]](#footnote-15) Based on this estimate, there are approximately 871[[16]](#footnote-16) additional individuals in the TGA who are HIV-positive but not yet aware of their status.

* 1. **HIV Disease Incidence[[17]](#footnote-17)**

Table B shows the number of new reports received each year from 2011 through 2013. The percent of change (Δ%) in each category total compared to the preceding year is also presented in the table.

In 2012, the combined number of new positive tests remained essentially flat compared to 2011 and, in the subsequent year, the combined number of new cases rose by only 2.3%. Over the three year period of 2011-2013, new AIDS cases accounted for an average of 22.1% of the total number of cases each year. It is important to note that this does not include previously reported HIV cases which converted to AIDS diagnoses within the respective periods, meaning that each new AIDS report shown in Table B represents a person whose first positive HIV test result was accompanied by a simultaneous AIDS diagnosis.

Table C shows the stratification of all new cases reported in 2013 across several demographic categories. It also shows the change (Δ) in each demographic percentage compared to 2011. As evidenced in the table, some of the qualities of the newly diagnosed cases have remained relatively consistent during the period while others have shown signs of significant shifts. For example, the percentage of new reports for males remained near the expected 80% each year while cases among Whites deceased by 14.6 points from 39.7% in 2011 to 25.1% in 2013 and those for Blacks and Hispanics (combined) increased by 14.2 points from 56.2% to 70.4%. In total for 2013, males represented 78.0% of the 223 reported cases; Whites represented 25.1%, Blacks represented 59.2%, and Hispanics represented 11.2%.

By age, nearly two-thirds (63.2%) of the new HIV infections occurred among persons aged 15-34 years, and nearly another third (31.4%) occurred among persons aged 35-54 years in 2013. MSM continued to be the single most common (57.0%) mode of exposure to HIV, and most of the new HIV infections in this group occurred among persons under the age of 55.

In the three-year period, there were 198 new HIV infections among foreign-born persons. Blacks accounted for most (41.7%) of these new infections, followed by Hispanics (25.6%), Whites (19.0%), and Asians and Pacific Islanders (12%). Similar to the foreign-born prevalence population, males accounted for most (80%) of the new HIV infections, and the most commonly reported modes of exposure were MSM and heterosexual contact (37.6% and 26.5%, respectively).

* 1. **Disproportionate Impact[[18]](#footnote-18)**

As in many metropolitan areas, HIV disease disproportionately affects minority populations within the Indianapolis TGA. Approximately one-quarter (26.5%) of the general population of the TGA are non-White, but minorities comprise 54.6% of the prevalence population and account for 74.9% of all new cases. In terms of race, Blacks appear to the most severely affected; their prevalence rate per 100,000 (821.1) was more than twice that of Hispanics (322.5) and more than four times that of Whites (181.3). Furthermore, Black women bear an additional burden, accounting for more than half (58.7%) of the living female cases in 2013.

It has long been recognized that HIV disproportionately impacts homosexual men (including MSMs who do not self-identify as homosexual). Based on CDC’s estimate,[[19]](#footnote-19) approximately 2% (between 1.4 and 2.7%) of the TGA’s general population (13 years and older) would be considered MSM. However, despite its size, this group accounts for more than three-fifths (63.2%) of the prevalence population and a similar percentage (60%) of the newly diagnosed cases.

* 1. **Populations of Special Interest[[20]](#footnote-20)**

Based on a review of the recent epidemiological information and a number of other data sources, including the electronic HIV/AIDS Reporting System *(eHARS)* andSTD surveillance data, the Part A grantee has identified four populations that merit special attention: Black persons, women of childbearing age, immigrants, and young adults. (See Table D in Appendix 1 for additional details regarding each population.)

1. **Black Persons**

Non-Hispanic Blacks represent only 15.2% of the TGA’s general population but account for 42.6% of the prevalent cases of HIV disease and 59.2% of the newly diagnosed cases in the TGA. Between 2011 and 2013, there were 360 new HIV infections diagnosed among Black persons in the area; over the same period, the percentage of Blacks in the prevalence population increased by 1.6 percentage points, more than three times that of any other group.

As mentioned earlier, the disparity between Blacks and other racial ethnic groups remains a major concern. As of the end of 2013, the prevalence rate per 100,000 of Blacks (821.1) was more than twice that of Hispanics (322.5) and more than four times that of Whites (181.3). Black women experience the vast majority (60.0%) of new infections among females, and they also represent the majority (58.7%) of the prevalent female cases. In comparison to other racial groups, newly diagnosed Black persons have historically been more likely to have no risk information recorded in their testing record, perhaps due to perceived confidentiality concerns.[[21]](#footnote-21) Blacks also account for the highest proportion of gonorrhea (GC) and Chlamydia (CT)cases in the TGA and nearly the same proportion of early syphilis as White residents.

1. **Women of Childbearing Age**

Women of childbearing age (15-44 years) comprise 41.4% of the TGA’s population and 15.8% of the new HIV cases in 2013. And while they account for only 9.2% of the overall prevalent cases, they constitute a significant proportion of the female prevalent cases (49.1%) and more than three-quarters of the newly diagnosed female cases from 2011-2013 (75.9%). Most (89.5%) of the HIV-positive women of this age reside in Marion County, and 58.6% of those are Black. Women of childbearing age also account for the majority of the TGA’s female GC and CT cases.

1. **Immigrants**

Approximately 6% of the TGA’s population is foreign-born (having emigrated primarily from African and Asian counties), but this group accounts for 12.0% of the prevalent cases and 30.0% of the newly diagnosed cases. Most members of the prevalence population are male (68.9%) and non-White (86.9%). The most common mode of exposure for this group is high-risk heterosexual contact (36.4%).

The number of new HIV infections diagnosed among foreign-born TGA residents has been steadily increasing since at least 2000. Additionally, some providers argue that cultural taboos regarding HIV, fear of deportation, and stigma may discourage some immigrants in the TGA from seeking HIV testing or care. Because of this, epidemiological data concerning this population may be less reliable.

1. **Young Adults**

Data indicates that 13.1% of the TGA’s population is between the ages 15-24. This age group accounts for a small but growing portion (4.5%) of prevalent cases and nearly a third (30.0%) of newly diagnosed cases. Between 2011 and 2013, there were 199 new HIV infections diagnosed in this age group; over the same period, the percentage of young adults in the prevalence population increased by 2.2 percentage points. Only the 25-34 age group experienced a larger percentage increase; most other age groups experienced a decrease.

The majority of the new HIV infections diagnosed in this group in 2013 were among Black males reporting MSM risk factors. Compared to other age groups, young adults account for the highest proportion of cases in the TGA. This group also accounts for about half of the TGA’s GC and more than a fourth of its early syphilis cases. The emergence of this population as a significant reservoir for HIV infection is concerning, given the exceptionally high rates of GC and CT seen in the TGA generally.

* 1. **Residents of the Surrounding Rural and Suburban Counties**

While the TGA residents outside of Marion County comprise approximately half of the TGA’s total general population, they have not historically accounted for a significant portion of the prevalent or newly diagnosed HIV cases.[[22]](#footnote-22) As of 2013, they comprised only 13.4% of the prevalent cases. They also do not account for a large percentage of the TGA’s CT cases (less than 20%) or its GC and syphilis cases (approximately 10% each) compared to Marion County.[[23]](#footnote-23) However, HIV-positive residents of the surrounding counties do merit some special consideration. Because of their geographic location, they are placed at a disadvantage compared to their urban counterparts who have a network of expert providers within close proximity that can effectively manage the needs of HIV patients. Furthermore, the 2013 incidence data in Table C does indicate an erosion of incidence in Marion County (down from 89.4% of all new cases in 2011 to 84.5% in 2013) and a corresponding increase in the combined incidence in the rural counties of Hendricks, Johnson, and Morgan.

* 1. **Description of the History of State and Regional Response to the Epidemic**

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

By 1991, the State of Indiana was receiving federal Ryan White Part B dollars. The award was used by ISDH to implement traditional AIDS Drug Assistance and Early Intervention Plans (ADAP and EIP, respectively) through a subcontractor. From the beginning, these services were available statewide.

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

In December 1992, FSSA transferred the administration of the HIV Care Coordination Program to ISDH, which then became responsible for issues concerning funding, policy setting, and program administration. By 1993, the number of care sites had increased to twelve. Since that time, two additional HIV Care Coordination sites have been funded by ISDH in Indianapolis, and clinic-based medical case management programs have been developed at Eskenazi (formally Wishard) and Indiana University (formerly Methodist) hospitals in Indianapolis.

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

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

In 2007, the City of Indianapolis received Ryan White Part A funding for the first time. The grant was awarded to the Mayor of Indianapolis who immediately entrusted its management to MCPHD and HHC.

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

These impressive resources – coupled with the long and successful partnerships between the Part A, B, C, and F grantees – have helped to ensure that HIV programming in the Indianapolis TGA is comprehensive and coordinated. Additional collaborations between the Part A grantee and CDC-funded prevention programs under the direction of the HIV Community Planning Group have also resulted in improved assess for clients to points of entry into the TGA’s full HIV care continuum. In compliance with the National HIV/AIDS Strategy and HIV Continuum of Care Initiative, the Part A grantee strives to implement programming that increases access to and utilization of medical and other core services; helps clients remain in care in order to optimize health outcomes; decreases disparities in access; reduces individual and community viral loads; and improves the overall quality of life for persons living with HIV. Community partnerships such as those mentioned help to ensure that the grantee can achieve these desired results as it continues to enhance its HIV care continuum.

* 1. **Unmet Need Estimate for 2013[[24]](#footnote-24)**

In preparation for the annual Ryan White Part A grant application, HHC creates an annual estimate of “unmet need” in an attempt to quantify the number of HIV-positive persons who know their status but who have not received HRSA-defined care in the 12-month report period. Because this annual estimate is based on a fiscal rather than calendar year, some of the information below may differ slightly from the epidemiological data already presented.

1. **Trends in Unmet Need Estimate**

As of 31 March 2014, an estimated 1,417 persons with HIV living in the TGA were aware of their HIV status but were not in care. This represents approximately 26.3% of the then-prevalent cases (5336). Of the total number disengaged from care, 43.2% had received an AIDS diagnosis, and 90% resided in Marion County. Overall, the majority of the unmet need population was composed of White MSMs between the ages of 45 and 54. However, among just the HIV (not AIDS) cases, Black MSMs comprised the majority.

Since 2006, the TGA has seen a remarkable 16.5% decline in its unmet need estimate (from 42.8% to 26.3% in the 2013 estimate). This reflects a mean decrease of 2.4% per year since Part A funding was initially awarded for the TGA, representing a strong negative correlation between years of Part A funding and the annual estimation of unmet need. While the rate of decrease has understandably slowed in more recent years, steady reductions continue to occur despite increasing prevalence of HIV. Since 2011, the estimate has dropped by 2% (from 28.3% to 26.3%).

Decreases in unmet need indicate that a smaller percentage of HIV-positive people in the TGA are disengaged from care and treatment compared to earlier periods. Contributing to this decline, Part A and Minority AIDS Initiative (MAI) funding has enabled the grantee to provide more core and support services in the TGA than ever before. In particular, the grantee has increased allocations for case management, EIS, and outreach services to ensure that persons with HIV – including those who are newly diagnosed or recently released from prison – have the necessary resources available to help them find and access care. These funding sources have also improved access by allowing the grantee to fund a greater number of different service providers throughout the TGA.

1. **Estimation Methods**

To develop the 2013 estimate, the Ryan White Part A Program’s Epidemiologist began by reviewing *eHARS* surveillance data to determine the total size of the population of persons living with HIV in the TGA for the period in question. As of 31 March 2014, the epidemiologist confirmed 2524 surveillance records for individuals living with HIV and 2812 records for those living with AIDS. From these, any record which also had corresponding CD4 or viral load laboratoryreports from any facility dated between 1 April 2013 and 31 March 2014 was identified using a record-matching program developed by the Regenstrief Institute in Indianapolis. This date range was adopted in order to facilitate comparisons with the State’s unmet need estimate and to accommodate the available information from Indiana Medicaid.

Next, Medicaid information from the same time period was reviewed and, here, any record which also had a corresponding Medicaid claim for an antiretroviral prescription filled between 1 April 2013 and 31 March 2014 was identified using the same Regenstrief Institute record-matching program.

Finally, the identified records were subtracted from the original prevalent case total to arrive at a cohort that represented a population which appeared to have not received any HIV medication or common laboratory services within the designed one-year time period. These remaining records comprise the TGA’s unmet need population. For FY2013, this population was estimated to consist of 805 individuals with HIV and 612 individuals with AIDS.

The grantee considers this method of computing the unmet need estimate for the TGA to be appropriate for a number of reasons. Indiana has a name-based HIV reporting system, an in-state laboratory reporting requirement, exceptional voluntary reporting from out-of-state laboratories, and a trusted database (*eHARS*) to track reports. The diligent monitoring of lab reporting by ISDH improves reporting compliance rates and permits confidence in the completeness of the reporting. HHC enjoys a strong working relationship with ISDH which facilitates the process of name-based matching of *eHARS* data with various sources of medication usage data. As a result, the Part A grantee was not required to do any modeling or generalized estimation when calculating the 2013 unmet need estimate. This allows for further subpopulation analysis and gives the grantee the ability to target resources and activities towards those populations most in need.

Note, however, that for the 2014 estimate, HRSA required grantees to adopt a new methodology called the HIV Continuum of Care Framework (COCF) that employs a modified definition of “in care.” Using this new methodology, the grantee estimated the 2014 unmet need to be 52.9%, a figure representing 2,891 HIV-positive status-aware individuals who did not receive HIV primary care at least twice and spaced at least three months apart during the year. Clearly, the magnitude of unmet need calculated using the COCF differs starkly from that calculated using the previous methodology (which would have yielded an estimate of only 27.3%). According to the COCF, nearly twice as many TGA residents fall under the definition of unmet need. Differences also exist in unmet need trends; for instance, the COCF methodology indicates a decrease in unmet need from 47.8% in 2012 to 46.4% in 2013, followed by the significant increase for 2014 noted above. In contrast, unmet need calculated using the previous methodology demonstrates only a small increase from 2013 to 2014.

* 1. **EIIHA Estimate of Status-Unaware Individuals**

As of 31 December 2013, data indicate that 5351 residents of the TGA are HIV-positive and aware of their status. This includes 2534 living HIV cases and 2817 living AIDS cases. The CDC currently estimates that about 14% of HIV-infected individuals in the U.S. are undiagnosed and unaware of their HIV-positive status.[[25]](#footnote-25) Applying the CDC’s percentage to the number of known cases, it is estimated that there are approximately 871 additional individuals in the TGA who are HIV-positive but status-unaware. This final figure is often referred to as the *Early Identification of Individuals with HIV/AIDS* (or EIIHA) estimate.

Compounding the problem, an average of 22.1% of new cases receive a concurrent AIDS diagnosis, meaning that their HIV disease has progressed untreated for a considerable period of time without any diagnostic testing. This underscores the need for early testing, education of the public about the importance of HIV status awareness, and collaboration among community partners to ensure a client-centered, easily accessible, and stigma-free system of care.

Using the demographics and other available data related to known persons with HIV in the TGA, the grantee develops and implements programs that target three main groups: HIV-positive but status-unaware individuals; status-aware individuals who are out of care; and newly diagnosed individuals who have yet to access care. The Planning Council utilizes such epidemiological data to set priorities, allocate resources, and redistribute Part A and MAI funds to address these groups. All funding decisions consider existing programs funded under Part C, by the State of Indiana, and other sources available in the TGA to ensure that resources are utilized effectively and efficiently.

1. **Description of the Current Continuum Of Care**

Since its inception in 2007, the Part A grantee has prioritized the following areas of concern: early disease detection for those who are HIV-positive but not yet aware of their status; access to care for those who are HIV-positive but are not engaged in care; and prevention education for those who are HIV-negative. These priorities help to direct the grantee’s efforts to improve continuum of care in the TGA by developing a system that efficiently identifies, informs, refers, and links unaware HIV-positive persons to care; that seeks to retain status-aware HIV-positive persons in care; that refers HIV-negative persons to the appropriate support services to help them remain HIV-negative; and that provides the highest caliber of HIV medical and support services. The Part A grantee collaborates and partners with key stakeholders, medical and supportive service providers, and other community leaders in its attempts to achieve these objectives.

To help facilitate early entry into and retention in care, the Planning Council has recommended significant funding allocations for EIS and Outreach Services targeting vulnerable and high-risk populations, as well as for Outpatient and Ambulatory Medical Care, Medical Case Management, and Case Management (non-medical).

* 1. **Overview**

The Indianapolis Ryan White Services Program (RWSP) encompasses the Part A, Part C, and MAI grants administered by HHC. It has used these funding sources to increase access to and expand the HIV continuum of care in the TGA. It has also maintained a strong partnership with the Part B grantee (ISDH) to ensure that services do not overlap and that funds are never supplanted. These collaborations are consistent with the National HIV/AIDS Strategy and HRSA’s goal to decrease HIV-related health disparities among vulnerable populations and historically underserved communities by increasing access to quality services. RWSP is currently providing services to more than 2300 active enrollees.[[26]](#footnote-26)

In the most recent grant year (FY2014: 1 March 2014 through 28 February 2015), RWSP enrolled 231 new consumers, re-enrolled 56 prior enrollees, and recertified 2039 existing members. Since first receiving Part A funding in 2007, the grantee has enrolled 2499 individuals. The majority of RWSP expenditures in FY2014 (approximately averaging 76.6%) supported the provision of essential core services as defined by HRSA.

In addition to directly funding Outpatient and Ambulatory Medical Care services, the Part A grantee has worked to enhance the continuum of care by expanding its Health Insurance Premium and Cost-Sharing Assistance services in collaboration with ISDH. Focusing on enrollees who live outside of Marion County, the Part A grantee was able to participate in the premium payments for 40 such individuals in FY2014. Another collaboration with ISDH, coordinated case management services, also resulted in success.

Case Management services, naturally, play a significant role in the continuum of care in the TGA. Upon entry into the HIV Care Coordination Program (which is supplemented by core and support Case Management service allocations by the Part A grantee), an individual is able to access a broad range of HIV-related services including programs to cover the cost of drugs and treatment. These programs include Medicare, Medicaid, the Healthy Indiana Plan, and the State’s HIV Medical Services Program which includes the health insurance assistance component. The latter works in conjunction with private insurance providers as well as those operating within the Health Insurance Marketplace made possible by the passage of the Affordable Care Act.

However, due to the eligibility requirements and enrollment restrictions for Medicare, Medicaid, and the HIV Medical Services Program, some case management clients are not immediately eligible for coverage. Until these individuals are able to secure such coverage, case managers arrange for assistance through a variety of other short-term options including hospital-based indigent programs and patient assistance programs offered by the pharmaceutical companies. The additional of Part A programming in the TGA helped to expand the available options for consumers in this situation to ensure access to medical care, drugs, and other key services even in the absence of insurance coverage.

In the design of the RWSPservice matrix, careful consideration was given to the existing continuum of care, as well as to the needs of emerging communities, communities of color, rural communities, status-unaware individuals, and the unmet need population. The Part A grantee has attempted to create programs that alleviate common barriers such as lack of transportation, unstable housing, and emergency financial needs. Moreover, it has diversified its allocations to support other activities – including substance abuse and mental health services – impacting an individual’s ability to adhere to treatment and remain in care. In fact, because of its correlation to positive health outcomes, retention in care has become a chief concern of the Part A grantee. Support services such as Medical Transportation and Case Management have clear benefits in this respect. For example, in a recent review of utilization data, clients who utilized the available transportation services had an average retention rate of 88% at the conclusion of the reporting period, surpassing the established goal of 75%. Likewise, Case Management (non-medical) service recipients had an average retention rate of 85%, again surpassing a goal of 75%.

* 1. **Ryan White Care and Service Inventory**

RWSP is part of a robust service continuum of care for persons with HIV in the Indianapolis TGA. The program is committed to providing low- or no-cost core and support services to the maximum number of eligible individuals who can be supported with existing funding. This is achieved through the efficient operation of the RWSP and its partnership with the Part B program administered by ISDH. The following section describes the services provided by Parts A, B, and C in the TGA. They are presented according the eight core and eight support service categories prioritized by the Part A Planning Council.

1. **Outpatient and Ambulatory Medical Care (including laboratory tests)**

The Part B grantee provides short-term access to medical care primarily through the EIP component of its HIV Medical Services Program. EIP provides immediate access to a limited array of HIV-related healthcare procedures. The EIP benefits expire once insurance coverage is secured and the program’s insurance assistance benefits become effective. EIP is available to Indiana residents (including those living within the TGA) who are HIV-positive, enrolled in HIV Care Coordination, earn less than 300% of the federal poverty level, are otherwise uninsured, and are under the age of 65.

The Part A grantee provides additional access to primary medical care by providing direct clinical services to eligible residents of the Indianapolis TGA. The majority of the primary medical services are provided by Eskenazi Hospital, Indiana University Health, and a newly launched clinic at the Damien Center. The clinical services are designed to supplement existing healthcare services in the Indianapolis area. These clinics provide access to quality early interventions, outpatient medical care, and necessary laboratory services as a stop-gap measure until the consumer can be transitioned into more comprehensive programs. The Part A program defines Outpatient and Ambulatory Medical Care as the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Services provided by the Part A program typically include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (including all medical subspecialties). Primary medical care for the treatment of HIV infection is expected to be consistent with the Public Health Service guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies. In addition to the services performed by the Eskenazi, IU Health, and Damien Center clinics, RWSP will also cover procedures performed by other specialty clinics on a fee-for-services basis under limited circumstances and with documented referral approval.

RWSP supports two additional, complimentary projects using its Part C program funding. Primary healthcare services are offered through Eskenazi Hospital, Indiana University Health, and several other agencies. These sites provide services to residents of Marion and the surrounding counties at little or no cost.

1. **Local AIDS Pharmaceutical Assistance Program (LPAP)**

The Part B grantee provides access to HIV drug treatments through the ADAP and Medicare Part D Assistance Plan (MDAP) components of its HIV Medical Services Program. ADAP provides immediate access to a limited formulary of HIV-related drugs. The formulary is updated regularly and includes all of the drugs that have been FDA-approved for the treatment of HIV disease. Like EIP, ADAP benefits expire once insurance coverage is secured and the program’s insurance assistance benefits become effective. ADAP is available to Indiana residents (including those living within the TGA) who are HIV-positive, enrolled in HIV Care Coordination, earn less than 300% of the federal poverty level, and are otherwise uninsured.

At age of 65, MDAP becomes available to similarly eligible individuals. MDAP coordinates coverage with a variety of participating providers under the Medicare Part D prescription drug plan. It pays for the deductibles, co-insurance, and co-payments for charges allowed by the approved Part D plan. MDAP coverage is dependent on Part D enrollment and is not available to those under 65 years of age. MDAP does not pay for the Part D plan premiums; these are the responsibility of the enrollee.

In the TGA, the Part A grantee provides limited access to HIV pharmaceuticals through its Local AIDS Pharmaceutical Assistance Program. LPAP is not considered a full-scale pharmacy or ADAP program. It currently works with the Eskenazi Hospital, IU Health, and Community Walgreens (formerly BioScrip) pharmacies to provide medications to eligible consumers who have no other current source of drug coverage.

LPAP benefits are available to eligible Part A enrollees who are not currently enrolled in or eligible for the HIV Medical Services Program through Part B. Instances when a consumer may be unable to secure enrollment in the Part B program include failure to complete the required recertification process (which invokes a 60-day bar from service) and failure to participate in the HIV Care Coordination Program (which renders the individual completely ineligible). Additionally, Part A enrollees seeking LPAP services must demonstrate that all other potential assistance options have been exhausted, including patient assistance programs offered by the pharmaceutical industry. A special service request must be approved by the grantee prior to the dispensation of medications.

Generally, the LPAP formulary mirrors that of ADAP. However, the Part A grantee will provide access to substitute medications that do not appear on the Part B formulary if those drugs are deemed necessary by a client’s physician. The LPAP service is administered under the additional guidance of a special advisory body that is responsible for ensuring that all Ryan White Program requirements and guidelines are followed by the grantee. This committee overlaps substantially with the Part B grantee’s ad hoc medical committee which provides input regarding the composition of the ADAP formulary. Currently, the Part A formulary contains 194 medications including 31 anti-retroviral drugs. There are no over the counter medications contained on either the Part A or the Part B formulary. All pharmacies delivering LPAP services must participate in the federal 340B drug pricing program, and dispensing or administrative fees are not allowed. Currently, there is no enrollment or monetary benefit caps associated with this service.

The ability to provide LPAP services is considered to be essential. Such services have been ranked among the top three funding priorities for the TGA by medical and non-medial service providers, and clients recently ranked LPAP services as one of their top two priorities. Medication costs, enrollment caps, patient assistance programs limitations, prior authorization restrictions, and imposed step therapy requirements are often cited as barriers to care which can delay access to appropriate HIV therapies. LPAP seeks to mitigate these barriers by providing more immediate access to prescribed drugs in urgent situations.

1. **Oral Health Services**

In FY2012, ISDH added dental services (including initial prophylaxis, periodic exams, and panoramic x-rays) to its insurance assistance plan’s benefits package through an arrangement with Delta Dental. These new dental services are comprehensive and available throughout the state (including the TGA) but have an annual monetary service cap of $2000.

In the TGA, Part A and C funding is used to offer dental services through the Indiana University School of Dentistry and MCPHD’s Pecar Dental Clinic. Services includes diagnostic, preventive, and therapeutic procedures provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers. There is a $2500 annual service cap per person. Clients receiving the HIAP dental coverage must exhaust those benefits in order to be eligible for the RWSP dental benefits. The services covered by RWSP exclude cosmetic and elective services and are generally more restrictive than the Part B Delta Dental coverage.

1. **Early Intervention Services (EIS)**

The Part A grantee funds nine agencies to conduct EIS activities in the TGA. These agencies include four medical facilities, four non-profit organizations, and the MCPHD’s Substance Use Outreach Services program. EIS activities are designed to identify HIV-positive persons who are unaware of their status and to facilitate their entry into care. Each of the funded agencies has established relationships within high-risk communities (such as the MSM, transgender, and recently incarcerated populations) to aid in this effort. Services are frequently conducted in hospital emergency rooms and other locations frequented by high-risk populations and members of communities with a disproportionate disease burden.

Individuals who test HIV-positive are provided immediate post-test counseling and a monitored referral to case management and medical services within 72 hours of the confirmed diagnosis. Those who test HIV-negative are provided additional risk counseling and are encouraged to seek additional prevention services and to be re-tested regularly as long as risk behaviors persist.

1. **Health Insurance Premium and Cost-Sharing Assistance**

As part of its HIV Medical Services Program, ISDH offers the Health Insurance Assistance Plan (HIAP) which leverages its Part B funding by purchasing insurance for enrollees through private carriers and those participating in the Indiana Health Insurance Marketplace. HIAP pays for the premium and other expenses associated with the purchased policies. HIAP is available to Indiana residents (including those living within the TGA) who are HIV-positive, enrolled in HIV Care Coordination, earn less than 300% of the federal poverty level, are otherwise uninsured, and are under the age of 65. The purchase of premiums through this plan is supplemented by Part A funds targeting enrollees living outside of Marion County.

1. **Mental Health Services**

In the TGA, the Part A grantee funds the Damien Center to serve its eligible enrollees (i.e., those who are uninsured or under-insured for mental health services). Allowable mental health services includepsychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the state to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

The Part C program began offering mental health care benefits in 2015. The Part B grantee's role in addressing mental health care in the TGA is limited to the services available through HIAP and the associated insurance policies. Due to the variety of policies that are purchased currently, no standard mental health benefits can be ascribed to the Part B program.

1. **Medical Case Management Services (including treatment adherence)**

As the gatekeeper for most Ryan White services, the largely state-funded HIV Care Coordination Program is integral to the HIV service continuum and strives to preserve continuity of care by adeptly assessing needs, strategically identifying resources, and diligently monitoring referrals. Currently, ISDH operates a statewide network of 59 case managers stationed at 16 geographically diverse care sites. The HIV Care Coordination Program consistently provides comprehensive case management services to more than 4300 consumers seeking assistance per quarter.[[27]](#footnote-27) While this ISDH program provides services that are often classified as *medical* case management, it does not meet the strict HRSA definition for this service category and is, therefore, described more fully later in the Case Management (non-medical) section.

In the TGA, the Part A program provides Medical Case Management through contractual arrangements with four entities that also provide primary HIV medical care in varying degrees. Medical Case Management offered though Part A is distinct from the HIV Care Coordination Program as it is primarily intended to intervene in the medical care of high-risk or non-compliant clients. Medical Case Management strives to ensure timely and coordinated access to medically appropriate levels of healthcare through ongoing assessment of the client’s ability to comply with established treatment plans and to remain engaged in care. The coordination and monitoring of medical treatments are essential components of the service.

It includes the provision of treatment adherence counseling to ensure readiness for, and compliance with, complex HIV disease treatments. Key activities include assessment of adherence barriers; development of an individualized medical adherence plan; coordination of education and other interventions required to implement the medical adherence plan; client monitoring to assess the efficacy of the medical adherence plan; and periodic re-evaluation and adaptation of the medical adherence plan as necessary for the duration of the plan (usually 6-8 encounters).

1. **Substance Abuse Treatment Services – Outpatient**

In the TGA, the Part A grantee funds two substance abuse treatment providers – the Bethlehem House and the Damien Center – to serve its eligible enrollees (i.e., those who are uninsured or under-insured for mental health services). The program provides medical and counseling services to address addiction issues in an outpatient setting, rendered by a physician, by a professional under the supervision of a physician, or by other qualified personnel.

Additionally, Indiana’s Department of Mental Health and Addiction (DMHA) receives an award according to Title 45, Part 96, Subpart L of the Code of Federal Regulations. DMHA subcontracts a portion of its award to ISDH to implement Special Populations Support Program (SPSP) services. The Division, in turn, grants awards to specific entities in different communities throughout the state (including the TGA). HIV-positive individuals are referred to the program’s support specialists who engage the consumer with interventions designed to minimize substance use and maximize compliance with all applicable treatment plans. The specialists work closely with the local HIV Care Coordination agency to ensure that the consumer receives a full complement of quality care.

Otherwise, the Part B grantee's role in addressing addiction in the TGA is limited to the services available through HIAP and the associated insurance policies. Due to the variety of policies that are purchased currently, no standard substance abuse treatment benefits can be ascribed to the Part B program.

1. **Case Management (non-medical)**

As mentioned above, as the gatekeeper for most Ryan White services, the largely state-funded HIV Care Coordination Program is integral to the HIV service continuum in the Indianapolis TGA and throughout the state. The program consists of goal-oriented activities that serve to locate, facilitate access to, and monitor the full range of HIV-related services in cooperation with the client. It encourages the most cost-effective use of medical and community resources and promotes the overall well-being of the individual. It respects cultural diversity, emphasizes confidentiality, and strives to ensure the client’s freedom of choice and self-determination. Its comprehensive and compassionate services are rendered in a safe, secure, and non-judgmental environment and are provided without cost to the client.

The primary goals of the HIV Care Coordination Program are to ensure the continuity of care, to promote self-sufficiency, and to enhance the quality of life for individuals living with HIV. This is achieved through the thoughtful coordination of services and the empowerment of the individual. The objectives of the HIV Care Coordination Program are: to promote a single point of access for a variety of health and human services; to develop an Individualized Care Plan (ICP) with the client; to link the individual’s specific needs to the most effective services at the most appropriate time; to monitor all client referrals to ensure success; to identify gaps in services and to broker community resources to address service needs; to advocate on the behalf of clients for availability, timeliness, effectiveness, and appropriateness of services; to reduce the fragmentation and duplication of services; to contain costs through efficient utilization of services; and to monitor and review the client’s needs and progress in relationship to the ICP, and to modify the plan as necessary.

The HIV Care Coordination network in the TGA – which consists of two medical facilities and three AIDS service organization – is augmented by Part A allocations for Case Management (non-medical). The Part A funds are not used for the coordination and monitoring of medical treatments *per se* but do support activities design to ensure readiness for entry and retention in care. Key activities mirror those of the HIV Care Coordination Program generally and include the initial assessment of service needs (including screenings for substance use and mental health issues); the development of an ICP; the coordination of services required to implement the plan; client monitoring to assess the efficacy of the plan; and a periodic re-evaluation and adaptation of the plan as necessary over the life of the client. Case managers assist in the completion of applications for insurance, financial assistance, and housing services, and they provide referrals to medical care, psychosocial services, legal assistance, transportation services, and Medical Case Management. The providers funded by Part A are the same as those comprising the HIV Care Coordination network in the TGA: Eskenazi Health, IU Health, the Damien Center, the Concord Center, and Step-Up, Inc.

1. **Emergency Financial Assistance (EFA)**

The Part A grantee provides financial assistance in the TGA to address two specific needs: food and utilities. Assistance is generally provided in the form of direct payments to the utility providers and designated vouchers for groceries that are distributed to clients. Direct payments to clients are not permitted. Assistance is strictly limited in frequency and duration. It is anticipated that clients would only utilize one unit of service within a grant year. Four different agencies are funded to provide this service in the TGA.

1. **Housing Services**

The Housing Opportunities for Persons with AIDS (HOPWA) program is the only major source of housing assistance for HIV-positive persons in the TGA. It not supported by any part of the Ryan White Program, and its funds are extremely limited. To address the some of the demand for housing assistance, the Part A grantee allocates funds each year to provide limited, short-term housing services to those enrollees who are ineligible for or have exhausted all other forms of assistance to prevent homelessness. Assistance is generally provided on a month-to-month basis and is not intended to be a long-term solution. Three agencies are funded to provide this service in the TGA: the Damien Center, the Concord Center, and Step-Up, Inc.

1. **Legal Services (including permanency planning)**

Part A funds may be used to pay for the legal services provided for an HIV-infected person to address legal matters directly necessitated by the individual’s HIV status. Services include the creation of powers of attorney, living wills, and resuscitation orders. They may also include interventions necessary to address barriers to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Part A Program. They do not include criminal defense or class action suits unless related to services eligible for funding under the Ryan White HIV Services Program. The Part A grantee funds the Damien Center to provide this service in the TGA.

1. **Linguistic Services**

In the TGA, Linguistic Services are provided by the Part A grantee using the resources of the larger MCPHD. No external providers are currently funded as sub-recipients for this service.

1. **Medical Transportation Services**

The Part B and C programs do not currently offer Medical Transportation Services. However, in the TGA, medical transportation is supported by the Part A grantee through contracts with an independent transportation services and three agencies – the Bethlehem House, Brothers United, and IU Health – that provide transportation assistance in the form of bus passes, fuel vouchers, and carrier services.

1. **Outreach Services**

Outreach Service are activities *other than counseling and testing* designed to identify HIV-positive persons and link them to medical and support services. Many out-of-care consumers are brought back into care through referrals into HIV Care Coordination. In Marion County specifically, the agencies funded to provide support services, have been effective in their efforts to reach consumers, especially substance abusing individuals in communities of color, who have been “lost to care,” bringing them back into the system to receive necessary social and medical services.

In the TGA, Part A and MAI funds are used to fund a program to assist case managers and other providers in their attempts to locate and reconnect consumers who have become disengaged from care. The Part A grantee funds outreach programs based at the Bethlehem House, Brothers United, the Eskenazi Health Emergency Department, and Step-Up, Inc.

1. **Psychosocial Support Services (including pastoral care and counseling)**

Psychosocial Support Services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. These services include nutrition counseling provided by a non-registered dietitian but exclude the provision of nutritional supplements. (Note that current Part A programming is provided only on an individual basis and excludes funding for activities such as support group facilitation.) The Part A grantee funds two providers in the TGA: the Bethlehem House and IU Health.

* 1. **Non-Ryan White Care and Service Inventory**

The Part A grantee developed its current service inventory[[28]](#footnote-28) to describe the key providers in the TGA for each priority service area. These entities or programs were identified by Part A Planning Council members and other partners from throughout the TGA based on direct and – in most cases – extensive experience with the noted providers, making the inventory an invaluable directory of “HIV-friendly” resources. Known as the *Indianapolis Transitional Grant Area Provider Resource Guide*, the inventory indicates how consumers may pay for the services and which are supported by Ryan White funding. Use of the inventory by the HIV Care Coordination Program helps to ensure continuity of care and a positive experience for consumers.

In additional to presenting a simple inventory of available HIV-related services in the TGA, the guide was designed to provide detailed information regarding the array RWSP services, their guidelines and parameters, and how to access them. The guide is also used as an education and marketing tool and is distributed widely to ensure awareness of the available services. The guide is revised and updated as needed but no less frequently than once every three years.

* 1. **Interaction between Ryan White and Non-Ryan White Services**

Of the many service providers listed in the Provider Resource Guide that are not funded by the Ryan White Program, three bear mentioning specifically here. Statewide, Indiana Medicaid annually serves in excess of 2500 individuals with a primary diagnosis of HIV. On average, the program will expend more than $20 million each year providing identifiable pharmaceutical services to enrollees with an HIV diagnosis code. This is known to regularly include more than $12 million in identifiable antiretroviral therapy costs. Indiana Medicaid also spends approximately $400,000 each year providing dental services to more than 800 adults and children living with HIV throughout the state.

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

The Department of Metropolitan Development (Division of Community Development and Financial Services) administers the HOPWA grant for the City of Indianapolis. As the fiscal agent, the City of Indianapolis apportions these funds among several local service providers to provide rental or emergency housing assistance to low-income HIV-positive persons living in the Indianapolis-Carmel MSA. The duration of the assistance can range from one to twelve months, based on the determination of the project sponsors, and may include utility assistance as well. The City’s HOPWA allocation typically exceeds $800,000 each year.

The Part A grantee maintains strong working relationships with the City of Indianapolis, the Health Foundation of Greater Indianapolis, and Indiana Medicaid. Its services are deliberatively structured to work in conjunction with those offered by these (and other) entities in order to maximize resources, limit duplication, and avoid supplanting any funds.

* 1. **Effect of and Response to State and Local Budget Reductions**

Since its inception in 2007, the Indianapolis TGA has not experienced a significant decrease in its annual Part A and MAI funding. However, contingency plans have been developed by the Part A Planning Council to reduce or eliminate funding for services based on their rank of prioritization. Service categories with fewer recipients, less direct impact on health outcomes, or other potential resources would be candidates for reduction or elimination. The imposition of greater cost sharing by enrollees is also a possibility, though it has not been endorsed by the Planning Council to date.

In addition to such contingency plans, the Part A grantee closely monitors service utilization, sub-grantee expenses, and enrollee outcomes to ensure that financial resources are used as efficiently as possible and achieve the desired health improvements for the target population. To this end, the grantee has consistently increased allocations for highly effective services such as Outpatient and Ambulatory Medical Care, Medical Case Management, Case Management (non-medical), and EIS over the past several years and has decreased allocations to areas such as Linguistic Services where the value has been less tangible.

The grantee also works diligently to ensure that Part A remains the payer of last resort. Essential to this endeavor is the application review and enrollee recertification process. Applicants must document incomes below the 300% federal poverty level threshold and residency within the boundaries of the TGA. Those seeking medical coverage or insurance assistance must demonstrate ineligibility for any other insurance or publicly funded care programs (such as Medicaid) as well. Program recertification interviews are conducted every six months by the assigned HIV Care Coordinators at which time updated residency, income, and health care coverage documentation is collected from all active participants and submitted to the grantee. As a matter of due diligence, the Part A grantee also verifies Medicaid eligibility status for a 90-day period following the dispensation of any services paid by Ryan White funds. If eligibility is confirmed within that period, subrogation processes are initiated, and mechanisms are in place to report recovered funds in aggregate on the grantee’s fiscal reports. Consumers with Medicaid coverage may remain Part A enrollees but will be eligible for only those services which their Medicaid does not cover.

1. **Description of Need**

The Part A and B grantees regularly conduct activities designed to ascertain the service needs of the state and region’s HIV-positive population. The information gathered from these activities is used in conjunction with surveillance data to develop service delivery plans that address the identified needs and barriers to quality care.

* 1. **Previous Assessments**

The following paragraphs briefly describe most of the significant needs assessment activities that have been conducted in the TGA and throughout the state since the beginning of the new millennium.

1. **2002 State Needs Assessment Report**

The original source of information used for planning was the state’s official HIV/AIDS Needs Assessment Report, which was prepared in February 2002 by the Partnership for Community Health, Inc., a consulting agency based in New York. The complete needs assessment contained three separate reports. The first was an epidemiological report, profiling potential service recipients. The second report presented the quantitative and qualitative information obtained through surveys and focus groups with more than 400 HIV-positive persons from various sub-populations including African Americans, Hispanics, heterosexual men and women, and injection drug users. This report focused on service needs and barriers to care as identified by the participants. The third report utilized information gathered from service providers to estimate the capacity of the system and any related gaps.

1. **2003 State Consumer Satisfaction Survey**

The Part B grantee conducted a satisfaction survey of its HIV Care Coordination and HIV Medical Services Program clients in the spring of 2003. The responses were submitted to sociologists at Indiana University – Purdue University Indianapolis for analysis. The survey included a battery of questions developed to measure client satisfaction with each program. The first part of the questionnaire pertained to case management services, the second part to medical services. Satisfaction was measured using a five point Likert scale in response to positive statements about the programs such that agreement corresponded with satisfaction. Additional questions gathered the client’s gender, race, current program enrollment status, length of enrollment, and place of service. A total of 726 questionnaires were returned and analyzed.

1. **2003 State Women and Families Needs Assessment**

The “Indiana HIV/AIDS Women, Children and Families Needs Assessment Study” was conducted in 2003 with HIV-positive women and HIV Care Coordination staff from around the state. The study documented the HIV-related needs of women and children in the State of Indiana with specific attention to the nature and quality of available supportive and care resources (e.g., housing, case management, medical care, legal services, child and family services, transportation, mental health, substance abuse, support groups), the experiences and satisfaction with services used, the barriers to supportive services and care resources, and the changes needed to improve existing services and the lives of women and children impacted by HIV. The study consisted of three phases. Phase one consisted of administering a small survey to 125 staff members from the HIV Care Coordination sites across Indiana. Phase two consisted of three focus groups conducted with a smaller sample (32) of the HIV Care Coordination staff in three different parts of the state: north, central, and south (representing 12 care sites). Phase three consisted of seven focus groups (involving 60 total participants) and in-depth interviews with two additional HIV-infected women. Data gathered paralleled that collected from care site staff but emphasized female consumer experiences.

1. **2004 State Needs Assessment Update**

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

The Division received 444 completed surveys in response. The design of the questionnaire allowed for the analysis of the degree to which a particular service was needed but not currently available. This discrepancy between need and availability (i.e., the “unmet need”) was considered to be of primary importance. In terms of overall unmet needs, respondents from smaller counties tended to report more needs that were not currently being met. These counties included Lawrence, Owen, Hamilton, Spencer, and Jay. Respondents from larger counties (such as Marion, Lake, and Allen) tended to report fewer unmet needs.

1. **2004 State Emergency Financial Assistance Project**

In October 2004, the Part B grantee launched a short-term emergency financial assistance project throughout Indiana. It allocated $600,000 in unobligated funds to the project and used its network of standard HIV Care Coordination sites and a third party payer to implement it. Requests for assistance were coded as either “Agency-Direct” or “Client-Direct.” The former were requests for reimbursement of bulk-quantity purchases of items to be distributed by the agency to needy clients. The latter were requests for reimbursement of payments made by the agency on behalf of a particular client. The care sites submitted a total of 1176 unduplicated requests between October 2004 and March 2005. Geographically, 21% of the requests originated from the TGA, and 11% of the funds where expended in the TGA.

1. **2005 State Needs Assessment Update**

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

1. **2007 State Consumer Focus Groups**

In 2007, the Part B grantee enlisted the assistance of is consumer committee to conduct small-scale focus groups throughout the various service regions of the state. For ten months, the members were given a different monthly topic to discuss with other HIV-positive constituents in their respective areas. Among the topics, the Part B grantee included its eight priority services which included the six original core services identified by HRSA. Each focus group utilized a simple survey form to document the participants’ opinions; some surveys were also administered individually by the HIV Care Coordination staff. The Part B grantee received a total of 586 survey responses.

1. **2008 State Never in Care Focus Group**

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

1. **2008 TGA Needs Assessment**

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

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

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

1. **2009 TGA Provider Capacity Assessment**

In the summer of 2009, 21 area HIV service providers responded to a survey that was developed and approved by the Ryan White Part A Planning Council Needs Assessment Committee. Providers chosen to participate in the survey were those that subcontracted with the Ryan White Parts A or C Programs, as well as those that were major providers of services to HIV-positive persons in the Indianapolis area. The purpose of the assessment of provider capacity and capability was to identify the extent to which HIV-related services in the area are accessible, available, and appropriate for people living with HIV in the Indianapolis TGA. Based on the number of referrals that providers reported giving, the most needed core services were case management, HIV-related medical care, and mental health care. The most needed support services were financial assistance, psychosocial support, and housing assistance. Nearly all of the agencies actively verified that their clients were engaged in HIV-related primary medical care.

1. **2009 State HIV Services Needs Assessment**

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

1. **2010 State HIV Care Coordination Satisfaction Survey**

In April 2010, the Part B grantee mailed 4063 satisfaction surveys to active, maintenance, and closed clients in the HIV Care Coordination Program at 13 of its locations. Surveys were mailed to consumers who wished to receive HIV specific mail as noted in the program’s database. A total of 698 surveys (17%) were returned to the Division and analyzed to measure client satisfaction and determine the level of customer service provided by case management staff funded by ISDH. Though all regions were represented, the majority of responses were received from the Indianapolis (33%) and Gary (11%) areas. The survey revealed that 84% of respondents have a favorable opinion of the HIV Care Coordination Program. Most unfavorable responses were related to questions of the timeliness of assistance and the availability of HIV Care Coordination staff.

1. **2010 State HIV Services Mini-Survey**

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

1. **2012 TGA Needs Assessment**

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

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

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

1. **2013 State HIV Services Needs Assessment**

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

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

* 1. **Care Needs**

Based on the information obtained through the activities described above, the size and demographics of the prevalence population, and the careful review of the service utilization trends, the Part A grantee and its Planning Council have prioritized and allocated funding for the following core and support service areas: Outpatient and Ambulatory Medical Care (including laboratory tests), Local AIDS Pharmaceutical Assistance Program (LPAP), Oral Health Services, Early Intervention Services (EIS), Health Insurance Premium and Cost-Sharing Assistance, Mental Health Services, Medical Case Management Services (including treatment adherence), Substance Abuse Treatment Services – Outpatient, Case Management (non-medical), Emergency Financial Assistance (EFA), Housing Services, Legal Services (including permanency planning), Linguistic Services, Medical Transportation Services, Outreach Services, Psychosocial Support Services (including pastoral care and counseling). The paragraphs which follow describe the grantee’s specific rationale for each category’s inclusion as a funded priority service for FY2015.[[29]](#footnote-29)

1. **Outpatient and Ambulatory Medical Care (including laboratory tests)**

According to the 2009 TGA Provider Capacity Survey, more than three-quarters (77%) of the respondents (all direct HIV service providers) indicated that clients often did not keep appointments due to completing financial obligations. The 2008 TGA Needs Assessment found that long waiting times and inconvenient hours of operations were also significant deterrents to fully engaging in care, particularly for those consumers who were employed. The 2005 State Needs Assessment Update revealed a disappointing reliance on emergency medicine; more than half of the respondents indicated they had sought care in an emergency department at least once in the past year, and a fifth had done so at least twice in the same time period. In the original 2002 Needs Assessment Report, more than half (53%) of the HIV-positive respondents indicated that primary medical care was the service most necessary to ensuring good health. Regardless of gender or race, respondents consistently ranked medical care as their top need. Even in the absence of severe symptoms, access to treatment, particularly primary medical care, was widely recognized by respondents as absolutely necessary to maintain and improve the health of HIV-positive individuals.

Underscoring the importance of this category, between 1 March 2014 and 28 February 2015, the Part A grantee provided primary medical care services to 908 clients. These accounted for 20.6% of all services utilized within the period and for 23.9% of the expended RWSP funds.

1. **Local AIDS Pharmaceutical Assistance Program (LPAP)**

The 2013 State HIV Services Needs Assessment report showed some marked improvements in access to medications compared to earlier assessments. According to the report, only 13% of consumer respondents reported limited access to medications due to lack of insurance (down from 29% in 2009). Likewise, only 24% of the sample reported difficulty obtaining drugs due to insufficient funds for high co-payments even when insurance benefits were available (down from 67%). In the 2010 State HIV Services Mini-Survey, antiretroviral medications were ranked as the single most important service to respondents. The 2005 State Needs Assessment Update also underscored the importance of access to pharmaceuticals; the majority (more than 40%) of its respondents ranked this area as their primary area of need.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided HIV-related pharmaceutical assistance services to 160 clients. These accounted for 1.5% of all services utilized within the period and for 7.3% of the expended RWSP funds.

1. **Oral Health Services**

The 2013 State HIV Services Needs Assessment results did not differ greatly from its 2009 counterpart on the topic of oral health. When asked which service (other than primary medical care and drug coverage) was most important to them, 26% of the client sample indicated dental care. The gap analysis in the 2009 State HIV Services Needs Assessment illustrated that 47% of those surveyed reported difficulty obtaining dental care at some point. Barriers at the time included the limited duration of the EIP dental benefits, strict income guidelines for discounted services, an inability to afford sliding scale payments (if eligible), high Medicaid spend-down amounts, and a complete lack of dental benefits through Medicare. Sixty-five percent of the respondents in the 2005 State Needs Assessment Update indicated some level of need for oral health services, but only 52% acknowledged receiving the necessary care.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided dental services to 191 clients. These accounted for 3.9% of all services utilized within the period and for 4.5% of the expended Part A funds.

1. **Early Intervention Services (EIS)**

Though not sponsored by either the Part A or the Part B grantee, a 2003 assessment conducted by Brothers United in Indianapolis revealed that 19% of the respondents had not received care for more than a year after initial diagnosis and that 18% had not yet received care at the time of the survey.

More recent analyses by the RWSP have indicated that – despite a 76.4% rate of success in linking the newly diagnosed to care -- many persons living with HIV have never been connected to or have failed to remain engaged in care. According to COCF estimates prepared for 2014, 52.9% of those with HIV in the TGA are out of care. Moreover, 5.6% have never received a CD4 test, and 10.1% have never received a viral load test. Additionally, it is estimated that nearly 900 individuals in the TGA are current infected but undiagnosed and not in care. Based on these figures and conscious of the goals outlined in the National HIV/AIDS Strategy, the Part A Planning Council has elevated the priority ranking for EIS and Outreach Services to numbers two and three, respectively.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided EIS to 5,132 persons. These accounted for 20.5% of all services utilized within the period and for 11.0% of the expended RWSP funds.

1. **Health Insurance Premium and Cost-Sharing Assistance**

Assessment data had consistently confirmed the need among the HIV-positive population for services that are traditionally covered, in whole or in part, by major medical insurance policies. These services include primary medical care, pharmaceuticals, mental health services, substance abuse services, and oral health care. Providing assistance with health insurance premiums and co-payments is understood to be the most cost effective, most sustainable, least restrictive, and least complicated way to provide these services for eligible clients.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided premium assistance – through its arrangement with the Part B grantee – to 40 clients. These accounted for 0.2% of all services utilized within the period and for 4.8% of the expended RWSP funds.

1. **Mental Health Services**

In the 2013 HIV Services Needs Assessment report, only 9% of the clients sampled identified mental health treatment as their most important non-HIV medical service. However, 26% reported that they had missed work, school, or appointments due to mental stress in the past 30 days. Of these respondents, 8% reported difficulty obtaining mental health services once or more in the past year (an improvement compared to 20% in 2009). However, 54% of the providers surveyed noted that mental health issues hinder their patients’ ability to access care. This corroborated the findings of the 2009 TGA Provider Capacity Survey which revealed that 62% of the providers surveyed attributed clients’ difficulties with remaining engaged in care to mental health issues. In the 2007 State Consumer Focus Groups, mental health was perceived as being essential to a person’s overall health and wellbeing, yet it remains one of the most under-utilized services in the TGA. Stigma surrounding mental illness is widely acknowledged as a major contributing factor to this trend.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided mental health services to 286 clients. These accounted for 7.5% of all services utilized within the period and for 4.4% of the expended RWSP funds.

1. **Medical Case Management Services (including treatment adherence)**

Historically, assessments have not differentiated between medical and non-medial forms of case management. However, in Indiana, the HIV Care Coordination Program has delivered the essential elements of both these service categories for the past 25 years and, therefore, the assessment results related to it are relevant to this section and to the Case Management (non-medical) section.

The 2013 State HIV Services Needs Assessment confirmed the long-recognized need for case management services. Of those surveyed, 48% reported always feeling comfortable sharing problems with their care coordinators. Thirty-four percent reported feeling comfortable some or most of the time, and only 18% reported never feeling comfortable. Of those surveyed, the majority of the clients (82%) reported that they had no difficulties getting case management services in the past year; this is the same percentage as in 2009. In the 2012 TGA Needs Assessment, consumers ranked case management as the most important support service. In the 2010 HIV Services Mini-Survey, case management services were ranked as the third most important service overall to respondents; only the categories of HIV-related medications and outpatient care were ranked higher. The 2009 State HIV Services Need Assessment indicated that the longer a client remains enrolled in care coordination (“more than one year” compared to “less than one year”), the more the client improves on several indicators, including access to food, housing, utility assistance, mental health care, HIV medication, and HIV medical care needs. It also documented that 89% of all respondents had accessed the service at least once in the preceding year.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided Medical Case Management services to 1750 clients. These accounted for 22.3% of all services utilized within the period and for 19.3% of the expended RWSP funds.

1. **Substance Abuse Treatment Services – Outpatient**

The 2013 State HIV Services Needs Assessment report showed that only 2% of consumer respondents identified drug and alcohol services as their most important non-HIV medical service need. However, 50% of the providers cited drug and alcohol use as a leading factor in their patients’ failure to consistently engage in care; similar results were seen in 2009. The qualitative data gathered during the 2007 State Consumer Focus Groups indicated that disclosure of a substance use issue remains difficult. Few participants – though demographically and geographically diverse – were willing to report personal chemical dependency concerns; although, overall, the concept of low-cost or free drug treatment was supported by respondents provided that such services were not promoted as “mental health care,” interestingly pointing to possibly greater stigma attached to mental illness than to drug abuse. A 2001 study found that MSM – the majority of the HIV-positive population – have a greater propensity for substance abuse compared to many other groups.[[30]](#footnote-30)

Between 1 March 2014 and 28 February 2015, the Part A grantee provided substance abuse treatment to 44 clients. These accounted for 1.3% of all services utilized within the period and for 1.4% of the expended RWSP funds.

1. **Case Management (non-medical)**

As noted above, assessments have not traditionally differentiated between medical and non-medial forms of case management. However, in Indiana, the HIV Care Coordination Program has delivered the essential elements of both these service categories for the past 25 years and, therefore, the assessment results related to it are relevant to this section and to the previous Medical Case Management section. Case management is consistently one of the most requested, most accessible and most utilized services in the HIV continuum of care.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided case management services to 1721 clients. These accounted for 18.7% of all services utilized within the period and for 10.0% of the expended RWSP funds.

1. **Emergency Financial Assistance (EFA)**

The 2013 State HIV Services Needs Assessment report confirmed the perennial need for emergency assistance. Twenty-six percent of the respondents reported that they were notified of possible disconnection from their utilities at least once in the past year, and 32% ranked emergency assistance as the most important non-medical need (not including case management). As in 2009, 89% of all consumer respondents claimed to have an annual income of less than $25,000; of these, 44% were earning less than $10,000 per year. In the 2009 State HIV Services Needs Assessment, 25% of the respondents reported being hungry one or more days in the past month. Among the respondents who had been prescribed medications, 57% reported being unable to obtain medications due to lack of money. Fifty-seven percent of the providers surveyed noted that difficulties paying and lack of insurance contribute to their patients’ inability to consistently access care.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided emergency utility assistance for 150 clients. These accounted for 0.9% of all services utilized within the period and for 1.4% of the expended RWSP funds. During the same period, the Part A grantee provided emergency food assistance for 432 clients. These accounted for 3.7% of all services utilized within the period and for 0.9% of the expended RWSP funds.

1. **Housing Services**

In the 2013 State HIV Services Needs Assessment report, 22% of the consumer sample identified housing assistance as the second most needed support service. Four percent had experienced homelessness or unstable housing within the previous year, and 5% had missed work, school, or a doctor’s appointment at least once in the last 30 days due to unstable housing. Eleven percent had been notified of possible eviction from their home. Thirty-two percent of the providers surveyed indicated that housing issues prevent their patients from accessing care regularly. In the 2010 State HIV Services Mini-Survey, housing services were ranked as the fourth most important service to respondents. Medical care, medications, and case management were the only categories ranked higher. These results substantiated those of the 2008 TGA Needs Assessment in which key informants identified housing as one of the most needed social services for persons with HIV in the Indianapolis TGA.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided housing assistance to 151 clients. These accounted for 0.8% of all services utilized within the period and for 3.1% of the expended RWSP funds.

1. **Legal Services (including permanency planning)**

The need for legal services has not been exhaustively surveyed by either the Part A or Part b grantee. However, anecdotal information indicates that many clients are either not aware of the availability of such services or do not know how to access them.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided legal assistance to 80 clients. These accounted for 1.0% of all services utilized within the period and for 0.8% of the expended RWSP funds.

1. **Linguistic Services**

Focus group participants in the 2008 TGA Needs Assessment indicated that language was a limiting factor in participating in support groups and in seeking care generally. This concern was greatest among Hispanic participants.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided translation services to 24 clients. These accounted for 0.6% of all services utilized within the period and for 0.3% of the expended RWSP funds.

1. **Medical Transportation Services**

In the 2013 State HIV Services Needs Assessment report, the Part B grantee noted that only 6% of the consumer respondents listed transportation as their most important need; however, 21% reported that they had missed work, school, or a doctor’s appointment at least once in the past 30 days due to a lack of transportation. Nine percent reported missing these types of obligations four or more times in the last 30 days. Thirty-seven percent of the providers surveyed ranked “lack of transportation” as a leading barrier to care. According to the 2009 TGA Provider Capacity Survey, nearly half (48%) of the providers reported that their clients experienced difficulties securing transportation to appointments for essential services. In the 2008 TGA Needs Assessment, key informants identified transportation as one of the most needed services for persons with HIV in the Indianapolis TGA. A substantial portion of the 2004 State Emergency Financial Assistance Project funds (nearly 5% or approximately $30,000) were used to address transportation-related needs. And in the original 2002 State Needs Assessment Report, nearly one quarter (24%) of the respondents indicated that transportation was the service most necessary to ensuring good health.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided medical transportation assistance to 292 clients. These accounted for 5.7% of all services utilized within the period and for 1.8% of the expended RWSP funds.

1. **Outreach Services**

The need for outreach services has not been exhaustively surveyed by either the Part A or Part B grantee. However, the annual Unmet Need estimate has consistently revealed that approximately 30% of the prevalence population is status-aware but not currently engaged in medical care. Through the Community Liaison project (supported by MAI funds), the Part A grantee has learned that majority of the Unmet Need group are either newly diagnosed or recently released from prison. Other factors contributing to the failure to seek care include depression, drug use, lack of or unfamiliarity with available resources, denial, fear, homelessness, and lack of personal readiness.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided outreach services to 165 persons which resulted in 90 individuals entering or re-entering care. These accounted for 1.1% of all services utilized within the period and for 1.8% of the expended RWSP funds. During the same period, the Part A grantee provided Health Education and Risk Reduction (HE/RR) services to 1328 persons. These accounted for 5.3% of all services utilized within the period and for 2.5% of the expended RWSP funds.

1. **Psychosocial Support Services (including pastoral care and counseling)**

Focus group participants in the 2008 TGA Needs Assessment survey indicated a significant need for counseling services and support groups to help them maintain the motivation to remain in care.

Between 1 March 2014 and 28 February 2015, the Part A grantee provided psychosocial support services to 82 clients. These accounted for 2.4% of all services utilized within the period and for 1.2% of the expended RWSP funds.

* 1. **Capacity Development Needs**

Since 2007, the Part A grantee has continually worked with its Planning Council and area providers to identify agencies that can deliver the priority services in the most efficient and effective manner possible. However, recognizing that capacity will never be fully sufficient to meet demand due to funding limitations, the Planning Council has instead provided two practical directives intended to enhance the reach and quality of services. The council has directed the grantee to increase the number of medical transportation options for consumer who live outside of the City of Indianapolis and to increase the number of consumers who receive mental health services by requiring all case management providers to systematically screen all enrollees for mental health concerns twice yearly.

1. **Description of Priorities for the Allocation of Funds**

Each year the Priorities and Allocations Committee of the Part A Planning Council is tasked with prioritizing the service categories assessed to be most valuable to HIV-positive persons living in the TGA. The committee is provided with detailed epidemiological information, service utilization details, and needs assessment results by the Part A grantee to aid in the decision-making process. Once the services are prioritized, the committee agrees on the individual service allocations. Three sets of potential allocations are submitted to the grantee, each one based on a different Part A funding scenario: a 5% decrease in the Part A award from HRSA, level funding, and a 5% increase in the Part A award.

* 1. **Size and Demographics of the Population with HIV**

As of 31 December 2013, the TGA was home to 5351 HIV-positive, status-aware men and women. An additional 871 infected but status-unaware persons are estimated to also live in the TGA. Of the confirmed cases, 52.6% have been diagnosed with AIDS. By gender, the prevalence population was 81.2% male and 18.8% female. Whites compromised 45.4% of the cases, while Blacks and Hispanics represented 42.6% and 7.1%, respectively. The majority of infected persons (54%) were over the age of 45, and the most frequently reported risk factor was high-risk homosexual contact (63.2%). Additional information regarding the prevalence population appears in Table A in Appendix 1.

* 1. **Needs of Individuals with HIV**

Based on the service needs described above, the size and demographics of the prevalence population, and the careful review of the service utilization trends, the Part A grantee and its Planning Council have prioritized and allocated funding for the following core and support service areas: Outpatient and Ambulatory Medical Care (including laboratory tests), Local AIDS Pharmaceutical Assistance Program (LPAP), Oral Health Services, Early Intervention Services (EIS), Health Insurance Premium and Cost-Sharing Assistance, Mental Health Services, Medical Case Management Services (including treatment adherence), Substance Abuse Treatment Services – Outpatient, Case Management (non-medical), Emergency Financial Assistance (EFA), Housing Services, Legal Services (including permanency planning), Linguistic Services, Medical Transportation Services, Outreach Services, Psychosocial Support Services (including pastoral care and counseling). The specific allocations per category for FY2015 (1 March 2015 through 28 February 2016) appear below and are also presented in Table E in Appendix 2. The figures shown represent the Planning Council’s final recommendations for the budget period. Appendix 2 also contains Table F which lists the services in order of priority as determined by the Priorities and Allocations Committee.

1. **Outpatient and Ambulatory Medical Care (including laboratory tests)**

The Part A grantee has allocated $994,043 to provide Outpatient and Ambulatory Medical Care in FY2015. It intends to employ the services of four different providers and to serve approximately 725 enrollees.

1. **Local AIDS Pharmaceutical Assistance Program (LPAP)**

The Part A grantee has allocated $100,234 to provide LPAP services FY2015. It intends to employ the services of three different providers and to serve approximately 100 enrollees.

1. **Oral Health Services**

The Part A grantee has allocated $159,169 to provide Oral Health Services in FY2015. It intends to employ the services of two different providers and to serve approximately 180 enrollees.

1. **Early Intervention Services (EIS)**

The Part A grantee has allocated $397,221 to conduct EIS activities in FY2015. It intends to employ the services of nine different providers and to impact approximately 8290 high-risk persons living in the TGA who are unaware of their HIV status.

1. **Health Insurance Premium and Cost-Sharing Assistance**

The Part A grantee has allocated $202,480 to provide Health Insurance Premium and Cost-Sharing Assistance in FY2015. It intends to employ the services of the Part B grantee to provide premium assistance to approximately 42 enrollees and the services of three additional agencies to provide deductible assistance to 20 enrollees.

1. **Mental Health Services**

The Part A grantee has allocated $138,600 to provide Mental Health Services in FY2015. It intends to employ the services of the Damien Center and to serve approximately 315 enrollees.

1. **Medical Case Management Services (including treatment adherence)**

The Part A grantee has allocated $565,202 to provide Medical Case Management Services in FY2015. It intends to employ the services of four different providers and to serve approximately 899 enrollees.

1. **Substance Abuse Treatment Services – Outpatient**

The Part A grantee has allocated $69,300 to provide Substance Abuse Treatment Services on an outpatient basis in FY2015. It intends to employ the services of two different providers and to serve approximately 90 enrollees.

1. **Case Management (non-medical)**

The Part A grantee has allocated $396,165 to provide Case Management in FY2015. It intends to employ the services of five different providers and to serve approximately 1059 enrollees.

1. **Emergency Financial Assistance (EFA)**

The Part A grantee has allocated $74,800 to provide EFA for utilities and food in FY2015. It intends to employ the services of a total of four providers to provide utility assistance to approximately 74 enrollees and food assistance to 310 enrollees.

1. **Housing Services**

The Part A grantee has allocated $104,500 to provide Housing Services in FY2015. It intends to employ the services of three different providers and to serve approximately 95 enrollees.

1. **Legal Services (including permanency planning)**

The Part A grantee has allocated $22,110 to provide Legal Services in FY2015. It intends to employ the services of the Damien Center and to serve approximately 67 enrollees.

1. **Linguistic Services**

The Part A grantee has allocated $7500 to provide Linguistic Services in FY2015. It intends to leverage internal resources and to serve approximately 30 enrollees.

1. **Medical Transportation Services**

The Part A grantee has allocated $73,223 to provide Medical Transportation Services in FY2015. It intends to employ the services of four different providers and to serve approximately 493 enrollees.

1. **Outreach Services**

The Part A grantee has allocated $60,235 to provide Outreach Services in FY2015. It intends to employ the services of four different providers and to connect to care approximately 286 previously diagnosed HIV-positive persons living in the TGA.

1. **Psychosocial Support Services (including pastoral care and counseling)**

The Part A grantee has allocated $50,354 to provide Psychosocial Support Services in FY2015. It intends to employ the services of two different providers and to serve approximately 180 enrollees.

To promote parity as these 16 services are planned and implemented, the Part A grantee specifically considers the unique needs of the TGA’s populations of special interest: Black persons, women of childbearing age, immigrants, and young adults. These are groups that, in the grantee’s assessment, bear a disproportionate disease burden or face unique challenges to accessing and remaining engaged in care.

The most important service needs identified by Black persons living with HIV in the TGA have included health insurance, housing assistance, substance abuse, psychosocial services, and medical transportation. In FY2014, the services most utilized by this group included primary medical care, case management, mental health services, and medical transportation.

The most important service needs identified by women of childbearing age living with HIV in the TGA have included health insurance coverage, mental health services, housing, emergency food assistance, and medical transportation. In FY2014, the services most utilized by this group included primary medical care, case management, mental health services, EFA, and medical transportation.

The most important service needs identified by foreign-born persons living with HIV in the TGA have included health insurance coverage, interpretation services, transportation, and housing. Although undocumented individuals are not excluded from the RWSP service system, lack of legal immigration status remains a major barrier for this population. In FY2014, the services most utilized by this group included primary medical care and case management.

The most important service needs identified by young adults living with HIV in the TGA have included health insurance coverage and medical transportation. In FY2014, the services most utilized by this group included primary medical care and case management.

1. **Description of Gaps in Care**

In the TGA, the Part A grantee has defined two kinds of gaps in care. The first, co-morbidities, relates to other disease states affecting the individual that prevent optimal HIV treatment outcomes. The second, societal issues, relates to larger community-wide problems and limitations in the continuum of care itself.

* 1. **Co-Morbidities**

The term “co-morbidity” is used to describe the presence of one or more additional disorders (or diseases) co-occurring with a primary disease or disorder. The additional disorder may be a medical, behavioral, or mental disorder.

1. **Tuberculosis**

According to the Indiana Tuberculosis Control Program 2013 Annual Report,[[31]](#footnote-31) 94 new cases of tuberculosis (TB) were reported to ISDH in 2013; this represented a 7.8% decrease from the previous year and continued a longstanding overall trend. TB cases in Indiana have declined from 1,883 reported in 1956 to an all-time low of 90 cases reported in 2010. Forty-seven of the new cases (50%) in 2013 originated from Indiana’s three most populous counties (Marion, Lake, and Allen). Marion County alone reported 36 new cases; at 3.9 per 100,000, Marion County’s incidence rate was nearly three times higher than the overall statewide rate (1.4 per 100,000).

High risk populations for TB infection include persons with HIV co-morbidity; statewide, six cases in 2012 and two cases in 2013 reported HIV as a co-morbid condition. Co-morbid TB and HIV infection is an AIDS-defining condition. Even though TB is one of the leading causes of death for those infected with HIV, TB can be effectively treated even if HIV infection is present.

While TB has been on the decline in the United States, it continues to be a serious problem among foreign-born persons in the U.S.[[32]](#footnote-32) In 2012, the TB rate among foreign-born persons (15.8 cases per 100,000) in the U.S was 11 times greater than the rate in U.S.-born persons (1.4 cases per 100,000). It is estimated that in 2012 alone, 63% of all TB cases in the U.S. occurred in foreign-born persons.[[33]](#footnote-33) Therefore, as Indianapolis’ population becomes more diverse and more foreign-born persons migrate to the area, the rate of TB infections has the potential to increase. TB is a complex disease to treat, requiring at a minimum six months of strict adherence to a treatment plan that includes several antibiotics.[[34]](#footnote-34) The cost to treat TB in an individual with HIV varies depending on the stage of the disease, the type of treatment, and the duration of the treatment.[[35]](#footnote-35) Treatment for drug-resistant TB is very expensive; a recent CDC study found that direct costs for treatment (including drugs, diagnostics, case management, and hospitalization) of multi-drug resistant TB averaged $134,000 per case, compared with $17,000 to treat drug-susceptible TB.[[36]](#footnote-36) Additionally, the patient must be monitored and counseled on the possibility of drug interactions, immune reconstitution inflammatory syndrome, and drug toxicity.

1. **Hepatitis C**

Hepatitis C (HCV) is a blood-borne illness and is one of the leading causes of chronic liver disease in the U.S.[[37]](#footnote-37) In HIV-positive individuals, HCV infection may progress more rapidly and treatment is more complicated due to potential drug interactions. Treatment for HIV-HCV co-infection is less successful than in mono-infected individuals. The CDC estimates that about one in four persons with HIV are co-infected with HCV.[[38]](#footnote-38)

In 2015, recent advances have made the treatment for HCV much easier and more effective than in the past. New drugs – such as simeprevir (Olysio) and sofosbuvir (Sovaldi) – taken in combination with other oral antiviral medications have been found to clear the virus from the liver in just 12 weeks. When either of these drugs is combined with injected peginterferon and an oral drug called ribavirin (Rebetol), HCV can be cleared in up to 90% of cases of the most common form of the virus (genotype 1). These new treatments, however, are very expensive (ranging from $80,000 to $100,000 for the full course of treatment), and require education, support for alcohol and drug use issues, and diligent monitoring.[[39]](#footnote-39)

1. **Other Sexually Transmitted Diseases**

Individuals infected with a sexually transmitted disease (STD) are at least twice as likely to acquire HIV through sexual contact. Compared to individuals who are mono-infected, individuals who are co-infected with HIV and an STD are more likely to transmit their HIV disease during sexual contact with an individual who is mono-or co-infected. This is of particular concern for the TGA due to the high rates of GC and CT and the on-going outbreak of syphilis in HIV-infected MSMs that began in 2008.

CT is the most commonly reported notifiable disease in the U.S; however, it is often asymptomatic and undiagnosed. CT is more common in females than males. In 2013, Marion County ranked 19th among the top 70 counties and independent cities in the U.S for CT cases. The CT rate for the Indianapolis-Carmel MSA was 613.5 cases per 100,000 in 2013, which was higher than the national rate of 446.6 per 100,000 in the same year.[[40]](#footnote-40) Nearly 2% of persons with HIV in Indiana who responded to the 2002 State Needs Assessment reported having been diagnosed with CT in the previous year. Of the 11,581 persons diagnosed with CT in 2014 in the TGA, 129 were also HIV-positive (a rate of 2265 per 100,000).[[41]](#footnote-41)

GC is another very common STDs in the U.S. If detected, GC is often treatable with one dose of antibiotics. Marion County has one of the highest GC rates in the nation, ranking 12th worst among the top 70 counties and independent cities in the U.S for GC infections. The GC rate in the Indianapolis-Carmel MSA was 187.5 cases per 100,000 in 2013, which was higher than the national rate of 106.1 cases per 100,000 in the same year.[[42]](#footnote-42) Of the persons with HIV in Indiana who responded to the 2002 State Needs Assessment, 2% reported having been diagnosed with GC in the previous year. In 2014, of the 3695 GC infections reported in the TGA, 162 were among HIV-positive persons (a rate of 2845 per 100,000).[[43]](#footnote-43)

Syphilis is a highly infective genital ulcerative disease, which is easily treated if detected in its early stages. After several years of having one of the lowest syphilis rates among big U.S. cities, the number of syphilis cases in the TGA began to rise in early 2008. According to the CDC, the rate of primary and secondary syphilis in the Indianapolis-Carmel MSA in 2013 was 7.6 cases per 100,000, which was higher than the national rate of 5.5 cases per 100,000 in the same year. (In 2013, the rate for all stages of syphilis in the TGA was 17.6 cases per 100,000; for the entire U.S., it was 18.0 cases).[[44]](#footnote-44) Of the 202 persons diagnosed with primary, secondary, or early latent syphilis in the TGA in 2014, 87 were also HIV-positive (a rate of 1528 per 100,000).[[45]](#footnote-45) The syphilis outbreak is ongoing, and data gathered since 2008 indicate that MSM and Blacks continue to be disproportionately impacted.

The diagnosis and treatment of CT, GC, or syphilis cost the patient $20 at the MCPHD STD Clinic, a publicly funded clinic.  Actual test costs to the clinic are negotiated at public health rates and range from $36.00-$76.00 per patient for the three STDs. Costs associated with clinician time, malpractice insurance, medical records maintenance, Disease Intervention Specialist activities, medications, and other material costs are absorbed by the clinic and result in no additional charges to the patient.[[46]](#footnote-46)

1. **Mental Illness**

In the 2013 HIV Services Needs Assessment report, only 9% of the clients sampled identified mental health treatment as their most important non-HIV medical service. However, 26% reported that they had missed work, school, or appointments due to mental stress in the past 30 days. Of these respondents, 8% reported difficulty obtaining mental health services once or more in the past year (an improvement compared to 20% in 2009). However, 54% of the providers surveyed noted that mental health issues hinder their patients’ ability to access care. This corroborated the findings of the 2009 TGA Provider Capacity Survey which revealed that 62% of the providers surveyed attributed clients’ difficulties with remaining engaged in care to mental health issues. In the 2007 State Consumer Focus Groups, mental health was perceived as being essential to a person’s overall health and wellbeing, yet it remains one of the most under-utilized services in the TGA. Among Part A enrollees, Hispanics remain the least likely group to utilize mental health services. Between 1 March 2014 and 28 February 2015, the Part A grantee provided mental health services to 286 clients. These accounted for 7.5% of all services utilized within the period and for 4.4% of the expended Part A funds.[[47]](#footnote-47)

1. **Addiction**

The 2013 State HIV Services Needs Assessment report showed that only 2% of consumer respondents identified drug and alcohol services as their most important non-HIV medical service need. However, 50% of the providers cited drug and alcohol use as a leading factor in their patients’ failure to consistently engage in care; similar results were seen in 2009. The qualitative data gathered during the 2007 State Consumer Focus Groups indicated that disclosure of a substance use issue remains difficult. Few participants – though demographically and geographically diverse – were willing to report personal chemical dependency concerns; although, overall, the concept of low-cost or free drug treatment was supported by respondents provided that such services were not promoted as “mental health care,” interestingly pointing to possibly greater stigma attached to mental illness than to drug abuse. Between 1 March 2014 and 28 February 2015, the Part A grantee provided substance abuse treatment to 44 clients. These accounted for 1.3% of all services utilized within the period and for 1.4% of the expended Part A funds.[[48]](#footnote-48)

Addiction is a particular concern for the Part A grantee. Substance abuse has been shown to decrease adherence to nutrition or medication regimens for persons with HIV. Furthermore, untreated mental illness often accompanies drug and alcohol abuse and plays an important role in an individual’s adherence to medical treatment. Drug and alcohol abuse are also associated with participation in behaviors that put individuals at risk of contracting or transmitting HIV, including engaging in unprotected sex.

* 1. **Societal Issues**

In the TGA, the term “societal issues” is used to describe larger community-wide problems and limitations in the continuum of care itself that ultimately affect an individual’s potential to realize positive health outcomes.

1. **Poverty and Homelessness**

HIV infection and poverty frequently co-occur. Poverty can be both a risk for and a result of HIV infection. In 2014, the Federal Poverty Level (FPL) for a single person was $11,670, and the most commonly used income limit for Ryan White services – 300% of the FPL – was $35,010. Nationally in the preceding year, only 14.5% of the general population was living below the poverty level.[[49]](#footnote-49) But within Marion County in 2014, circumstances were less favorable; it was estimated that 21.4% of all residents were living below 100% of the FPL.[[50]](#footnote-50) Unfortunately, Part A service recipients were even more impoverished; in 2014, 58.6% were living below 100% of the FPL, another 28.0% were living between 101-200%, and the balance was living between 201-300%.[[51]](#footnote-51)

The recession that began in 2008 has resulted in an increase in persons seeking various forms of assistance in the TGA. Connect2Help2-1-1 is a free information resource serving central Indiana. Its mission is to facilitate connections between people who need human services and those who provide them. Between 1 April 2014 and 31 March 2015, Connect2Help2-1-1 answered 134,319 calls from persons living in the TGA, and another 87,147 TGA residents accessed the Connect2Help2-1-1 service through its website. The majority of inquiries were regarding assistance with utilities and housing.[[52]](#footnote-52)

The 2015 annual count of homeless persons found 1666 homeless individuals in Marion County. On 28 January 2015, the Indiana University Public Policy Institute and the Coalition for Homelessness Intervention and Prevention (CHIP) coordinated the annual Point-in-Time Count of those experiencing homelessness. The count is conducted in accordance with requirements set forth by the U.S. Department of Housing and Urban Development (HUD). HUD requires local counts to estimate the extent of homelessness nationwide. In addition to reporting to HUD, the data collected from the count is used to assess changes over time and identify emerging needs of those experiencing homelessness in Indianapolis and Marion County at large. The number of individuals found in 2015 decreased slightly compared to the prior year when 1,897 persons were counted. (The 2015 results were more similar to those of 2012 and 2013.) A point-in-time count by definition will not count everyone who experiences homelessness, but this snapshot is the best evidence available to quantify the nature and extent of HUD-defined homelessness in Indianapolis.[[53]](#footnote-53)

The actual number of homeless individuals in the TGA will necessarily be higher than that of just Marion County. Based on previous estimates of 10-16%,[[54]](#footnote-54) there may approximately 535 to 856 persons with HIV in the TGA who are homeless at any given time.

In 2014, HOPWA subcontractors in the TGA served a total of 371 households. Of this number, 103 received short-term housing, 239 received long-term housing, and 29 received other types of supportive services. The total cost per unit of assistance for the year was $1658.03. Black persons constituted the majority of the clients (56.33%) receiving housing assistance from HOPWA.[[55]](#footnote-55)

1. **Former Incarceration**

Those who have been incarcerated in the past are disproportionately impacted by HIV. The Indiana Department of Correction (IDOC) has a consistent adult inmate population that averages 29,000 with approximately 16,000 inmates being released each year.[[56]](#footnote-56) Roughly one-third are released into the TGA.[[57]](#footnote-57) IDOC tests all inmates for HIV at intake, and has historically diagnosed approximately 300 new HIV cases among inmates HIV annually.[[58]](#footnote-58) Since approximately 1% of the IDOC inmate population is HIV-positive, an estimated 160 inmates with HIV are released each year.

Inmates who are HIV-positive often find it difficult to entry into the continuum of HIV care upon release. Newly released inmates with HIV face myriad barriers including poverty, homelessness, and addiction.[[59]](#footnote-59) To address these issues, the Part B grantee entered into a formal agreement with IDOC in 2010 to facilitate the introduction of HIV Care Coordination into the prison setting immediately upon identification of a positive inmate. Existing case management services offered by IDOC are now complemented by the local HIV Care Coordination provider, and services continue for the term of the incarceration, including the entire discharge process. Once released, the former inmate is either fully integrated into the local continuum of HIV care or arrangements are made for services wherever the inmate plans to relocate.

While invaluable for the client, the facilitation itself is extremely time-consuming, both for the HIV Care Coordinator and for ISDH. Each referral requires coordination between the HIV Care Coordination Program Manager at ISDH, OCDR, the Director of Case Management at IDOC, the facility-level Case Management Supervisor, and the IDOC case manager assigned to the offender. All these connections must be made – and all the necessary releases signed – before the case can be assigned to the local HIV Care Coordinator. Once the assignment is made, ISDH monitors the case until the individual has been successfully integrated into the HIV Care Coordination system. To date, no cost evaluations of this new process have been conducted; however, it is certain that this closely managed and complex process carries a cost much greater than the standard referral into care.

1. **Geographic Isolation**

In 2011, 13.4% of the prevalence population lived outside of Marion County. Despite early indications to the contrary, by the end of 2013, this percentage had remained unchanged. However, during the same period, the percentage of Part A enrollees living outside of Marion County had actually decreased from 7.7% to 5.2%.[[60]](#footnote-60) And while these figures are relatively low, the grantee remains concerned about the serious challenges faced by those living beyond the boundaries of metropolitan Indianapolis.

The majority of the HIV service providers in the TGA are located in Marion County. This requires persons with HIV in the rural parts of the TGA to either commute to Marion County or to receive services from local providers who do not specialize in the care and treatment of HIV disease. (While the City of Indianapolis provides adequate public transportation in the form of *IndyGo* bus services within Marion County, such options are essentially non-existent in other parts of the TGA placing low-income persons living in less urban areas at a distinct disadvantage.)

In addition to this access and quality issue, residents of less urban areas face increased stigma compared to their urban counterparts. This often serves as a deterrent to disclosure and engagement in care. In FY2014, the services most utilized by this group included primary medical care, case management, EIS, outreach, and psychosocial support services.

1. **Description of Prevention and Service Needs**

The primary source of funding for HIV Counseling and Testing Services in the Indianapolis TGA comes from the ISDH through a Cooperative Agreement with the CDC. According to ISDH, CDC funding for HIV prevention programming has remained level over the last several years while the demand for Counseling, Testing, and Referral (CTR) services and other prevention programs has only increased. Exacerbating the issue, ISDH has failed to secure any state or local government funds to augment its efforts. Therefore, the allocation of Part A funds to provide early HIV intervention services in the TGA will provide a welcome supplement to the State’s existing programming but will not supplant any State or federal funds.

However, any amount of funding that the RWSP dedicates to case-finding efforts lessens the amount of funding that can be used to provide direct services to existing cases. As the Part A grantee has developed its EIIHA strategy, it has relied on a number of community partners to fill the gaps left by a lack of State funding for prevention programs. Paramount among these partnerships is the collaboration with the Health Foundation of Greater Indianapolis which has granted a substantial amount funds to providers within the TGA to implement new or enhance existing prevention programs including those designed to link status-unaware and return status-unaware individuals to the HIV service delivery system.

Beyond the limits of available funding, other prevention challenges include the lack of coordination between various prevention and CTR programs, the lack of resources to fully integrate the EIIHA strategy into the TGA’s system of care, the inability to blend care and prevention funding in a manner that would increase effectiveness and efficiency, and geographic challenges of providing prevention services outside of the TGA’s urban center.

1. **Description of Barriers to Care**

In addition to the issues surrounding the task of identifying, engaging, and maintaining people in care, the Part A Grantee recognizes a number of other gaps and barriers. These exist despite a healthy continuum of care and a wealth of quality service providers. For planning purposes, they have been correlated to each of the grantee’s priority service areas and impact both those considered to be in and out of care according to the HRSA definition of “unmet need.” The following paragraphs briefly describe the most evident issues for each service category. These barriers include the obstacles experienced by the consumer, those facing the providers, and those inherent in the program and the larger system of care.

* 1. **Service Barriers**

The following paragraphs briefly describe the most evident issues for each service category. These barriers include the obstacles experienced by the consumer, those facing the providers, and those inherent in the program and the larger system of care. Certain obvious cross-category barriers (such as the general limitations necessitated by the amount of the annual Part A grant award, the fact that Part A services can only be delivered by a finite number of contracted Part A sub-grantees, lack of client awareness of services and benefits, lack of provider knowledge regarding service protocols and parameters, cultural competency issues, and the implications of the HRSA-prescribed 75/25 allocation rule) are not included in the following description.

1. **Outpatient and Ambulatory Medical Care (including laboratory tests)**
   * 1. **System Barriers**
2. Health insurance provider networks (including those utilized by Indiana Medicaid and its Healthy Indiana Plan) often prevent consumers from accessing the most appropriate or preferred physicians.
3. Facility-based indigent programs for primary care are limited to one large, urban hospital.
4. Public health programs (like those offered by Parts A and B) follow strict eligibility criteria which limit participation.
5. Indiana Medicaid guidelines do not allow the recipients to earn an adequate income without compromising or jeopardizing their coverage.
   * 1. **Provider Barriers**
   1. The number of infectious disease specialists practicing in the TGA is small outside of Marion County, resulting in high patient volume per provider.
   2. General practitioners are often reluctant to treat HIV disease due to its complexity and a lack of sufficient knowledge and training.
      1. **Consumer Barriers**
         * 1. The inability to afford primary medical care without assistance affects the rate at which HIV-positive persons access such care.
           2. The consumer’s physical and mental health can prevent timely access to medical care.
           3. Minority consumers often report a mistrust of the medical establishment that may result in a delay of entry into care.
           4. Consumers cite a lack of effective communication with medical providers which may negatively impact adherence and retention in care.
           5. Employed consumers report long wait times for appointments at hours convenient to their work schedule.
           6. New consumers report receiving referrals that do not consider the consumer’s current insurance coverage or the cultural appropriateness of the provider to which the consumer is being referred.
6. **Local AIDS Pharmaceutical Assistance Program (LPAP)**
7. **System Barriers**
8. Health insurance provider networks (including those utilized by Indiana Medicaid and Medicare Part D plans) often prevent consumers from accessing the most appropriate or preferred pharmacies.
9. Facility-based indigent programs for pharmaceuticals are limited.
10. LPAP is limited to only temporary assistance and will not be extended to persons who fail to seek more permanent drug coverage from another source.
11. Most Medicare Prescription Drug Plans have a coverage gap, a period of time when there is a temporary limit placed on plan coverage of drug costs, resulting in additional out-of-pocket costs to any member who is not eligible for and enrolled in Medicare’s Extra Help program.
12. The manufacturer-sponsored patient assistance programs are designed to be short-term, and the application process can be cumbersome.
13. IDOC may fail to issue the standard 30-day supply of medications if an inmate is released earlier than expected.
14. **Provider Barriers**
    1. Providers may be reluctant to prescribe antiretroviral medications to consumers who exhibit indications of substance use or mental illness.
    2. HIV Care Coordination and Part A Case Management providers may not consistently deliver routine adherence messages due to high client volume.
15. **Consumer Barriers**
    1. The inability to afford medication without assistance affects the rate at which HIV-positive persons access such drug treatment.
    2. The consumer’s physical and mental health may interfere with adherence to prescribed treatments.
    3. Adverse side effects and potential drug interactions may prevent consumers from adhering to treatment without sufficient support and education.
16. **Oral Health Services**
17. **System Barriers**
18. The Oral Health Services offered by the Part A grantee have a monetary service cap of $2500 and require the grantee’s prior approval of the provider’s treatment plan.
19. The dental insurance program offered by the Part B grantee has a monetary service cap of $2000 and a limited formulary of covered services.
20. Indiana Medicaid has a monetary service cap of $600 for dental benefits.
21. **Provider Barriers**
    1. Many dentists are reluctant to treat patients with HIV disease due to a lack of sufficient knowledge and training.
    2. Many dental providers do not accept Indiana Medicaid or have a waiting list for Medicaid patients.
22. **Consumer Barriers**
23. The inability to afford dental care without assistance affects the rate at which HIV-positive persons access such services.
24. Consumers report that dental hygiene is not often considered a priority due to other more urgent needs (such as shelter and food).
25. **Early Intervention Services (EIS)**
26. **System Barriers**
27. HIV prevention services are funded by a wide variety of sources and, therefore, lack consistency in implementation and in the availability of outcome data.
28. **Provider Barriers**
29. EIS sub-grantees must have the capacity to conduct testing, referral, linkage, and health education activities, a standard that limits the number of participating providers.
30. Many providers who perform HIV testing are disconnected from the formal system of care and are unaware of many of the available resources for linkage to and retention in care.
31. **Consumer Barriers**
32. Many individuals at high-risk for HIV infection delay or avoid testing due to competing needs, fear, and denial.
33. **Health Insurance Premium and Cost-Sharing Assistance**
34. **System Barriers**
35. Plans offered through the Indiana Health Insurance Marketplace are only available during short “open enrollment periods” unless the applicant can document a qualifying event.
36. Plans offered through the Indiana Health Insurance Marketplace are not available to undocumented persons.
37. The participating carriers in the Indiana Health Insurance Marketplace have been unwilling to systematically coordinate benefits with the Part B grantee or to accept more than a pre-designated percentage of HIAP enrollees.
38. **Provider Barriers**
39. The variety of plans and benefits available through the Indiana Health Insurance Marketplace is overwhelming to those attempting to assist consumers.
40. Information regarding the plans covered by HIAP (including the coverage and network limitations of each plan) is not disseminated by the Part B grantee sufficiently in advance of the annual open enrollment period.
41. **Consumer Barriers**
42. The inability to afford health insurance without assistance affects the rate at which HIV-positive persons acquire such coverage.
43. The variety of plans and benefits available through the Indiana Health Insurance Marketplace is overwhelming to consumers.
44. **Mental Health Services**
45. **System Barriers**
46. A wide disparity exists in the mental health benefits offered by plans through the Indiana Health Insurance Marketplace and on the private market.
47. The Part A grantee, due to federal guidelines, must limit its services to only outpatient mental health treatments.
48. **Provider Barriers**
    1. Some mental health providers may not be equipped to address common issues that accompany an HIV diagnosis such as status disclosure, sexuality, and chronic illness.
    2. Many facilities are operating at capacity and have waiting lists for all new patients, regardless of insurance coverage.
49. **Consumer Barriers**
50. The inability to afford mental health care without assistance affects the rate at which HIV-positive persons access such services.
51. Many consumers are reluctant to seek or sustain mental health treatment due to the stigma of such a diagnosis.
52. **Medical Case Management Services (including treatment adherence)**
53. **System Barriers**
54. The definition of and parameters for Medical Case Management services funded by Part A have not been uniformly observed by all Medical Case Management providers.
55. **Provider Barriers**
    1. Some providers may be reluctant to limit their activities to those which meet the definition of Medical Case Management.
    2. Disparities in the degree of training exist among provider related to the provision of treatment adherence counseling.
    3. Some providers may be unable to provide Medical Case Management services to consumers who are not patients at the provider’s clinic.
56. **Consumer Barriers**
57. Some consumers are reluctant to allow their various providers to communicate and share the information necessary to adequately coordinate their medical care.
58. A lack of personal readiness is often cited as a cause of non-adherence.
59. **Substance Abuse Treatment Services – Outpatient**
60. **System Barriers**
61. A wide disparity exists in the addiction treatment benefits offered by plans through the Indiana Health Insurance Marketplace and on the private market.
62. Some plans offered through the Indiana Health Insurance Marketplace and on the private market do cover common medications used to treat chemical dependency (such as Methadone).
63. The Part A grantee, due to federal guidelines for core services, must limit its services to only outpatient substance abuse treatment.
64. **Provider Barriers**
    1. Some addiction treatment providers may not be equipped to address common issues that accompany an HIV diagnosis such as sexuality and chronic illness.
    2. Many facilities are operating at capacity and are unable to serve new patients (regardless of insurance coverage) within a reasonable period of time.
65. **Consumer Barriers**
66. The inability to afford addiction treatment without assistance affects the rate at which HIV-positive persons access such services.
67. The lack of personal readiness is often cited as a reason to avoid or delay entry into substance abuse treatment.
68. For many consumers, abstinence-based programs are less attractive than those following the harm reduction model.
69. Many consumers are reluctant to seek or sustain addiction treatment due to the stigma of such a diagnosis.
70. **Case Management (non-medical)**
71. **System Barriers**
72. The definition of and parameters for Case Management (non-medical) services funded by Part A have not been uniformly or consistently enforced by the Part A grantee.
73. **Provider Barriers**
    1. Due to limited State funding, HIV Care Coordination staffing is not adequate to meet demand, with Care Coordinators regularly managing caseloads that exceed the optimal case manager-to-client ratio of 1:40.
74. **Consumer Barriers**
75. Employed consumers report long wait times for appointments at hours convenient to their work schedule.
76. **Emergency Financial Assistance (EFA)**
77. **System Barriers**
78. The Part A grantee limits its financial assistance to two categories: utilities and food.
79. Most assistance programs – including township trustees and the statewide Direct Emergency Financial Assistance program – have monetary assistance caps.
80. Some assistance programs – such as utility assistance through HOPWA – are time-limited.
81. **Provider Barriers**
    1. The available resources – from all potential sources – are not sufficient to meet the demand for assistance.
82. **Consumer Barriers**
83. Some consumers report a non-specific reluctance to seek financial assistance despite the need for such assistance.
84. **Housing Services**
85. **System Barriers**
86. An overall lack of affordable, accessible, adequate, and safe low-income housing exists in the Indianapolis TGA.
87. Most assistance programs – including rental assistance through HOPWA – are time-limited and do little to promote long-term housing solutions.
88. Many of the available housing programs impose restrictions that prevent certain populations (e.g., the previously incarcerated and individuals with substance abuse or mental health issues) from being eligible for service.
89. **Provider Barriers**
90. Many providers are operating at capacity and have a waiting list for new applicants.
91. **Consumer Barriers**
92. The inability to afford housing without assistance affects the rate at which many HIV-positive persons achieve stable housing.
93. Many marginalized groups (including women; the chemically addicted; minorities; persons with a history of incarceration; those with mental health issues, poor credit histories, or physical handicaps; gay men and women; transgendered persons; and undocumented persons) frequently report encountering discriminatory housing practices.
94. **Legal Services (including permanency planning)**
95. **System Barriers**
96. A lack of affordable legal services exists within the Indianapolis TGA.
97. **Provider Barriers**
98. The provision of HIV-related legal services is not a lucrative endeavor.
99. **Consumer Barriers**
100. The inability to afford legal services without assistance affects the rate at which HIV-positive persons access such advice.
101. Many consumers remain unaware that limited, HIV-related legal services are available in the TGA.
102. **Linguistic Services**
103. **System Barriers**
104. A lack of culturally competent, HIV-knowledgeable translation services exists within the Indianapolis TGA.
105. **Provider Barriers**
     1. Most providers do not have the capacity to translate all African dialects.
     2. Many providers do not have sufficient resources to adequately serve non-English deaf consumers.
106. **Consumer Barriers**
107. Many consumers remain unaware that translation and linguistic services are available in the TGA.
108. Cultural difference between the interpreter or provider and the patient may discourage communication and impact service quality.
109. **Medical Transportation Services**
110. **System Barriers**
111. For consumers who live outside of Marion County, there is limited or no public transit and relatively few cab companies.
112. **Provider Barriers**
     1. Many non-profit providers do not possess the resources to provide a comprehensive transportation program.
113. **Consumer Barriers**
114. The inability to afford transportation without assistance affects the rate at which HIV-positive persons access many medical and support services.
115. Where public transportation is available, it can be difficult to use for consumers with children or disabilities.
116. Transportation paid by Medicaid is contingent on coverage and availability and is limited to only approved “medically necessary” travel.
117. **Outreach Services**
118. **System Barriers**
119. A lack of awareness exists in the Indianapolis TGA regarding the differences between Part A outreach services and those funded by the CDC and the ISDH HIV Prevention Program.
120. **Provider Barriers**
     1. The identification and location of persons who are status-aware but out of care is time- and resource-intensive and is often conducted outside of traditional working hours.

1. **Consumer Barriers**
2. A lack of personal readiness may result in an individual failing to comply and benefit from outreach efforts designed to link them to care.
3. **Psychosocial Support Services (including pastoral care and counseling)**
4. **System Barriers**
5. There are currently no standard curriculum for the provision of psychosocial support services that would ensure consistency and comprehensiveness.
6. **Provider Barriers**
   1. Providers find it difficult to measure the impact of this service on participants’ overall health and well-being.
   2. Some psychosocial support service providers may not be equipped to address common issues that accompany an HIV diagnosis such as status disclosure, sexuality, and chronic illness.
   3. Some psychosocial support service providers may not be equipped to screen and refer participants to more appropriate levels of mental health care.
7. **Consumer Barriers**
8. Many consumers are reluctant to participate in psychosocial support services due to the association with mental illness.
9. Consumers familiar with the informal nature of support groups may not be attracted to more structured interventions that incorporate personal goals and objectives.
   1. **Barriers to Routine Testing**

The CDC recommends that diagnostic HIV testing and opt-out HIV screening become a part of routine clinical care in all healthcare settings. The recommendations are intended for providers in all healthcare settings, including hospital emergency departments, STD clinics or other venues offering clinical STD services, tuberculosis clinics, substance abuse treatment clinics, public health clinics, correctional healthcare facilities, and primary care settings.

The Part A grantee’s EIIHA strategy supports the CDC recommendations by planning for the targeted delivery of early intervention and risk reduction services in conjunction with other effective prevention initiatives in the TGA. It, however, does not address HIV testing in general practice where true “routine” testing must necessarily occur; this is a function of lack of authority and is not the result of prohibitive state or local legislation.

1. **Evaluation of the 2012-2015 Comprehensive Plan**

Monitoring the achievement of the Comprehensive Plan’s goals and objectives is critical for understanding which elements of the program need to be modified or improved. The responsibility for monitoring the goals and objectives is shared by the grantee and the Systems of Care Committee of Part A Planning Council.

An essential component of the monitoring process is the creation of a Progress Report by the Systems of Care Committee at the conclusion of each multi-year planning cycle. The 2012-2015 Comprehensive Plan was reviewed by the committee during the last calendar quarter of 2014, and its report was issued to the grantee in January 2015. The grantee, as well as an external consultant, participated in the review process.

* 1. **Successes**

Based on this review, the Systems of Care committee concluded that the Part A grantee, working in collaboration with its Planning Council and contracted providers, had achieved the majority (79%) of its 150 primary objectives. Some additional objectives (17%) were judged to have been only partially achieved; many of these are scheduled to be fully addressed in the next fiscal year.

* 1. **Challenges**

Only six objectives (4%) were not achieved, four of which were suggested for removal or combination with other objectives. To create the most useful document possible, the reviewers recommended that any other objectives identified as superfluous also should be removed from the slate of new goals and objectives for 2015-2017.

One of the two critical unachieved objectives called for the Part A grantee to participate in quarterly meetings with the other Ryan White grantees operating in the TGA. Typically, “All Parts” meetings have been convened by the Part B grantee. However, due to substantial personnel changes in the Part B program, no “All Parts” meeting have been convened since late 2013. To remedy this issue, the Part A grantee will begin to convene these meetings in FY2016.

The other critical unachieved objective called for the grantee to increase the availability of Oral Health Services in “non-traditional settings.” To clarify this objective, for 2015-2017, it will be revised to direct the grantee to “explore opportunities to expand the number of participating providers outside of Marion County.” It will no longer be limited to dental services but will be placed in a newly created category for “universal” service goals and objectives.

**SECTION II: WHERE DO WE NEED TO GO?**

1. **Plan To Meet Identified Challenges**

The Part A grantee was largely successful in its attempts to achieve the objectives outlined in the 2012-2015 Comprehensive Plan. To address the challenges illuminated by the two unmet objectives, the Part A grantee intends to assume the responsible for convening quarterly meetings with the other Ryan White Program grantees (Parts B, C, and F) operating in the TGA and to explore innovative ways to expand the number of participating Part A providers outside of Marion County.

1. **Proposed Care Goals**

All of the Ryan White Program grantees and providers are committed to conscientiously addressing the needs of HIV-positive persons living in the state and to improving the continuum of care. Providing the highest quality services in a cost-effective and equitable manner is a primary concern. Equally important is a commitment to serving those with the least resources, both in monetary terms and with respect to access to services.

In the TGA, the collective grantees have successfully addressed many of the identified priority service needs. However, as noted in Section I, significant barriers and limitations still exist. Part A Planning Council members have developed the following recommendations to help the grantees and their service providers address the identified barriers to care for the underserved populations and to provide better quality services. These recommendations serve as broad proposed goals for care and the delivery system. They suggest actions and activities to help the TGA realize its vision for an ideal, high quality, and comprehensive continuum of care.

* 1. **Recommendations to Address Identified Service Barriers**

The following recommendations are organized to correspond with the barriers to care described earlier and are intended to complement rather than reiterate the Service Delivery Plan Goals and Objectives in Section III.

1. **Outpatient and Ambulatory Medical Care (including laboratory tests)**
   * + 1. **System Barriers**
2. The Part A and B grantees should continue collaborations with service providers to ensure that case managers are well-trained to provide health insurance navigation services that reduce the potential for provider network restrictions to negatively impact access to the most appropriate or preferred physicians.
3. To lessen reliance on the TGA’s facility-based indigent programs for primary care, the Part A grantee should continue to expand its network of Outpatient and Ambulatory Medical Care service providers.
4. The Part A, B, and C grantees should establish complementary eligibility criteria that are as generous as possible while remaining compliant with federal guidelines.
5. The Part A and B grantees should continue collaborations with service providers to ensure that consumers are able to retain any state and federal benefits for the maximum allowable duration but are also encouraged to reduce reliance on such benefits by re-entering the workforce whenever possible.
   * + 1. **Provider Barriers**
6. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to identify additional infectious disease specialists, including those practicing outside of metropolitan areas.
7. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to adequately educate primary care and other providers regarding HIV disease symptoms, testing recommendations, and treatment guidelines.
   * + 1. **Consumer Barriers**
8. The Part A and C grantee should minimize any cost-sharing requirements for primary medical care to the extent allowed by the federal guidelines.
9. The Part A, B, and C grantees should continue collaborations with service providers to ensure access to treatment, despite barriers caused by poor health and mental illness.
10. The Part A, B, and C grantees should continue collaborations with service providers to ensure consumer access to treatment, despite barriers caused by fear or mistrust of the medical establishment.
11. The Part B grantee and its consumer committee should reinstitute its regional meetings to facilitate effective communication between providers and consumers.
12. The Part A grantee should work with its subcontractors to increase the availability of primary medical care during hours more convenient for employed consumers (e.g., early morning, evening, or weekend hours).
13. The Part A grantee should work to educate its subcontractors regarding all of the available resources in the TGA and to encourage appropriate referrals that consider the consumer’s cultural background and current insurance coverage.
14. **Local AIDS Pharmaceutical Assistance Program (LPAP)**
    * + 1. **Systems Barriers**
15. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers are well-trained to provide health insurance navigation services that reduce the potential for provider network restrictions to negatively impact access to the most appropriate or preferred pharmacies.
16. To lessen reliance on the TGA’s facility-based indigent programs for pharmaceuticals, the Part A grantee should continue to expand its network of LPAP service providers.
17. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers consistently pursue more permanent drug coverage for consumers seeking LPAP assistance to avoid unnecessary service denials.
18. The Part A, B, and C grantees should establish eligibility criteria that allow for the provision of LPAP assistance – to the extent allowed by the federal guidelines – for consumers are enrolled in Medicare Part D and experiencing a coverage gap.
19. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers consistently initiate applications for manufacturer-sponsored patient assistance programs early to minimize delays to therapy and reduce any undue burden on the consumer.
20. To lessen the potential for inmates to be released without the standard 30-day supply of medications, the Part B grantee and the HIV Care Coordination Program should continue their collaborations with IDOC to provide pre-release case management services.
    * + 1. **Provider Barriers**
    1. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to adequately educate primary care providers regarding treatment guidelines for patients who exhibit indications of substance use or mental illness.
    2. The Part A, B, and C grantees should collaborate with service providers to ensure that case managers receive periodic *Partnership for Health* refresher trainings to ensure that routine adherence messages are routinely delivered despite high client volume.
       * 1. **Consumer Barriers**
    3. The Part A grantee should minimize any cost-sharing requirements for LPAP services to the extent allowed by the federal guidelines.
    4. The Part A, B, and C grantees should continue collaborations with service providers to ensure consumer access to pharmaceuticals, despite barriers caused by poor health and mental illness.
    5. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers are well-trained to provide advice and support related to the potential adverse side effects and potential drug interactions that may prevent consumers from adhering to treatment.
21. **Oral Health Services**
22. **System Barriers**
23. The Part A grantee should assess the impact of its monetary service cap of $2500 and its prior approval policy for Oral Health Services and – if found to be frequent barriers to care – consider adjusting them.
24. The Part B grantee should assess the impact of its monetary service cap of $2000 and its dental service formulary limitations and – if found to be frequent barriers to care – consider adjusting them.
25. The Part A grantee should establish eligibility criteria that allow for the provision of dental assistance – to the extent allowed by the federal guidelines – for consumers enrolled in Indiana Medicaid but who have exhausted the annual dental benefits.
26. **Provider Barriers**
    1. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to increase the training opportunities targeted to dentists to expand the number of providers willing and qualified to serve those with HIV.
    2. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers can effectively negotiate with dental providers for the acceptance of Medicaid as payment for their clients in need.
27. **Consumer Barriers**
28. The Part A grantee should minimize any cost-sharing requirements for dental services to the extent allowed by the federal guidelines.
29. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to adequately equip providers to educate their clients and patients regarding the negative impact of poor oral hygiene on the immune system.
30. **Early Intervention Services (EIS)**
31. **System Barriers**
32. The Part A grantee should collaborate with the other funders of prevention services to develop standard operating procedures and specific service parameters to ensure consistency among all prevention providers operating within the Indianapolis TGA.
33. **Provider Barriers**
34. The Part A grantee should provide training opportunities for potential EIS sub-grantees to assist in the development of capacity to conduct all four EIS activities: testing, referral, linkage, and health education.
35. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to educate “disconnected” providers of HIV testing (such as private physicians and small rural clinics) regarding the formal system of HIV care and the resources available within the TGA.
36. **Consumer Barriers**
37. The Part A grantee should continue its efforts to target high-risk individuals in non-threatening venues where the potential for HIV testing – despite any competing needs, fear, and denial – is maximized.
38. **Health Insurance Premium and Cost-Sharing Assistance**
39. **System Barriers**
40. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers are well-trained to identify and document “qualifying events” in order to avoid any unnecessary delays caused by the enforcement of an open enrollment period by the Indiana Health Insurance Marketplace.
41. The Part A, B, and C grantees should explore partnerships with commercial insurance carriers (not associated with the Indiana Health Insurance Marketplace) to offer premium assistance to eligible individuals regardless of immigration status.
42. To regain control of the enrollment process and benefits, the Part B grantee should resume its efforts to identify commercial insurance carriers (not associated with the Indiana Health Insurance Marketplace) willing to partner with the grantee in the delivery of its HIAP service.
43. **Provider Barriers**
44. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers are well-educated regarding the variety of plans and benefits available through the Indiana Health Insurance Marketplace.
45. The Part B grantee should determine and announce the plans to be covered under HIAP at least three months prior to the annual open enrollment period.
46. **Consumer Barriers**
47. The Part A grantee should minimize any cost-sharing requirements for insurance assistance to the extent allowed by the federal guidelines.
48. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers are well-trained to properly advise and support consumers as they navigate the variety of plans and benefits available through the Indiana Health Insurance Marketplace.
49. **Mental Health Services**
50. **System Barriers**
51. To order to better standardize benefits, including those for mental health services, the Part B grantee should resume its efforts to identify commercial insurance carriers (not associated with the Indiana Health Insurance Marketplace) willing to partner with the grantee in the delivery of its HIAP service.
52. The Part A grantee should require each of its mental health service providers to maintain written referral agreements with low-cost, accessible in-patient mental health programs.
53. **Provider Barriers**
    1. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to increase the training opportunities targeted to mental health providers to expand the number who are willing and equipped to serve those with HIV.
    2. The Part A grantees should continue collaborations with the Part F grantee in an effort to expand the capacity of its funded mental health service providers.
54. **Consumer Barriers**
55. The Part A grantee should minimize any cost-sharing requirements for mental health services to the extent allowed by the federal guidelines.
56. The Part A grantees should continue collaborations with service providers to encourage the co-location of mental health services with other HIV-related service such as medical care or case management in order to alleviate any perceived stigma associated with seeking services at traditional mental health treatment facilities.
57. **Medical Case Management Services (including treatment adherence)**
58. **System Barriers**
59. The Part A, B, and C grantees should develop standard operating procedures and specific service parameters to ensure consistency among all Medical Case Management providers.
60. **Provider Barriers**
    1. The Part A grantee should develop a mechanism to ensure that agencies funded to provide Medical Case Management are not providing other similar services – such as Case Management (non-medical) – which have different reimbursement rates.
    2. The Part A, B, and C grantees should collaborate with service providers to ensure that case managers receive periodic *Partnership for Health* refresher trainings to ensure that routine adherence messages are routinely delivered in a consistent and standardized manner.
    3. The Part A grantee should continue its efforts to ensure that Medical Case Management services are available regardless of the consumer’s chosen medical provider.
61. **Consumer Barriers**
62. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers are well-trained to explain to consumers the purpose of cross-provider communications in the delivery of health care and to alleviate any perceived privacy concerns.
63. The Part A, B, and C grantees should collaborate with service providers to ensure that case managers receive periodic *Stages of Change Theory* refresher trainings to ensure that consumers are properly motivated to become adherent to therapy.
64. **Substance Abuse Treatment Services – Outpatient**
65. **System Barriers**
66. To order to better standardize benefits, including those for substance abuse treatment services, the Part B grantee should resume its efforts to identify commercial insurance carriers (not associated with the Indiana Health Insurance Marketplace) willing to partner with the grantee in the delivery of its HIAP service.
67. The Part A grantee should continue to cover common medications used to treat chemical dependency (such as Methadone) on a limited and individual basis for consumers whose insurance plan does not provide such coverage.
68. The Part A grantee should explore the possibility of expanding its substance abuse treatment programming to include residential treatment which is an allowable support service.
69. **Provider Barriers**
    1. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to increase the training opportunities targeted to addiction treatment providers to expand the number who are willing and equipped to serve those with HIV.
    2. The Part A grantees should continue collaborations with the Part F grantee in an effort to expand the capacity of its funded substance abuse treatment providers.
70. **Consumer Barriers**
71. The Part A grantee should minimize any cost-sharing requirements for addiction treatment services to the extent allowed by the federal guidelines.
72. The Part A, B, and C grantees should collaborate with service providers to ensure that case managers receive periodic *Stages of Change Theory* refresher trainings to ensure that consumers are properly motivated to seek substance abuse treatment services.
73. The Part A grantee should expand its network of Substance Abuse Treatment Service providers to include a range of treatment philosophies including abstinence and harm reduction.
74. The Part A grantees should continue collaborations with service providers to encourage the co-location of substance abuse treatment services with other HIV-related service such as medical care or case management in order to alleviate any perceived stigma associated with seeking services at traditional treatment facilities.
75. **Case Management (non-medical)**
76. **System Barriers**
77. To ensure consistency and avoid confusion with the Medical Case Management service category, the Part A, B, and C grantees should collaborate to ensure that the standards for Case Management (non-medical) services remain consistent with the HIV Care Coordination Program policies and procedures.
78. **Provider Barriers**
79. The Part B grantee should request additional State funds and should continue to utilize all available Part B supplemental funds to augment the staffing of its HIV Care Coordination Program and, thereby, alleviate some of the caseload burden.
80. **Consumer Barriers**
81. The Part A grantee should work with its subcontractors to increase the availability of case management services during hours more convenient for employed consumers (e.g., early morning, evening, or weekend hours).
82. **Emergency Financial Assistance (EFA)**
83. **System Barriers**
84. The Part A grantee should explore the feasibility of expanding EFA to additional categories (beyond utilities and food) within the federal guidelines.
85. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers regularly advocate for their clients with the local utility providers to facilitate access to budget billing programs before seeking aid from programs with low monetary assistance caps (such as those offered by township trustees and the statewide Direct Emergency Financial Assistance program).
86. To lessen reliance on the existing time-limited utility assistance programs, the Part A and B grantees should continue collaborations with service providers to locate other agencies that can provide additional utility assistance for low-income individuals.
87. **Provider Barriers**
88. The Part A grantee should continue to encourage the involvement of providers and consumers in fund-raising efforts (such as the Indianapolis AIDS Walk) that result in additional funds becoming available to address emergency financial needs.
89. **Consumer Barriers**
90. The Part A, B, and C grantees should continue collaborations with service providers to ensure consumer access to emergency financial assistance, despite barriers caused by any perceived stigma or reason for reluctance.
91. **Housing Services**
92. **System Barriers**
93. To address the overall lack of affordable, accessible, adequate, and safe low-income housing in the Indianapolis TGA, the collective grantees should support and assist the Indiana Housing and Community Development Authority in its efforts to implement the recommendations described in the Indiana HIV/AIDS Housing Plan.
94. To lessen reliance on time-limited housing assistance programs, the Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers include budget management in the care plans for low-income clients and promote program like the Social Security Administration’s *Ticket to Work* that transition consumers to employment without the loss of benefits or entitlements.
95. The Part A, B, and C grantees should continue collaborations with service providers as they research ways to improve access to adequate housing assistance for marginalized populations such as the mentally ill, substance users, those without citizenship status, and ex-offenders and to improve access to “appropriate” housing for the disabled and women with children.
96. **Provider Barriers**
97. The Part A, B, and C grantees should continue to collaborations with service providers to ensure that case managers are well connected with their local public housing providers and are able to efficiently navigate those systems.
98. **Consumer Barriers**
    1. The Part A grantee should minimize any cost-sharing requirements for housing services to the extent allowed by the federal guidelines.
    2. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers can effectively advocate for their clients with providers who may otherwise be reluctant to provide housing to marginalized populations (such as women; the chemically addicted; minorities; persons with a history of incarceration; those with mental health issues, poor credit histories, or physical handicaps; gay men and women; transgendered persons; and undocumented persons).
99. **Legal Services (including permanency planning)**
100. **System Barriers**
101. The Part A grantee should develop a formal relationship with the American Civil Liberties Union of Indiana to facilitate assistance for consumers seeking advice or remedies related to matters that are not within the scope of Part A legal services.
102. **Provider Barriers**
103. The Part A grantee should assess the extent to which its reimbursements are commensurate with industry standards and – if the rates are found to be a frequent barrier – consider adjusting them.
104. **Consumer Barriers**
     1. The Part A grantee should minimize any cost-sharing requirements for legal services to the extent allowed by the federal guidelines.
     2. The Part A, B, and C grantees should continue collaborations with service providers to ensure consumer access to legal assistance, despite barriers caused by any initial lack of awareness of the availability of such services.
105. **Linguistic Services**
106. **System Barriers**
107. The Part A grantee should continue to cultivate its internal resources to address translation requests in a culturally competent and HIV-knowledgeable manner.
108. **Provider Barriers**
     1. The Part A grantee should assess the degree to which its internal resources are able to translate African dialects and – if unable to translate the most frequently requested dialects – consider securing additional resources to address the gap.
     2. The Part A grantee should ensure that funds are available to assist non-English deaf consumers.
109. **Consumer Barriers**
110. The Part A, B, and C grantees should continue collaborations with service providers to ensure consumer access to translation services, despite barriers caused by any initial lack of awareness of the availability of such services.
111. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers are well-trained to encourage communication between their non-English-speaking consumers and other service providers through the use of interpreters (including those who may not share the consumer’s cultural background) and, thereby, minimize any negative impact on service quality caused by the language barrier.
112. **Medical Transportation Services**
113. **System Barriers**
114. To address the lack of public transportation outside of Marion County, the Part A grantee should continue to cultivate relationships with commercial providers who are willing to accept the Indiana Medicaid reimbursement rate for services, as required by the federal guidelines.
115. **Provider Barriers**
116. To address the lack of adequate non-profit transportation providers, the Part A grantee should continue to cultivate relationships with commercial providers who are willing to accept the Indiana Medicaid reimbursement rate for services, as required by the federal guidelines.
117. **Consumer Barriers**
     1. The Part A grantee should minimize any cost-sharing requirements for medical transportation services to the extent allowed by the federal guidelines.
     2. To address the difficulties presented by public transportation for consumers with children or disabilities, the Part A grantee should continue to cultivate relationships with commercial providers who are willing to accept the Indiana Medicaid reimbursement rate for services, as required by the federal guidelines.
     3. The Part A, B, and C grantees should continue collaborations with service providers to locate low-cost transportation options (other than public transit) for essential travel that may not qualify as “medically necessary” (e.g., travel to work).
118. **Outreach Services**
119. **System Barriers**
120. The Part A grantee should collaborate with the other funders of outreach services to develop standard operating procedures and specific service parameters to ensure consistency among all outreach providers operating within the Indianapolis TGA.
121. **Provider Barriers**
122. The Part A grantee should assess the extent to which its reimbursements are adequate given the time and effort involved in locating out-of-care consumers (an activity often performed outside of traditional working hours) and – if the rates are found to be a frequent barrier – consider adjusting them.
123. **Consumer Barriers**
124. The Part A, B, and C grantees should collaborate with service providers to ensure that outreach providers receive periodic *Stages of Change Theory* refresher trainings to ensure that the individuals who they encounter are properly motivated to enter and remain in care.
125. **Psychosocial Support Services (including pastoral care and counseling)**
126. **System Barriers**
127. The Part A grantee should develop a standard curriculum, operating procedures, and specific service parameters to ensure consistency among all psychosocial support providers operating within the Indianapolis TGA.
128. **Provider Barriers**
     1. The Part A grantee should develop a standardized tool to assist in measuring the impact of this service on participants’ overall health and well-being.
     2. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to increase the training opportunities targeted to psychosocial support providers to expand the number who are willing and equipped to serve those with HIV.
     3. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to increase the training opportunities targeted to psychosocial support providers to expand the number who are trained to screen and refer participants to more appropriate levels of mental health care when indicated.
129. **Consumer Barriers**
130. The Part A, B, and C grantees should continue collaborations with service providers to ensure consumer access to psychosocial support services, despite barriers caused by any perceived association with mental illness.
131. The Part A, B, and C grantees should continue collaborations with service providers to ensure that case managers are well-trained to explain the benefits of structured psychosocial support services to consumers who are more attracted to less formal interventions such as support groups.
     1. **Recommendations to Address Identified Barriers to Routine Testing**

As noted earlier, the Part A grantee’s EIIHA strategy does not address HIV testing in general practice where true “routine” testing must necessarily occur. This is simply a function of lack of authority and is not the result of prohibitive state or local legislation. However, it should continue to support the CDC’s recommendations for routine HIV testing by planning for the delivery of early intervention and risk reduction services in conjunction with other effective prevention initiatives in the TGA.

The grantee’s early HIV intervention services are described in detail in earlier sections. Its risk reduction service is a component of its larger MAI program. Designated as an HE/RR program by HRSA, this component provides individual education and promotes health literacy related to HIV disease transmission. Its primary goal is to reduce the risk of transmission among minorities and the currently or formerly incarcerated. HE/RR activities are designed to promote behavior change through the use of regular behavioral self-appraisals.

1. **Unmet Need Goals for Status-Aware Individuals**

The barriers facing status-aware HIV-positive persons who are out of care are not necessarily unique. Many infected persons experience poverty, mental health concerns, and lack of transportation. The need for health insurance, primary care, and oral health services is also common. However, those who delay or avoid entry into care appear to have less awareness of services generally. They also frequently express concerns regarding confidentiality, stigmatization, and embarrassment about HIV status.

* 1. **Unmet Need Targets**

In addressing the unmet need population, the Planning Council has recommended that the Part A grantee focus its identification and engagement efforts on two primary groups of status-aware individuals: those who were once in care but have disengaged and recently diagnosed persons who fail to access care within six months of diagnosis.

* 1. **Identification and Engagement Goals**

Part A Planning Council members have developed the following recommendations to help the grantee ensure that all HIV-positive persons in the TGA have access to its continuum of care. These recommendations serve as broad proposed goals for the identification and engagement of the unmet need population. They suggest actions and activities to help the TGA realize its vision for an ideal, high quality, and comprehensive continuum of care. The following recommendations are intended to complement rather than reiterate any of the Unmet Need Goals and Objectives in Section III.

1. The MAI program and Part A Outreach providers should partner with case management agencies and other providers (such as substance abuse treatment providers, post-incarceration release centers, and consumer advocates) in a systematic and coordinated manner in an effort to locate the target population and support their transition into the system of care.
2. In collaboration with the HIV Surveillance Program, the HIV Care Coordination Program, and the IDOC, the MAI program should continue to support efforts to connect recently released individuals to the system of care.
3. The MAI program should continue to provide intensive, motivational support services designed to identify and remedy any barriers to care.
4. The MAI program and Part A Outreach providers should partner with case management agencies and other providers (such as medical facilities) in a systematic and coordinated manner in an effort to facilitate the referrals into care.
5. **EIIHA Goals for Status-Unaware Individuals**

The barriers facing status-unaware individuals are not dissimilar to those facing status-aware persons who fail to engage in the system of care. Both groups may experience poverty, mental health concerns, and lack of transportation. The status-unaware may also hold concerns regarding confidentiality and feel stigmatized or embarrassed about behaviors that have placed them at risk for HIV. Denial is also common theme among those who delay testing.

To address the nearly 900 HIV-positive TGA residents who estimated to be status-unaware, the Part A grantee intends to continue implementation of its EIIHA strategy (described in Section III) which necessitates adequate funding of its EIS and Outreach services using Part B funds, adequate funding of its HE/RR and Communities Liaison services using MAI funds,[[61]](#footnote-61) and the continuation of strong partnerships with the HIV Prevention Program at ISDH and other providers of prevention and outreach services.

* 1. **EIIHA Targets**

In addressing the unaware population, the Planning Council has recommended that the Part A grantee focus its identification and engagement efforts on two primary groups of individuals: members of populations that experience a disproportionate disease burden (such as Black persons and gay men) and persons who frequent locations known to attract high-risk populations (such as emergency rooms and GLBT bars).

* 1. **Identification and Engagement Goals**

Part A Planning Council members have developed the following recommendations to help the grantee ensure that all HIV-positive persons in the TGA become aware of their status and seek appropriate medical care. These recommendations serve as broad proposed goals for the identification and engagement of the unaware population. They suggest actions and activities to help the TGA realize its vision for an ideal, high quality, and comprehensive continuum of care. The following recommendations are intended to complement rather than reiterate any of the EIIHA Goals and Objectives in Section III.

1. EIS providers should partner with other testing programs in a systematic and coordinated manner in an effort to locate the target population and support their transition into the system of care.
2. EIS providers should continue efforts to test persons as early as possible, minimizing concurrent HIV and AIDS diagnoses.
3. EIS providers should partner with case management agencies and other providers (such as medical facilities) in a systematic and coordinated manner in an effort to facilitate the referrals into care.
4. EIS providers should partner with agencies offering counseling and support to high-risk HIV-negative persons in a systematic and coordinated manner in an effort to prevent future infections.
5. **Proposed Solutions To Close Care Gaps**

In the TGA, the Part A grantee has defined two kinds of gaps in care. The first, co-morbidities, relates to other disease states affecting the individual that prevent optimal HIV treatment outcomes. Common co-morbidities include TB, Hepatitis C, other STDS, mental illness, and addiction. The second type of gap, societal issues, relates to larger community-wide problems and limitations in the continuum of care itself. Common societal issues include poverty and homelessness, former incarceration, and geographic isolation.

Part A Planning Council members have developed the following recommendations to help the grantee ensure that all HIV-positive persons have access to care despite any gaps that may exist. These recommendations serve as broad proposed goals for reducing disparities and increasing access to care. They suggest actions and activities to help the TGA realize its vision for an ideal, high quality, and comprehensive continuum of care. The following recommendations are intended to complement rather than reiterate any of the Service Delivery Plan Goals and Objectives in Section III.

1. **Co-Morbidities**

As noted earlier, the term “co-morbidity” is used to describe the presence of one or more additional disorders (or diseases) co-occurring with a primary disease or disorder. The additional disorder may be a medical, behavioral, or mental disorder.

1. **Tuberculosis**

To address the significant incidence of TB among HIV-positive persons in the Indianapolis TGA, the Part A grantee should continue its early identification and engagement efforts, ensure that TB treatments remains available through its Outpatient and Ambulatory Medical Care service component, and encourage retention in care through proper training of its case management providers.

1. **Hepatitis C**

To address the incidence of Hepatitis C among HIV-positive persons in the ITGA, the Part A grantee should continue its early identification and engagement efforts, ensure that Hepatitis C treatments remains available through the Part B grantee’s HIAP component, continue to explore the possibility of adding such treatments to its formulary, and encourage retention in care through proper training of its case management providers.

1. **Other Sexually Transmitted Diseases**

To address the incidence of common STDs among HIV-positive persons in the Indianapolis TGA, the Part A grantee should continue its partnerships with prevention programs, STD clinics, and disease intervention services operating within the Indianapolis TGA.

1. **Mental Illness**

To address the incidence of mental illness among HIV-positive persons in the Indianapolis TGA, the Part A grantee should continue to ensure than case management providers screen enrollees for mental health concerns every six months (beginning at enrollment) and refer as appropriate; mental health service providers perform an exhaustive psychological assessment prior to initiating treatment and every six months thereafter; mental health service providers refer participants for in-patient services when appropriate; and psychosocial support providers regularly screen and refer participants to more appropriate levels of mental health care when indicated.

1. **Addiction**

To address the incidence of addiction among HIV-positive persons in the Indianapolis TGA, the Part A grantee should continue to ensure that case management providers screen enrollees for substance abuse issues every six months (beginning at enrollment) and refer as appropriate; substance abuse treatment providers perform an exhaustive addiction assessment prior to initiating treatment and every six months thereafter; and treatment providers refer participants for in-patient services when appropriate.

1. **Societal Issues**

As noted earlier, in the TGA, the term “societal issues” is used to describe larger community-wide problems and limitations in the continuum of care itself that ultimately affect an individual’s potential to realize positive health outcomes.

1. **Poverty and Homelessness**

To address the impact of poverty and homelessness on HIV-positive persons in the Indianapolis TGA, the Part A grantee should continue its engagement efforts, allocate adequate funds to its EFA and housing assistance service components, and ensure that its case management providers include budget management in the care plans of low-income clients and those with unstable housing.

1. **Former Incarceration**

To address the impact of incarceration on HIV-positive persons in the Indianapolis TGA, the Part A, B, and C grantees should continue their relationships with IDOC to provide pre-release case management services in the prison setting and to facilitate post-release integration of the inmate into the local continuum of HIV care (using both case management and HE/RR program resources).

1. **Geographic Isolation**

To address the impact of geographic isolation on HIV-positive persons in the Indianapolis TGA, the Part A grantee should continue to allocate adequate funds for medical transportation services, focusing attention on providers who are able to service areas outside of Marion County; supplement the Part B grantee’s HIAP service component to ensure health insurance coverage for those TGA residents living in less urban areas; and collaborate with the Part F grantee to identify and provide training and support to willing service providers located in the outlying counties.

The Part A Planning Council recognizes that societal impediments to care are not limited to the categories noted above. Other commonly noted issues include barriers related to language for non-English speakers, physical disabilities, and illiteracy. Moreover, for those trying to overcome such issues, the feeling of hopelessness that often results from difficult or failed attempts to access the service continuum can, itself, become a barrier to care.

1. **Proposed Solutions To Address Care Overlaps**

Part A Planning Council members have developed the following recommendations to help the grantee avoid any unnecessary overlaps in the provision of HIV care within the Indianapolis TGA. These recommendations serve as broad proposed goals for the Part A grantees planning efforts. They suggest actions and activities to help the TGA realize its vision for an ideal, high quality, and comprehensive continuum of care. The following recommendations are intended to complement – but may also reiterate – the Service Delivery Plan Goals and Objectives in Section III.

* 1. **Ryan White Program Grantees**

The RWSP is supported by multiple funding streams which have been combined to create a comprehensive program to serve the Indianapolis TGA. These streams include Part A, Part C, and MAI funds awarded by HRSA. The RWSP also maintains are exceptionally strong partnership with the Part B grantee and its TGA residents enjoy many of the benefits afforded by Part B programming.

1. **All Parts**

To prevent care overlaps, the Part A grantee should continue to plan and implement its services in coordination with all of the Ryan White Program grantees serving the TGA (including Part F) and participate in the quarterly “All Parts” meetings established to ensure uniformity of services, consistency of eligibility requirements, and avoidance of any service duplication.

* 1. **Planning Council**

Each year the Priorities and Allocations Committee of the Part A Planning Council is tasked with prioritizing the service categories assessed to be most valuable to HIV-positive persons living in the TGA. The committee is provided with detailed epidemiological information, service utilization details, and needs assessment results by the Part A grantee to aid in the decision-making process.

1. **Priorities and Allocations Committee**

To further prevent duplication of services, the Part A grantee should continue to annually present to the Priorities and Allocations Committee information regarding the availability of other public funding for HIV services within the TGA and allow the committee to reduce or eliminate funding for any prioritized service if other adequate funding is available

1. **Proposed Coordinating Efforts**

Part A Planning Council members have developed the following recommendations to help the grantee ensure systematic and thorough coordination with other funders and service providers across the continuum of care in the Indianapolis TGA. These recommendations serve as broad proposed goals for the Part A grantees coordinating efforts. They suggest actions and activities to help the TGA realize its vision for an ideal, high quality, and comprehensive continuum of care. The following recommendations are intended to complement rather than reiterate any of the Service Delivery Plan Goals and Objectives in Section III; however, a description of the activities necessary implement these recommendations does appear separately in that section.

* 1. **Part B and ADAP**

ISDH is the Part B grantee and provides the state’s ADAP benefits as a precursor to comprehensive health insurance coverage through the HIAP component of its HIV Medical Services Program. Neither ADAP nor the HIV Services Program at large has implemented a waiting list in several years.

1. If a waiting list for ADAP or the HIV Medical Services Program at large is implemented, the Part A grantee should reallocate its funds to minimize the impact of such a list on those seeking services.
2. The Part A, B, and C grantee should continue to exchange enrollment, recertification, utilization, and other data necessary for the successful coordination of care to the extent allowed by law.
3. The Part A, B, and C grantees should continue to participate in the quarterly “All Parts” meetings (mentioned above) to ensure uniformity of services, consistency of eligibility requirements, and avoidance of any service duplication.
   1. **Part C**

MCPHD has received Part C funding from HRSA since 1991. The RWSP has since fully integrated Part C programming into its service delivery system. Part C funds are currently used to supplement EIS activities (by providing HIV counseling and testing) and Outpatient and Ambulatory Medical Care services (for newly diagnosed individuals).

1. The RWSP should continue to use Part C funds to supplement EIS activities by providing HIV counseling, testing, and referral services.
2. The RWSP should continue to use Part C funds to supplement Outpatient and Ambulatory Medical Care services for newly diagnosed individuals.
   1. **Part D**

Indiana is not a Part D funding recipient.

* 1. **Part F**

Indiana is not a direct recipient of Part F funding. Indiana is served by the Midwest AIDS Training and Education Center (MATEC) which is located at the University of Illinois at Chicago. MATEC has a local performance site in Indiana housed within Eskenazi Health Services, a division of the Health and Hospital Corporation of Marion County. The site is known as MATEC Indiana.

1. The Part A, B, and C grantees should continue to ensure that the Part F grantee (i.e., MATEC) is represented on their respective planning councils.
2. The Part A grantee should continue to support the Part F grantee in its efforts to locate and educate providers of HIV-related services in the less urban portions of the TGA.
   1. **Non-Ryan White Private Providers**

The Part A grantee developed its current service inventory[[62]](#footnote-62) to describe the key providers in the TGA for each priority service area. These entities or programs were identified by Part A Planning Council members and other partners from throughout the TGA based on direct and – in most cases – extensive experience with the noted providers, making the inventory an invaluable directory of “HIV-friendly” resources. Known as the *Indianapolis Transitional Grant Area Provider Resource Guide*, the inventory includes a wide variety of non-Ryan White private providers.

1. The Part A grantee should continue to ensure that the *Provider Resource Guide* is updated at least once every three years and that it accurately reflects the services offered by non-Ryan White private providers.
2. The Part A grantee should continue to ensure than non-Ryan White private providers are invited to participate on the Part A Planning Council.
   1. **Prevention Programs**

The Part A grantee’s EIIHA strategy appears in Section III. It is reliant on a wide variety of collaborations including an essential partnership with the HIV Prevention Program at ISDH. The following recommendations represent a *selection* of the EIIHA strategy’s coordinating efforts, including those related to partner notification and “prevention with positives” initiatives.

1. The Part A grantee should continue to partner with Disease Intervention Service programs which deliver results to those who fail to return, offers partner notification and linkage to care services for those with positive results, and provide risk reduction education and linkage to prevention services for those with negative results.
2. The Part A grantee should continue to partner with agencies providing Disease Intervention Services to encourage co-location agreements with Counseling and Testing programs to facilitate partner notification and partner testing services.
3. As a low-cost but highly effective “prevention with positives” initiative, the Part A and B grantees should continue to partner with the HIV Care Coordination Program to ensure that all case managers consistently implement the modified *Partnership for Health* intervention with their active client population.
4. For general planning purposes, the Part A grantee should continue to exchange local and statewide epidemiological information (i.e., HIV incidence and prevalence data) with the HIV Prevention Program and the Office of Clinical Data and Research at ISDH.
5. To the planning of engagement and re-engagement efforts, the Part A grantee should continue to exchange data (including testing volume, positivity rates, and failure rates for result delivery) with the HIV Prevention Program and its contractors.
6. The Part A grantee should continue to partner with city hospital emergency departments and other agencies that provide services tailored to vulnerable and at-risk populations to encourage universal HIV screening.
7. The Part A grantee should continue to partner with agencies utilizing peer-based outreach models to facilitate identification, screening, and linkage to care.
8. The Part A grantee should continue to partner with the CTR program at Marion County Substance Use and Outreach Services Program which serves high-risk and under-served populations including intravenous drug users and minority women.
9. The Part A grantee should continue to partner with CTR programs serving high-risk and under-served populations, including non-English speakers and undocumented persons.
10. The Part A grantee should continue to partner with CTR program which also offer pre-natal services (including first and third trimester HIV testing), screening for syphilis and other STDs, and referrals to trusted medical services for those who test HIV-positive.
11. The Part A grantee should continue to partner with other CTR programs which provide routine testing to individuals who are self-referred, named as partners of HIV-positive persons, or participating in HE/RR activities.
12. The Part A grantee should continue to partner with agencies that provide rapid HIV testing and have been trained to coordinate monitored referrals for case management and medical care as appropriate.
13. The Part A grantee should continue to partner with proven outreach programs that target high-risk populations and have demonstrated experience serving Black persons, Hispanics, GLBT youth, the homeless, the mentally ill, and chemically dependent persons.
    1. **Substance Abuse Treatment Programs**

Partnerships with substance abuse treatment providers are essential to the Part A grantee’s efforts to reduce barriers to care, encourage retention, and promote positive health outcomes.

1. The Part A grantee should continue to partner with the programs that provide client-centered substance abuse treatment services.
2. The Part A grantee should continue to maintain memoranda of understanding with and to utilize the substance abuse treatment services of additional agencies on a fee-for-service basis when contracted resources are not available.
   1. **STD Programs and HIV Surveillance**

The need for partnerships with STD programs and HIV surveillance programs is not dissimilar to the need for partnerships with prevention programs generally.

1. For general planning purposes, the Part A grantee should continue to exchange epidemiological information (i.e., HIV incidence and prevalence data) information with the internal Marion County HIV/AIDS Surveillance Program.
2. To assist in re-engagement linkage efforts, the Part A grantee should continue to exchange laboratory data (including CD4 and viral load test dates and results) with the internal Marion County HIV/AIDS Surveillance Program.
3. The Part A grantee should continue to partner with the Bell Flower Clinic and STD programs which promote concurrent HIV testing and have the resources to conduct partner notification and linkage to care services for those with positive results and to provide risk reduction education and linkage to prevention services for those with negative results.
   1. **Medicare**

When an enrollee reaches the age of 65, eligibility for the Part B grantee’s HIAP service component ends, and the enrollee is transitioned to the MDAP component which coordinates coverage with a variety of participating providers under the Medicare Part D prescription drug plan. It pays for the deductibles, co-insurance, and co-payments for charges allowed by the approved Part D plan. MDAP coverage is dependent on Part D enrollment and is not available to those under 65 years of age. MDAP does not pay for the Part D plan premiums; these are the responsibility of the enrollee. All MDAP costs are covered by the Part B grantee, and no associated costs are assigned to Part A under the premium-payment agreement (which is exclusive to the HIAP benefit).

1. The Part A grantee should continue to partner and exchange relevant data with the Part B grantee to ensure that the transition from HIAP to MDAP does not adversely impact the consumer’s ability to access Part A services.
2. The Part A and B grantees should develop standardized materials to distribute to enrollees in common (enrolled in both RWSP and MDAP) explaining that RWSP funds cannot to used to pay any portion of a charge covered in whole or in part by Medicare.
   1. **Medicaid**

Consumers seeking medical coverage or insurance assistance must demonstrate ineligibility for any other insurance or publicly funded care programs such as Medicaid and its Healthy Indiana Plan. Program recertification interviews are conducted every six months by the assigned HIV Care Coordinators at which time health care coverage documentation is collected from all active participants and submitted to the grantee. As a matter of due diligence, the Part A grantee also verifies Medicaid eligibility status for a 90-day period following the dispensation of any services paid by Ryan White funds. If eligibility is confirmed within that period, subrogation processes are initiated, and mechanisms are in place to report recovered funds in aggregate on the grantee’s fiscal reports. Consumers with Medicaid coverage may remain Part A enrollees but will be eligible for only those services which their Medicaid does not cover.

1. The Part A grantee should continue to partner with the Office of Medicaid Policy and Planning in order to maintain access to *Web interChange*, the electronic eligibility database for Indiana Medicaid.
2. The Part A grantee should continue to ensure that Medicaid enrollees are ineligible for Part A Outpatient and Ambulatory Medical Care and LPAP services but remain eligible for other RWSP services which are not covered by Medicaid.
   1. **Children’s Health Insurance Programs**

The Part A grantees does not maintain a separate formal relationship with the Indiana Children’s Health Insurance Program (CHIP). In Indiana, CHIP is a component of the Medicaid program called Hoosier Healthwise.

* 1. **Community Health Centers**

The Part A grantee does not maintain a formal relationship with the Office of Rural Health at ISDH which is responsible for the state’s community health centers. It does, however, frequently partner with health centers to deliver early intervention and other services as noted in the preceding sections.

**SECTION III: HOW WILL WE GET THERE?**

In order attain an improved system of care, achievement of specific Administrative, Universal Service, Core Service Delivery, and Support Service Delivery goals and objectives will be necessary. The goals and objectives for 2015-2017 were developed by the Part A Planning Council and its Systems of Care Committee with assistance from the Part A grantee and an external consultant. They were designed and will be implemented in compliance with the National Monitoring Standards and the Part A Planning Council’s Standards of Care.

The complete *Ryan White Services Program:**Part A Goals and Objectives* appears in Appendix 3.

1. **Closing Care Gaps**

In the TGA, the Part A grantee has defined two kinds of gaps in care: co-morbidities and societal issues. Many elements of the 2012-2015 goals and objectives that appear in the *Ryan White Services Program:**Part A Goals and Objectives* address these two gaps in a broad manner. However, additionally, the Part A grantee has developed these additional strategies designed to impact co-morbidities and societal issues specifically.

1. **Co-Morbidities**

In order to minimize the incidence or impact of tuberculosis, Hepatitis C, other STDs, mental illness, and addiction on HIV-positive persons living in the Indianapolis TGA, the Part A grantee intends to incorporate the following meta-strategy into its programming design.

1. **Strategy**

The Part A grantee will identify and connect to the appropriate resources the greatest number of members living with the most prevalent co-morbid conditions (i.e., tuberculosis, Hepatitis C, other STDs, mental illness, and addiction) by conducting thorough and routine screenings and assessments for such conditions.

1. **Plan**

This strategy is implemented through collaborations using the care team approach. The key collaborators are the funded medical, mental health, and substance abuse providers; the local and State disease intervention programs; the HIV Care Coordination Program and – by extension – the Medical Case Management and Case Management (non-medical) providers; and the consumers.

To execute this strategy, the various case management providers conduct comprehensive assessment interviews at intake and at regular intervals thereafter to identify persons who appear to be living with the key co-morbid conditions.

Using this assessment information, the case management providers develop an individualized care plan (ICP) for each member. Once an ICP has been created and reviewed with the consumer, the case management provider develops an ad hoc care team to manage the identified co-morbid conditions. Members of the care team may include medical, mental health, and substance abuse professionals; pharmacists; disease intervention specialists; other case managers; linkage specialists; support staff; peers; and the member.

Throughout the process, the case management provider encourages the member’s engagement and maintenance in the care specifically prescribed to address the co-morbid conditions by providing monitored referrals; by conducting frequent case conferences with the other members of the ad hoc care team; and by diligently working to eliminate any barriers identified in the member’s ICP.

1. **Activities**

To implement this plan, the completion of the following activities is necessary.

* 1. The HIV Care Coordination Program staff and, by extension, the Medical Case Management and Case Management (non-medical) providers will be well-trained in conducting assessments for the identified co-morbid conditions.
  2. The various case management providers will establish formal data sharing agreements with the potential members of the ad hoc care teams.
  3. Once established, the case management providers will coordinate and document the major activities of the care team, including case conferences.
  4. Based on the comprehensive assessment, the case management provider will refer the member to one or more of the providers on the care team. The referral will be monitored to successful completion, which may involve several further interactions with the member and the care team to ensure that the member presents and participates in the care process. A referral monitored in this manner is considered a “gold standard” referral.
  5. The case management providers will remain in frequent contact with the member to ensure engagement and maintenance in care and successful completion of the ICP.

1. **Timeline**

The activities described above are currently occurring or will begin in early 2015. Applicable activities will be completed by 28 February 2017 which is the end of the planning period. However, with renewed funding, the activities described will continue for as long as they remain applicable and are approved by the Ryan White Part A Planning Council.

1. **Societal Issues**

In order to minimize the impact of poverty and homelessness, former incarceration, and geographic isolation, the Part A grantee intends to incorporate the following meta-strategy into its programming design.

1. **Strategy**

The Part A grantee will identify and connect to the appropriate resources the greatest number of members impacted by the most disruptive societal issues (i.e., poverty and homelessness, former incarceration, and geographic isolation) by conducting thorough and routine assessments for such issues.

1. **Plan**

This strategy is also implemented through collaborations using the care team approach. The key collaborators are the funded providers of emergency assistance, housing, re-entry, and transportation services; the HIV Care Coordination Program and, by extension, the Medical Case Management and Case Management (non-medical) providers; and the consumers.

To execute this strategy, the various case management providers conduct comprehensive assessment interviews at intake and at regular intervals thereafter to identify persons who appear to be impacted by these common societal issues.

Using this assessment information, the case management providers develop an ICP for each member. Once an ICP has been created and reviewed with the consumer, the case management provider develops an ad hoc care team to manage the identified co-morbid conditions. Members of the care team may include providers of emergency assistance, housing, re-entry, and transportation services; budget planning experts; job coaches; other case managers; linkage specialists; support staff; peers; and the member.

Throughout the process, the case management provider encourages the member’s engagement and maintenance in the intervention specifically prescribed to address the relevant societal issues by providing monitored referrals; by conducting frequent case conferences with the other members of the ad hoc care team; and by diligently working to eliminate any barriers identified in the member’s ICP.

1. **Activities**

To implement this plan, the completion of the following activities is necessary.

1. The HIV Care Coordination Program staff and, by extension, the Medical Case Management and Case Management (non-medical) providers will be well-trained in conducting assessments for the identified societal issues.
2. The various case management providers will establish formal data sharing agreements with the potential members of the ad hoc care teams.
3. Once established, the case management providers will coordinate and document the major activities of the care team, including case conferences.
4. Based on the comprehensive assessment, the case management provider will refer the member to one or more of the providers on the care team. The referral will be monitored to successful completion, which may involve several further interactions with the member and the care team to ensure that the member presents and participates in the care process. A referral monitored in this manner is considered a “gold standard” referral.
5. The case management providers will remain in frequent contact with the member to ensure engagement and maintenance in care and successful completion of the ICP.
6. **Timeline**

The activities described above are currently occurring or will begin in early 2015. Applicable activities will be completed by 28 February 2017 which is the end of the planning period. However, with renewed funding, the activities described will continue for as long as they remain applicable and are approved by the Ryan White Part A Planning Council.

1. **Addressing the Status-Aware**

Many elements of the 2012-2015 goals and objectives that appear in the *Ryan White Services Program:**Part A Goals and Objectives* (see Appendix 3) address the unmet need population. However, additionally, the Part A grantee has developed the following activities designed to impact those who are aware of their HIV-positive status but are not currently receiving HIV care and treatment.

1. **Strategy**

The Part A grantee will identify and connect to care the greatest number of members of the unmet need population by utilizing information from the members’ most recent care provider or testing site to locate and contact the member directly.

1. **Plan**

This strategy is implemented through collaborations. The key collaborators are the counseling testing providers, the local and State surveillance programs, the HIV Care Coordination Program and, by extension, the Medical Case Management and Case Management (non-medical) providers.

To execute this strategy, the MAI program and the Part A Outreach providers use two primary sources of information to identify persons who appear to belong to the unmet need population: surveillance reports of known HIV-positive persons who have no indication of CD4 or viral load testing within the prior 12 months; and case management reports of clients who have been unable to be located for a period for 12 months or longer.

Using these reports, the MAI program and the Part A Outreach providers seeks additional locating information from the providers known to have last interacted with the member. These providers will most commonly be case managers or HIV testing counselors but may also include medical personnel.

Once sufficient location information has been secured, the MAI Community Liaison and the Part A Outreach providers attempt to contact the member directly. If successful, the MAI Community Liaison or Part A Outreach provider encourages the member to engage (or re-engage) in care by providing a monitored referral to one of the HIV Care Coordination agencies where further assessments and referrals (for medical and other appropriate services) will be completed.

1. **Activities**

To implement this plan, the completion of the following activities is necessary.

1. The MAI Liaison and all contracted Part Outreach providers will be well-trained in public health investigation techniques.
2. The MAI Liaison and all contracted Part Outreach providers will establish formal data sharing agreements with the agencies representing the three sources of unmet need member data and establish a schedule for the receipt of such data.
3. Upon receipt, the MAI Liaison and all contracted Part Outreach providers will work in collaboration with the Part A grantee to analyze the unmet need member data.
4. The MAI Liaison and all contracted Part Outreach providers will establish formal data sharing agreements with the agencies representing the two primary sources of locating information for the unmet need member and will establish a routine and schedule for eliciting such information.
5. The MAI Liaison and all contracted Part Outreach providers will utilize proven public health investigation techniques to locate the identified unmet need members.
6. Upon discovery, the MAI Liaison or contracted Part Outreach provider will refer the unmet need member to one of the local HIV Care Coordination agencies. The referral will be monitored to successful completion, which may involve several further interactions with the member and the HIV Care Coordination agency to ensure that the member was presents and participates in the case management process. A referral monitored in this manner is considered a “gold standard” referral. Once the member enrolls in HIV Care Coordination, a comprehensive assessment will be completed and the appropriate referrals (also gold standard) will be provided for medical care and other services.
7. If a successful referral cannot be confirmed within 30 days, the MAI Liaison or contracted Part Outreach provider will repeat the location and referral process.
8. **Timeline**

The activities described above are currently occurring or will begin in early 2015. Applicable activities will be completed by 28 February 2017 which is the end of the planning period. However, with renewed funding, the activities described will continue for as long as they remain applicable and are approved by the Ryan White Part A Planning Council.

1. **Addressing the Status-Unaware**

Many elements of the 2012-2015 goals and objectives that appear in the *Ryan White Services Program:**Part A Goals and Objectives* (see Appendix 3) address the status-unaware population. However, additionally, the Part A grantee has developed the following activities designed to impact those who are not yet aware of their HIV-positive status. Together, these activities represent a high-level summary of the Part A grantee’s detailed *Early Identification of Individuals with HIV/AIDS Strategy.* Complementing the National HIV/AIDS Strategy, successful implementation of this EIIHA strategy will result in a reduction of the number of new HIV infections and improved access to care.

In the TGA, the estimated number of living HIV-positive individuals who were unaware of their status as of 31 December 2013 can be calculated as “(**p**/1-**p**) x **N**” where **p** equals the national proportion of undiagnosed HIV cases (14%), and **N** equals the number of individuals living with HIV as of 31 December 2013 (5351). The calculation for the Indianapolis TGA is: (.14/.86) x 5351 = **871.** This number is referred to as the EIIHA population estimate.

1. **Strategy**

The Part A grantee will identify and connect to care the greatest number of members of the EIIHA population by utilizing surveillance data, epidemiological statistics, and partner information to target persons most likely to be infected and testing them.

1. **Plan**

This strategy is implemented through collaborations. The key collaborators are the counseling testing providers, the Disease Intervention Specialists, the local and State surveillance programs, the HIV Care Coordination Program and, by extension, the Medical Case Management and Case Management (non-medical) providers.

To execute this strategy, the Part A EIS providers use two sources of information to identify persons who appear to belong to the EIIHA population: *eHARS* surveillance reports indicating geographic area of highest recent incidence and most prevalent risk characteristics; and Disease Intervention reports of persons who have tested HIV-positive but who were unable to be located and have been unaware of their results for more than six months.

Using the surveillance reports, the EIS providers coordinate their field testing activities with other counseling and testing providers in the identified high-risk geographic area. Using the Disease Invention reports, they seek additional locating information from the providers known to have last interacted with the member. These providers will most commonly be HIV testing counselors but may also include medical personnel.

Once a coordinated testing logistics have been arranged with the other area counseling and testing providers (and the gatekeepers for the venue, as applicable), the EIS provider begins systematic testing operations, pre-screen potential subjects, and testing those indicating the highest levels of risk based on the available epidemiological data. If a new case discovered, the EIS provider conducts the standard post-test counseling and encourages the member to engage in care by providing a monitored, gold standard referral to one of the HIV Care Coordination agencies where further assessments and referrals (for medical and other appropriate services) will be completed. (If available, the services of a linkage specialist may be utilized to facilitate the referral.)

Concurrently, once sufficient locating information has been secured for persons identified on the Disease Invention reports, EIS providers attempt to contact the EIIHA member directly. If successful, the EIS provider encourages the member to engage in care by providing a monitored, gold standard referral to one of the HIV Care Coordination agencies where further assessments and referrals (for medical and other appropriate services) will be completed.

1. **Activities**

To implement this plan, the completion of the following activities is necessary.

1. The EIS providers will be well-trained in approved Counseling, Testing, and Referral procedures.
2. The EIS providers will be prepared to share data with the agencies representing the two sources of EIIHA member data and establish a schedule for the receipt of such data.
3. Upon receipt, EIS providers will work in collaboration with the Part A grantee to analyze the EIIHA member data.
4. The EIS providers will be prepared to work with the other counseling and testing providers in the identified high-risk geographic areas (and with the gatekeepers for targeted venues, as applicable).
5. The EIS providers will follow standard Counseling, Testing, and Referral procedures to approach potential test subjects in the field, screen them for risk, and perform HIV testing for those indicating the highest levels of risk.
6. Upon discovery of a new HIV-positive case, the EIS provider will conduct the standard post-test counseling and refer the EIIHA member to one of the local HIV Care Coordination agencies. The referral will be monitored to successful completion, which may involve several further interactions with the member and the HIV Care Coordination agency to ensure that the member was presents and participates in the case management process. A referral monitored in this manner is considered a “gold standard” referral. Once the member enrolls in HIV Care Coordination, a comprehensive assessment will be completed and the appropriate referrals (also gold standard) will be provided for medical care and other services.
7. The EIS providers will also be prepared to share data with the agencies representing the primary sources of locating information and establish a routine and schedule for eliciting such information.
8. The EIS providers will utilize proven public health investigation techniques to locate the identified individuals.
9. Upon discovery, the EIS provider will deliver the test results, offer post-test counseling, and refer the individual to one of the local HIV Care Coordination agencies. The referral will be monitored to successful completion, which may involve several further interactions with the member and the HIV Care Coordination agency to ensure that the individual presents and participates in the case management process. Once the member enrolls in HIV Care Coordination, a comprehensive assessment will be completed and the appropriate referrals (also gold standard) will be provided for medical care and other services.
10. If a successful referral cannot be confirmed within 30 days, the EIS provider will repeat the location and referral process.
11. **Timeline**

The activities described above are currently occurring and are planned to continue. Applicable activities will be completed by 28 February 2017 which is the end of the planning period. However, with renewed funding, the activities described will continue for as long as they remain applicable and are approved by the Ryan White Part A Planning Council.

1. **Addressing Special Populations**

To promote parity as the TGA’s 16 services are planned and implemented, the Part A grantee specifically considers the unique needs of the TGA’s populations of special interest: Black persons, women of childbearing age, immigrants, and young adults. These are groups that, in the grantee’s assessment, bear a disproportionate disease burden or face unique challenges to accessing and remaining engaged in care.

These populations do not correspond completely with the special populations identified by HRSA: adolescents, the homeless, transgendered persons, and injection drug users. Therefore, the Part A grantee has developed the following activities designed to ensure that these populations are not excluded or marginalized as Part A programming is planned and implemented in the Indianapolis TGA.

1. **Strategy**

The Part A grantee will offers services and interventions that consider the special needs of adolescents, the homeless, transgendered persons, and injection drug users.

1. **Plan**

To execute this strategy, the Part A grantee will provide surveillance data and needs assessment results related to these populations to the Priorities and Allocations Committee of its Planning Council. The committee will be directed to specifically consider the needs of adolescents, the homeless, transgendered persons, and injection drug users as it prioritizes services and recommends allocations. The committee will prioritize services, allocate funds, and provide directives to the grant that have thoughtfully considered the impact of such decisions of these special populations.

1. **Activities**

To implement this plan, the completion of the following activities is necessary.

1. The Part A grants will gather relevant surveillance data from the Marion County HIV/AIDS Surveillance Program that focuses on the four special populations as they relate to HIV incidence.
2. The Part A grants will gather from scholarly sources relevant needs assessment information that focuses on the four special populations as they relate to HIV disease.
3. The Part A grantee will present the surveillance and needs assessment data to the Priorities and Allocations Committee in writing prior to its deliberations.
4. The Part A grantee will present a synopsis of the same information orally during their first Planning Council meeting in which priorities and allocations are to be considered.
5. The committee will consider the information during their deliberations and will issue a statement to accompany their formal written prioritization and allocation recommendations to the Part A grantee which summarizes the impact that the data review had on the final outcome of the recommendations.
6. The Part A grantee will adopt the recommendations upon approval from the Planning Council at large.
7. **Timeline**

The activities described above are currently occurring and are planned to continue. Applicable activities will be completed by 28 February 2017 which is the end of the planning period. However, with renewed funding, the activities described will continue for as long as they remain applicable and are approved by the Ryan White Part A Planning Council.

1. **Activities to Implement Coordinating Efforts**

Many elements of the 2012-2015 goals and objectives that appear in the *Ryan White Services Program:**Part A Goals and Objectives* (see Appendix 3) address the grantee’s efforts to coordinate services. However, additionally, the Part A grantee has developed the following activities designed to illuminate some of those activities.

1. **Part B and ADAP**

The Part A and B grantees will communicate frequently, meet in person no less frequently than quarterly, and agree to coordinate their respective programs in a manner that is transparent and beneficial to consumers.

1. **Part C**

The Part A and C grantees will continue to combine their respective resources, coordinate their service components, and market their programs jointly as the RWSP.

1. **Part D**

Indiana is not a Part D funding recipient.

1. **Part F**

The Part A and F grantees will communicate frequently, meet in person no less frequently than quarterly, and agree to coordinate their respective trainings in a manner that is complementary and consistent with one another.

1. **Non-Ryan White Private Providers**

The Part A grant will develop specific opportunities for non-Ryan White Providers to become educated regarding Part A services and the HIV continuum of care.

1. **Prevention Programs**

The Part A grantee will support prevention efforts by endorsing the continued use of EIS and Outreach funds to target the EIIHA and unmet need populations, respectively, with high quality and proven prevention activities, including those related to partner notification and “prevention with positives” initiatives.

1. **Substance Abuse Treatment Programs**

The Part A and B grantees will develop a common tool to be used by its case managers to ensure the consistency of the substance abuse screening process.

1. **STD Programs and HIV Surveillance**

The Part A grantee will renew its data sharing agreements with applicable STD and Surveillance programs to facilitate the exchange of information necessary to plan and evaluate services.

1. **Medicare**

The Part A grantee will continue to support the Part B grantee’s operation of the MDAP service component.

1. **Medicaid**

The Part A grantee will renew its data sharing agreements with OMPP to facilitate the exchange of information necessary to conduct enrollment and eligibility processes.

1. **Children’s Health Insurance Programs**

The Part A grantees does not maintain a separate formal relationship with the Indiana Children’s Health Insurance Program (CHIP). In Indiana, CHIP is a component of the Medicaid program called Hoosier Healthwise.

1. **Community Health Centers**

The Part A grantee does not maintain a formal relationship with the Office of Rural Health at ISDH which is responsible for the state’s community health centers. It does, however, frequently partner with health centers to deliver early intervention and other services as noted in the preceding sections.

1. **Health People 2020**

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

1. **Statewide Coordinated Statement of Need**

Indiana’s Comprehensive Plan – which is prepared by the Part B grantee at ISDH – fully incorporates the SCSN (as Section 1, Part 1). As a general statement of the needs of persons living with HIV in the state, the SCSN seeks to describe the epidemiological trends, service history, needs assessments, priority service areas, gaps in and barriers to care for the affected population, unmet need estimates, unaware of status estimates, and prevention collaborations occurring in the state.

The goals and objectives contained in the plan presented here for the Indianapolis TGA are in complete concurrence with the current SCSN which was last revised in 2013. No subsequent revision has been issued by (and no further requests for updated information have been received from) the Part B grantee.

1. **Affordable Care Act**

While the passage of the Affordable Care Act in mid-2010 has made healthcare more accessible for millions of Americans, its enactment has created some challenges. As a result of the Act, Indiana’s existing high-risk insurance pool ceased operations in 2014. The high-risk pool had been the foundation upon which the Part B grantee’s HIAP service component had been built. Replacing the risk pool, Indiana created its Health Insurance Marketplace. While the risk pool was limited to one carrier, and HIAP benefits were limited to one plan, the coverage was comprehensive, equitable, and constant.

The same is not true for coverage secured through the Marketplace. The consumer’s degree of choice as expanded exponentially and, consequently, the Part B grantee’s ability to ensure equal coverage for all HIAP enrollees has dissipated. Consumers can choose from multiple plans offered by multiple carriers, each with its own benefits, limitations, deductibles, and coverage area. Complicating matters, the carriers are not consistent from year to year which has resulted in mass policy terminations and re-enrollments. Unlike the relationship that ISDH enjoyed with the risk pool, coordinating enrollment with the Marketplace carriers has been a disjointed, inefficient, and contentious process. Intervention by the Indiana Department of Insurance did not improved matters.

From the perspective of the Part A grantee, the course of action has been and will be to continue to provide Outpatient and Ambulatory Medical Care, LPAP, and other core services to those HIAP enrollees who are negatively impacted by the transition until such time as comprehensive coverage is restored. The Part A grantee remains committed to working closely with its Part B counterpart to overcome these challenges and, to that point, intends to assume the responsibility of convening the quarterly “All Parts” meetings to ensure that they occur despite the complete turnover of the entire Part B program staff since early 2014 when the Marketplace was launched.

1. **National HIV/AIDS Strategy**

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

1. **Reducing New HIV Infections**

As described herein, the Part A grantee seeks to prevent new infections through its partnerships with HIV prevention providers and its targeted EIS testing initiatives. It strives to develop and maintain community-level collaborations that integrate HIV prevention and care services in order to address the barriers that prevent individuals from learning their HIV status.

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

The HIV Care Coordination Program was established to achieve the goal of increasing access to care and, thereby, improving the health outcomes of those living with HIV disease. Current protocols are in place to encourage a seamless linkage from the point of testing to continuous and coordinated quality care for those found to be infected with HIV. The program offers long-term assistance that is designed to support HIV-positive people who have with co-occurring health conditions and those who have challenges meeting their basic needs. The Part A grantee’s case management, EIS, Outreach, and MAI Community Liaison programs support, augment, and substantially improve the rates of success along this continuum.

1. **Reducing HIV-Related Disparities and Health Inequities**

By locating case management services in regions throughout the TGA and state and by offering insurance-based medical care, the Part A, B, and C grantees have been able to overcome a number of barriers related to patient demographics and geographic location. In a 2012 analysis of the lifespan of HIV-positive Hoosiers, it was found that those enrolled in the continuum’s care and service programs live 93% longer on average than those who are not connected to these programs. The analysis also showed that enrollees living in rural areas achieved better results than those living in urban areas, demonstrating that Part A and B programs provide a leveling effect that impacts the disparity between access to care in rural and urban parts of the state.

1. **Achieving a More Coordinated National Response to the HIV Epidemic**

While national influence is unlikely, the Part A grant strives to assist in the efficient coordination of the state’s response to the epidemic by participating in opportunities for all Ryan White grantees, funded and non-funded service providers, other local and State agencies, and consumers to work together to coordinate guidelines, service components, and target populations so that redundancy is minimal and impact on affected communities is maximized. The Part A and B advisory bodies – as well as the routine “All Parts” meetings – provide such opportunities and have played a critical role in helping the state and region achieve their goals, provide care and services to an unprecedented number of consumers, avoid a waiting list for HIV drugs, and prepare for future challenges.

1. **Budgetary Concerns**

Since its inception in 2007, the Indianapolis TGA has not experienced a decrease in its annual Part A and MAI funding. However, contingency plans have been developed by the Part A Planning Council to reduce or eliminate funding for services based on their rank of prioritization. Service categories with fewer recipients, less direct impact on health outcomes, or other potential resources would be candidates for reduction or elimination. The imposition of greater cost sharing by enrollees is also a possibility, though it has not been endorsed by the Planning Council to date.

In addition to such contingency plans, the Part A grantee closely monitors service utilization, sub-grantee expenses, and enrollee outcomes to ensure that financial resources are used as efficiently as possible and achieve the desired health improvements for the target population. To this end, the grantee has consistently increased allocations for highly effective services such as Outpatient and Ambulatory Medical Care, Medical Case Management, Case Management (non-medical), and EIS over the past several years and has decreased allocations to areas such as Linguistic Services where the value has been less tangible.

**SECTION IV: HOW WILL WE MONITOR PROGRESS?**

1. **Progress Monitoring**

Using the National Monitoring Standards as its guide, the Part A grantee continually monitors its various contracts through the use of site visits, programmatic audits, and utilization analyses. Each of these is performed at least annually. In addition, Part A claim reviews are conducted on a monthly basis, and service provision reports are analyzed quarterly to determine compliance with quantitative guidelines.

Specifically monitoring the achievement of the Comprehensive Plan’s goals and objectives is critical for understanding which elements of the program need to be modified or improved. The responsibility for monitoring the goals and objectives is shared by the grantee and the Systems of Care Committee of Part A Planning Council. An essential component of the monitoring process is the creation of a Progress Report by the Systems of Care Committee at the conclusion of each multi-year planning cycle. The 2012-2015 Comprehensive Plan was reviewed by the committee during the last calendar quarter of 2014, and its report was issued to the grantee in January 2015. The grantee, as well as an external consultant, participated in the review process.

Based on this review, the Systems of Care committee concluded that the Part A grantee, working in collaboration with its Planning Council and contracted providers, had achieved the majority (79%) of its 150 primary objectives. Some additional objectives (17%) were judged to have been only partially achieved; many of these are scheduled to be fully addressed in the next fiscal year. Only six objectives (4%) were not achieved, four of which were suggested for removal or combination with other objectives. To create the most useful document possible, the reviewers recommended that any other objectives identified as superfluous also should be removed from the slate of new goals and objectives for 2015-2017.

1. **Impact of the EIIHA Initiative**

To better understand and address the population of people with HIV who do not yet know their status, the Part A grantee created its first EIIHA population estimate and strategy in 2010. The current strategy is detailed in Section III and focuses on early disease detection for those who are HIV positive but status-unaware, connecting to care those who are HIV positive but not in care, improving overall access to care, and referring those who test HIV-negative to HIV prevention and HE/RR programs in accordance with the National HIV/AIDS Strategy and HIV Continuum of Care Initiative. To date, the grantee’s EIIHA strategy has been highly effective in helping high-risk individuals remain negative (thereby reducing the number of new infections), as well as in decreasing the number of people who are status-unaware. Further, implementation of the strategy has helped to optimize health outcomes through improved access to care, reduce health disparities, and strengthen the continuum of care in general.

EIIHA services are delivered through a collaborative partnership between the Ryan White Part A, B, and C grantees, the MAI program, HIV and STD prevention programs, key stakeholders, medical and support services providers, and other community leaders. Together, these entities address areas of unmet need, identify hard to reach populations at high-risk for HIV infection, and develop strategies, activities, and programs to increase HIV testing, early detection, and entry into and retention in care. Specifically EIIHA funds are used in the provision of targeted HIV testing and counseling; referral services; linkage to care activities; and health education and literacy training to enable clients to navigate the HIV system of care.

Since 2010, the RWSP has relied on epidemiological and service utilization data, as well as its own Unmet Need and EIIHA estimates, to formulate and monitor the EIIHA plan. Aided by the strategic funding efforts in the 2015 EIIHA plan, the RWSP has made significant progress towards its goals for early HIV identification and enhanced entry into care. For example, of the 61 individuals identified as positive through EIS programming, 49 (80.3%) were diagnosed with HIV rather than AIDS (implying early detection), and 46 of the 61 cases (75.5%) entered care within 90 days of diagnosis. In all, 113 individuals entered or re-engaged with care in FY2014, and 231 consumers enrolled and accessed Ryan White services for the first time. Some of the strategic funding decisions that led to these successes included the utilization of Part C funds to enhance counseling testing and referral programs, MAI funds to improve HE/RR and outreach services, and Part A funds to increase funding for EIS and outreach programming.

1. **Improved Use of Client-Level Data**

All RWSP sub-grantees, as a condition of award, must record service provision data at the client-level. This data is managed using various data systems including CAREWare, RISE, and *eHARS;* CAREWare has served as the primary data management system for most sub-grantees since October 2009. The Part A grantee extracts data from CAREWare to monitor adherence to the HIV/AIDS Bureau (HAB) performance measures and to identify areas in need of clinical quality improvement. RISE is a database that was designed for internal use by the Part A grantee; it is used to track enrollment, service utilization, and retention in care at an individual-level. Lastly *eHARS* is the statewide surveillance system that is used to monitor and track HIV incidence, prevalence, risk factors, and demographics. The Part A grantee’s Quality Management (QM) program relies on *eHARS* to establish system-wide quality improvement goals and identify high-risk populations.

1. **Use of Data to Monitor Service Utilization**

The utilization data entered into CAREWare is monitored no less frequently than monthly by the Part A grantee. Together with claims data, this information is used to adjust service category allocations and amend contract as needed over the course of the fiscal period in order to address demand. Re-allocations from one service category to another require the approval of the Part A Planning Council if greater than 5%. However, even lesser re-allocations are reviewed with the Planning Council for transparency and to elicit feedback regarding the possible causes for the increased demand in one area compared to the decreased demand in another.

1. **Measurement of Clinical Outcomes**

The goal of the QM program is to improve access to quality medical and supportive services for HIV-positive persons in the Indianapolis TGA. To achieve this goal, the QM program continuously monitors and evaluates quality and access to care. It participates in cross-disciplinary collaboration with epidemiologists, consumers, and HIV care providers to identify high-risk, high-priority patient populations; determine causal links between core and supportive services and client-level outcomes; determine service areas in need of improvement; and ensure that the RWSP provider network in the TGA functions in a seamless manner and improves the HIV continuum of care.

QM program monitors clinical performance measures on a quarterly basis to ensure that RWSP providers adhere to evidence-based practice guidelines and persons with HIV in the TGA receive high quality care. Since 2008, the Group 1 HAB performance measures have been used as a framework for monitoring quality of HIV care and for measuring client-level health outcomes. The QM program uses quantitative data obtained from service utilization, HIV surveillance databases, and electronic health records to evaluate clinical measures such as progression from HIV to AIDS; stage of HIV infection at initial diagnosis; maternal to child transmission; retention in HIV care; and HIV mortality rate. Additional HAB measures have been incorporated since 2008, including several in 2012.

The QM program works in collaboration with the RWSP Epidemiologist to obtain statistics on the number of clients who presented with AIDS at first diagnosis or who progressed to AIDS within 12 months of the initial diagnosis; the number of perinatally acquired HIV-infections; the percentage of clients retained in care at the end of the grant year; and the number of deaths within five years of an HIV/AIDS diagnosis. These data serve as a baseline measure for monitoring the long-range impact of the provision and utilization of comprehensive care on health outcomes. Expected short-term impacts include improved access to care as a result of supportive services such as transportation assistance; increased knowledge of HIV; increased utilization of support services; a reduced number of patients who are inactive or that have disengaged from care; and improved access to appropriate antiretroviral treatment.

Annually, the QM program compiles the information from the quality reviews and issues its Clinical Quality Management Report which is presented to the Planning Council and serves as an additional source of information to be utilized in the process of planning, prioritizing, and implementing quality HIV services in the Indianapolis TGA.

The program also maintains a QM plan which provides an infrastructure for ensuring quality of care and parity in access to care. It outlines a strategy for addressing the major client-level health concerns for HIV-positive persons and meeting the national and local HIV-related quality goals and indicators. The plan contains five major goals: contains five broad goals: to increase early HIV disease detection; to improve entry into and retention in care; to improve access of recommended levels of care; to assure the provision of quality core medical and supportive services; and to maintain a comprehensive QM plan. Client-level objectives address HAB measures related to medical visits, antiretroviral therapy, opportunistic prophylactic treatment, CD4 counts, and therapy for pregnant women. Systems-level objectives include the percentage of persons who present with HIV (but not AIDS) at initial diagnosis and the percentage of persons retained in care. These objectives serve as indicators used to measure progress towards improved health outcomes, reduction in health disparities, linkage to and retention in care, and other major goals outlined by national policy makers in directives such as the National HIV/AIDS Strategy, the National Monitoring Standards, and Healthy People 2020.

Additionally, the QM plan includes performance measures that address all of the core and supportive services. To ensure consistency between the QM program goals and the “crosswalk” released by HAB on 11 June 2015, the services that most directly support improved health outcomes provide the framework for the grantee’s QM program. To monitor progress towards implementing the five stages in the HIV care continuum, seven unique performance measures have been adopted. These measures expand across the 15 funded service categories. Performance outcomes provide quantifiable evidence that can be used to evaluate the quality of care in the TGA and identify improvement opportunities that will support attainment of the goals outlined in the National HIV/AIDS Strategy.

*This page has been left blank intentionally.***CONCLUSION**

The Indianapolis Transitional Grant Area Comprehensive Plan for FY2015-2017 provides a thorough description of the service delivery system for HIV care funded through Part A of the Ryan White Program and other state and federal programs. It highlights the collaborations that the Part A grantee has established with other HIV-related programs in the region to maintain a cohesive continuum of care. It also provides a description of the needs of persons living with HIV in the state and summarizes the perceived barriers to meeting those needs. The plan recommends a number of actions designed to overcome the identified barriers and summarizes the goals and objectives intended to address each priority service need.

**Limitations**

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

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

**Future Plans**

On 19 June 2015, HRSA issued a joint statement with the Centers for Disease Control and Prevention (CDC) announcing their guidance for a new *Integrated HIV Prevention and Care Plan*. This new plan is to be created collaboratively by the Part A, B, C, and F grantees, and its content is to pertain to the five full calendar years of 2017-2021. The integrated plan will be due to HRSA and the CDC on 30 September 2016.

Relevant sections of this document may be updated in 2016 to create a subsequent revision reflecting current trends and developments. However, thereafter, it is expected that the Indianapolis Transitional Grant Area Comprehensive Plan will be subsumed by Indiana’s *Integrated HIV Prevention and Care Plan* for 2017-2021.

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**APPENDIX 1. EPIDEMIOLOGICAL INFORMATION**

**TABLE A. HIV DISEASE PREVALENCE[[63]](#footnote-63)**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Prevalence**  **As of 12/31/13** | **% pop[[64]](#footnote-64) (2013)** | **HIV** | | | **AIDS** | | | **Combined** | | | |
| **#** | **%** | **Δ[[65]](#footnote-65)** | **#** | **%** | **Δ** | **#** | **%** | **Δ** | **Rate[[66]](#footnote-66)** |
| **Gender** |  |  |  |  |  |  |  |  |  |  |  |
| Male | 48.8 | 2010 | 79.3 | 0.2 | 2335 | 82.9 | -0.3 | 4345 | 81.2 | -0.1 | 488.6 |
| Female | 51.2 | 524 | 20.7 | -0.2 | 482 | 17.1 | 0.3 | 1006 | 18.8 | 0.1 | 107.8 |
| Total | 100 | 2534 | 100 | 0.0 | 2817 | 100 | 0.0 | 5351 | 100 | 0.0 |  |
| **Race** |  |  |  |  |  |  |  |  |  |  |  |
| White | 73.5 | 1125 | 44.4 | -3.0 | 1305 | 46.3 | -1.6 | 2430 | 45.4 | -2.3 | 181.3 |
| Black | 15.2 | 1112 | 43.9 | 2.1 | 1168 | 41.5 | 1.2 | 2280 | 42.6 | 1.6 | 821.1 |
| Hispanic | 6.5 | 168 | 6.6 | 0.8 | 212 | 7.5 | 0.2 | 380 | 7.1 | 0.5 | 322.5 |
| Asian/Pacific | 2.7 | 58 | 2.3 | 0.0 | 45 | 1.6 | 0.2 | 103 | 1.9 | 0.1 | 213.8 |
| Other | 2.1 | 71 | 2.8 | 0.1 | 87 | 3.1 | 0.0 | 158 | 3.0 | 0.1 | 420.9 |
| Total | 100 | 2534 | 100 | 0.0 | 2817 | 100 | 0.0 | 5351 | 100 | 0.0 |  |
| **Age[[67]](#footnote-67)** |  |  |  |  |  |  |  |  |  |  |  |
| <15 | 21.4 | 34 | 1.3 | -1.2 | 47 | 1.7 | -4.1 | 81 | 1.5 | -2.8 | 20.8 |
| 15-24 | 13.1 | 194 | 7.7 | 4.0 | 47 | 1.7 | 0.6 | 241 | 4.5 | 2.2 | 101.0 |
| 25-34 | 14.3 | 598 | 23.6 | 2.2 | 266 | 9.4 | 2.1 | 864 | 16.2 | 2.3 | 331.1 |
| 35-44 | 13.6 | 609 | 24.0 | -0.8 | 644 | 22.9 | 0.9 | 1253 | 23.4 | 0.2 | 505.8 |
| 45-54 | 14.1 | 718 | 28.3 | -2.9 | 1109 | 39.4 | 0.5 | 1827 | 34.1 | -1.2 | 710.2 |
| 55-64 | 11.8 | 305 | 12.1 | -0.9 | 565 | 20.0 | 0.0 | 870 | 16.3 | -0.5 | 405.7 |
| 65+ | 11.7 | 76 | 3.0 | -0.4 | 139 | 4.9 | 0.0 | 215 | 4.0 | -0.2 | 100.8 |
| Total | 100 | 2534 | 100 | 0.0 | 2817 | 100 | 0.0 | 5351 | 100 | 0.0 |  |
| **Risk** |  |  |  |  |  |  |  |  |  |  |  |
| MSM | -- | 1500 | 59.2 | 0.6 | 1592 | 56.5 | -0.2 | 3092 | 57.8 | 0.2 | 169.6 |
| IDU[[68]](#footnote-68) | -- | 212 | 8.4 | -0.6 | 365 | 13.0 | -0.8 | 577 | 10.8 | -0.8 | 31.6 |
| Heterosexual | -- | 460 | 18.2 | 0.0 | 546 | 19.4 | 0.7 | 1006 | 18.8 | 0.4 | 55.2 |
| Perinatal | -- | 29 | 1.1 | 0.1 | 29 | 1.0 | 0.0 | 58 | 1.1 | 0.0 | 3.2 |
| Other/No Risk | -- | 333 | 13.1 | 0.0 | 285 | 10.1 | 0.3 | 618 | 11.5 | 0.2 | 33.9 |
| Total | -- | 2534 | 100 | 0.0 | 2817 | 100 | 0.0 | 5351 | 100 | 0.0 |  |
| **County** |  |  |  |  |  |  |  |  |  |  |  |
| Boone | 3.3 | 18 | 0.7 | -0.1 | 22 | 0.8 | 0.0 | 40 | 0.7 | -0.1 | 66.1 |
| Brown | 0.9 | 11 | 0.4 | 0.0 | 11 | 0.4 | 0.0 | 22 | 0.4 | 0.0 | 146.1 |
| Hamilton | 16.3 | 109 | 4.3 | 0.0 | 118 | 4.2 | 0.2 | 227 | 4.2 | 0.1 | 76.5 |
| Hancock | 3.9 | 22 | 0.9 | 0.1 | 36 | 1.3 | 0.0 | 58 | 1.1 | 0.0 | 81.6 |
| Hendricks | 8.4 | 61 | 2.4 | 0.0 | 82 | 2.9 | 0.1 | 143 | 2.7 | 0.1 | 93.1 |
| Johnson | 8.0 | 64 | 2.5 | 0.0 | 73 | 2.6 | -0.1 | 137 | 2.6 | 0.0 | 94.0 |
| Marion | 50.9 | 2215 | 87.4 | 0.0 | 2418 | 85.8 | -0.1 | 4633 | 86.6 | 0.0 | 499.1 |
| Morgan | 3.8 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Putnam | 2.1 | 25 | 1.0 | 0.0 | 38 | 1.3 | 0.0 | 63 | 1.2 | 0.0 | 167.9 |
| Shelby | 2.4 | 9 | 0.4 | 0.0 | 19 | 0.7 | -0.1 | 28 | 0.5 | -0.1 | 62.9 |
| Total | 100 | 2534 | 100 | 0.0 | 2817 | 100 | 0.0 | 5351 | 100 | 0.0 |  |

**TABLE B. NEW CASE REPORTS BY CALENDAR YEAR 2011-2013**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **New Cases by Year** | **HIV** | | **AIDS** | | **Total Disease** | |
| **#** | **Total Δ%[[69]](#footnote-69)** | **#** | **Total Δ%** | **#** | **Total Δ%** |
| **2011** | 161 | -- | 58 | -- | 219 | -- |
| **2012** | 179 | 11.2 | 39 | -32.8 | 218 | 0.0 |
| **2013** | 174 | -2.8 | 49 | 25.6 | 223 | 2.3 |

**TABLE C. HIV DISEASE INCIDENCE[[70]](#footnote-70)**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Incidence**  **CY 2013** | **% pop[[71]](#footnote-71) (2013)** | **HIV** | | | **AIDS[[72]](#footnote-72)** | | | **Combined** | | | |
| **#** | **%** | **Δ** | **#** | **%** | **Δ** | **#** | **%** | **Δ** | **Rate[[73]](#footnote-73)** |
| **Gender** |  |  |  |  |  |  |  |  |  |  |  |
| Male | 48.8 | 137 | 78.7 | 1.7 | 37 | 75.5 | -9.0 | 174 | 78.0 | -1.0 | 19.6 |
| Female | 51.2 | 37 | 21.3 | -1.7 | 12 | 24.4 | 9.0 | 49 | 22.0 | 1.0 | 5.2 |
| Total | 100 | 174 | 100 | 0.0 | 49 | 100 | 0.0 | 223 | 100 | 0.0 |  |
| **Race** |  |  |  |  |  |  |  |  |  |  |  |
| White | 73.5 | 43 | 24.7 | -13.9 | 13 | 26.5 | -18.3 | 56 | 25.1 | -14.6 | 4.2 |
| Black | 15.2 | 103 | 59.2 | 8.9 | 29 | 59.2 | 19.5 | 132 | 59.2 | 11.7 | 47.5 |
| Hispanic | 6.5 | 20 | 11.5 | 3.4 | 5 | 10.2 | -0.1 | 25 | 11.2 | 2.5 | 21.2 |
| Asian/Pacific | 2.7 | <5 | 1.2 | -1.3 | <5 | 4.1 | 2.4 | <5 | 1.8 | -0.5 | 8.3 |
| Other | 2.1 | 6 | 3.4 | 2.2 | <5 | 0.0 | -3.5 | 6 | 2.7 | 0.9 | 16.0 |
| Total | 100 | 174 | 100 | 0.0 | 49 | 100 | 0.0 | 223 | 100 | 0.0 |  |
| **Age[[74]](#footnote-74)** |  |  |  |  |  |  |  |  |  |  |  |
| <15 | 21.4 | <5 | 0.6 | 0.6 | <5 | 0.0 | 0.0 | <5 | 0.5 | 0.4 | 0.3 |
| 15-24 | 13.1 | 64 | 36.8 | 7.0 | 7 | 14.3 | 3.9 | 71 | 31.8 | 7.2 | 29.7 |
| 25-34 | 14.3 | 60 | 34.5 | 0.9 | 10 | 20.4 | -8.9 | 70 | 31.4 | -1.0 | 26.8 |
| 35-44 | 13.6 | 26 | 14.9 | -7.4 | 13 | 26.5 | 0.7 | 39 | 17.5 | -5.8 | 15.7 |
| 45-54 | 14.1 | 19 | 10.9 | 0.4 | 12 | 24.5 | -1.4 | 31 | 13.9 | -0.7 | 12.1 |
| 55-64 | 11.8 | <5 | 1.7 | -0.8 | 6 | 12.3 | 5.4 | 9 | 4.0 | 0.4 | 4.2 |
| 65+ | 11.7 | <5 | 0.6 | -0.7 | <5 | 2.0 | 0.3 | <5 | 0.9 | -0.5 | 0.9 |
| Total | 100 | 174 | 100 | 0.0 | 49 | 100 | 0.0 | 223 | 100 | 0.0 |  |
| **Risk** |  |  |  |  |  |  |  |  |  |  |  |
| MSM | -- | 105 | 60.3 | 5.7 | 22 | 44.9 | -6.8 | 127 | 57.0 | 3.1 | 7.0 |
| IDU[[75]](#footnote-75) | -- | 10 | 5.8 | 0.8 | <5 | 4.1 | -2.8 | 12 | 5.4 | -0.1 | 0.7 |
| Heterosexual | -- | 35 | 20.1 | -0.4 | 15 | 30.6 | 11.6 | 50 | 22.4 | 2.3 | 2.7 |
| Perinatal | -- | <5 | 0.6 | 0.6 | <5 | 0.0 | 0.0 | <5 | 0.4 | 0.4 | 0.1 |
| Other/No Risk | -- | 23 | 13.2 | -6.7 | 10 | 20.4 | -2.0 | 33 | 14.8 | -5.7 | 1.8 |
| Total | -- | 174 | 100 | 0 | 49 | 100 | 0.0 | 223 | 100 | 0.0 |  |
| **County** |  |  |  |  |  |  |  |  |  |  |  |
| Boone | 3.3 | <5 | 1.1 | 0.5 | <5 | 0.0 | -1.7 | <5 | 0.9 | 0.0 | 3.3 |
| Brown | 0.9 | <5 | 0.0 | 0.0 | <5 | 0.0 | 0.0 | <5 | 0.0 | 0.0 | 0.0 |
| Hamilton | 16.3 | <5 | 1.7 | -2.0 | <5 | 8.2 | 6.4 | 7 | 3.1 | -0.1 | 2.4 |
| Hancock | 3.9 | <5 | 1.7 | 1.1 | <5 | 0.0 | -1.7 | 3 | 1.4 | 0.4 | 4.2 |
| Hendricks | 8.4 | 6 | 3.5 | 1.6 | <5 | 2.0 | -1.4 | 7 | 3.1 | 0.8 | 4.6 |
| Johnson | 8.0 | 7 | 4.0 | 2.2 | <5 | 0.0 | 0.0 | 7 | 3.1 | 1.8 | 4.8 |
| Marion | 50.9 | 147 | 84.5 | -5.0 | 43 | 87.8 | -0.2 | 190 | 85.2 | -3.8 | 20.5 |
| Morgan | 3.8 | <5 | 2.3 | 1.0 | <5 | 0.0 | 0.0 | <5 | 1.8 | 0.9 | 5.8 |
| Putnam | 2.1 | <5 | 0.6 | 0.0 | <5 | 0.0 | -3.4 | <5 | 0.5 | -0.9 | 2.7 |
| Shelby | 2.4 | <5 | 0.6 | 0.6 | <5 | 2,0 | 2.0 | <5 | 0.9 | 0.9 | 4.5 |
| Total | 100 | 174 | 100 | 0.0 | 49 | 100 | 0.0 | 223 | 100 | 0.0 |  |

**TABLE D. SPECIAL POPULATION DETAILS[[76]](#footnote-76)**

|  |  |
| --- | --- |
| **ALL POPULATIONS** | |
| Estimated population in the TGA in 2013 | 1,822,776 |
| Number of people living with HIV (non-AIDS) | 2,534 |
| Number of people living with AIDS | 2,817 |
| Prevalence of HIV infection (includes AIDS) in the TGA | 29.4 per 10,000 |
| Number of new HIV diagnoses from 2011-2013 | 514 |
| Number of new AIDS diagnoses from 2011-2013 | 146 |
| **NON-HISPANIC BLACKS** | |
| Estimated population in the TGA in 2013 | 277,668 (15.2%) |
| Number in the TGA diagnosed with HIV (not-AIDS) | 1,112 (43.9%) |
| Number in the TGA diagnosed with AIDS | 1,168 (41.5%) |
| Prevalence of HIV infection (including AIDS) in the TGA | 82.1 per 10,000 |
| Number of new HIV diagnoses between 2011 and 2013 | 290 (56.4%) |
| Number of new AIDS diagnoses from 2011-2013 | 70 (48.0%) |
| **WOMEN OF CHILDBEARING AGE (15-44 YEARS)** | |
| Estimated population in the TGA in 2013 | 755,320 (41.4%) |
| Number in the TGA diagnosed with HIV (not-AIDS) | 298 (11.8%) |
| Number in the TGA diagnosed with AIDS | 196 (7.0%) |
| Prevalence of HIV infection (including AIDS) in the TGA | 6.5 per 10,000 |
| Number of new HIV diagnoses between 2011 and 2013 | 90 (17.5%) |
| Number of new AIDS diagnoses from 2011-2013 | 14 (9.6%) |
| **IMMIGRANTS** | |
| Estimated population in the TGA in 2013 | 109,455 (6.0%) |
| Number in the TGA diagnosed with HIV (not-AIDS) | 301 (11.9%) |
| Number in the TGA diagnosed with AIDS | 339 (12.0%) |
| Prevalence of HIV infection (including AIDS) in the TGA | 58.5 per 10,000 |
| Number of new HIV diagnoses between 2011 and 2013 | 145 (28.2%) |
| Number of new AIDS diagnoses from 2011-2013 | 53 (36.3%) |
| **YOUNG ADULTS (15-24 YEARS, BASED ON CURRENT AGE)** | |
| Estimated population in the TGA in 2013 | 238,703 (13.1%) |
| Number in the TGA diagnosed with HIV (not-AIDS) | 194 (7.7%) |
| Number in the TGA diagnosed with AIDS | 47 (1.7%) |
| Prevalence of HIV infection (including AIDS) in the TGA | 10.1 per 10,000 |
| Number of new HIV diagnoses between 2011 and 2013 | 183 (35.6%) |
| Number of new AIDS diagnoses from 2011-2013 | 16 (11.0%) |
| **RESIDENTS OF SUBURBAN AND RURAL COUNTIES** | |
| Estimated population in the TGA in 2013 | 928,281 (50.9%) |
| Number in the TGA diagnosed with HIV (not-AIDS) | 319 (12.6%) |
| Number in the TGA diagnosed with AIDS | 399 (14.2%) |
| Prevalence of HIV infection (including AIDS) in the TGA | 7.7 per 10,000 |
| Number of new HIV diagnoses between 2011 and 2013 | 18 (3.5%) |
| Number of new AIDS diagnoses from 2011-2013 | 10 (6.8%) |

**APPENDIX 2. RYAN WHITE SERVICES PROGRAM: PART A ALLOCATIONS AND PRIORITIES**

**TABLE E. FY2015 FINAL ALLOCATIONS BY SERVICE CATEGORY[[77]](#footnote-77)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Category** | **Clients To Serve** | | **Proposed Allocation** | | **Percent of Budget** |
| **CORE SERVICES** | | | | | | |
| **1** | Outpatient and Ambulatory Medical Care (including laboratory tests) | 725 | | $994,043 | | 28.39% |
| **2** | AIDS Drug Assistance Program (ADAP) | 0 | | $0 | | 0.00% |
| **3** | Local AIDS Pharmaceutical Assistance Program (LPAP) | 100 | | $100,234 | | 2.86% |
| **4** | Oral Health Services | 180 | | $159,169 | | 4.55% |
| **5** | Early Intervention Services (EIS) | 8290 | | $397,221 | | 11.34% |
| **6** | Health Insurance Premium and Cost-Sharing Assistance – Premiums | 42 | | $202,480 | | 5.78% |
|  | Health Insurance Premium and Cost-Sharing Assistance – Deductibles | 20 | |
| **7** | Home Health Care | 0 | | $0 | | 0.00% |
| **8** | Home and Community-Based Health Services |  | |  | |  |
| **9** | Hospice Care | 0 | | $0 | | 0.00% |
| **10** | Mental Health Services | 315 | | $138,600 | | 3.96% |
| **11** | Medical Nutrition Therapy | 0 | | $0 | | 0.00% |
| **12** | Medical Case Management Services (including treatment adherence) | 899 | | $565,202 | | 16.14% |
| **13** | Substance Abuse Treatment Services – Outpatient | 90 | | $69,300 | | 1.98% |
|  | ***core sub-total*** |  | | **$2,626,249** | | **75.00%** |
|  | | | | | | |
| **SUPPORT SERVICES** | | | | | | |
| **1** | Case Management (non-medical) | 1059 | | $396,165 | | 11.32% |
| **2** | Child Care Services | 0 | | $0 | | 0.00% |
| **3** | Emergency Financial Assistance (EFA) – Utilities | 74 | | $74,800 | | 2.14% |
|  | Emergency Financial Assistance (EFA) – Food | 310 | |
| **4** | Food Bank and Home-Delivered Meals | 0 | | $0 | | 0.00% |
| **5** | Health Education and Risk Reduction | 1352 | | $86,208 | | 2.46% |
| **6** | Housing Services | 95 | | $104,500 | | 2.99% |
| **7** | Legal Services (including permanency planning) | 67 | | $22,110 | | 0.63% |
| **8** | Linguistic Services | 30 | | $7,500 | | 0.21% |
| **9** | Medical Transportation Services | 493 | | $73,223 | | 2.09% |
| **10** | Outreach Services | 286 | | $60,235 | | 1.72% |
| **11** | Psychosocial Support Services (including pastoral care and counseling) | 180 | | $50,354 | | 1.44% |
| **12** | Referral to Health Care and Supportive Services |  | |  | |  |
| **13** | Rehabilitation Services |  | |  | |  |
| **14** | Respite Care | 0 | | $0 | | 0.00% |
| **15** | Substance Abuse Treatment – Residential |  | |  | |  |
| **16** | Treatment Adherence Counseling |  | |  | |  |
|  | ***support sub-total*** |  | | **$875,095** | | **25.00%** |
|  | | | | | | |
|  | ***total*** | |  | | **$3,501,344** | **100%** |

**TABLE F. FY2015 SERVICES PRIORITIZED[[78]](#footnote-78)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **RANKED SERVICE CATEGORIES** | **CONTACTED PROVIDERS** | **ALLOCATIONS** |
| **1** | Case Management (non-medical) | * Concord Center * Damien Center * Eskenazi Health * IU Health – Lifecare * Step-Up, Inc. | $396,165 |
| **2** | Health Insurance Premium and Cost-Sharing Assistance – Premiums ⯅ | * Indiana State Department of Health | $202,480 |
|  | Health Insurance Premium and Cost-Sharing Assistance – Deductibles ⯅ | * Community Walgreens Pharmacy * Eskenazi Health * Indiana State Department of Health * IU Health – Lifecare |
| **3** | Outpatient and Ambulatory Medical Care (including laboratory tests) ⯅ | * Community Physicians Network * Damien Center * Eskenazi Health * IU Health – Lifecare | $994,043 |
| **4** | Local AIDS Pharmaceutical Assistance Program (LPAP) ⯅ | * Community Walgreens Pharmacy * Eskenazi Health * IU Health – Lifecare | $100,234 |
| **5** | AIDS Drug Assistance Program (ADAP) ⯅ | -- | $0 |
| **6** | Medical Case Management Services (including treatment adherence) ⯅ | * Damien Center * Eskenazi Health * IU Health – Lifecare * Step-Up, Inc. | $565,202 |
| **7** | Mental Health Services ⯅ | * Damien Center | $138,600 |
| **8** | Early Intervention Services (EIS) ⯅ | * Brothers United * Damien Center * Eskenazi Health * IU Health – Horizon House * IU Health – Lifecare * MCPHD Substance Use Outreach Services * Michael & Susan Smith Emergency Department at Eskenazi Health * Shalom Health Center * Step-Up, Inc. | $397,221 |
| **9** | Housing Services | * Concord Center * Damien Center * Step-Up, Inc. | $104,500 |
| **10** | Oral Health Services ⯅ | * IU School of Denistry * MCPHD Dental Clinic | $159,169 |
| **11** | Medical Transportation Services | * Bethlehem House * Brothers United * IU Health – Lifecare * Sweet Chariot Transportation | $73,223 |
| **12** | Substance Abuse Treatment Services – Outpatient ⯅ | * Bethlehem House * Damien Center | $69,300 |

|  |  |  |  |
| --- | --- | --- | --- |
| **13** | Psychosocial Support Services (including pastoral care and counseling) | * Bethlehem House * Brothers United | $50,354 |
| **14** | Emergency Financial Assistance (EFA) – Utilities | * Concord Center * Damien Center * Step-Up, Inc. | $74,800 |
|  | Emergency Financial Assistance (EFA) – Food | * Concord Center * IU Health – Lifecare * Step-Up, Inc. |
| **15** | Outreach Services | * Bethlehem House * Brothers United * Michael & Susan Smith Emergency Department at Eskenazi Health * Step-Up, Inc. | $60,235 |
| **16** | Legal Services (including permanency planning) | * Damien Center | $22,110 |
| **17** | Linguistic Services | -- | $7,500 |
| **18** | Health Education and Risk Reduction | -- | $86,208 |
| **19** | Medical Nutrition Therapy ⯅ | -- | $0 |
| **20** | Food Bank and Home-Delivered Meals | -- | $0 |
| **21** | Home Health Care ⯅ | -- | $0 |
| **22** | Child Care Services | -- | $0 |
| **23** | Hospice Care ⯅ | -- | $0 |
| **24** | Respite Care | -- | $0 |
|  | ***total*** |  | **$3,501,344** |

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**APPENDIX 3. RYAN WHITE SERVICES PROGRAM: PART A GOALS AND OBJECTIVES**

**Introduction**

This section will be separated into Administrative, Universal Service, Core Service Delivery, and Support Service Delivery goals and objectives.

**2015-2017 Administrative Goals and Objectives**

In order to attain an improved system of care, achievement of the following administrative goals and objectives will be necessary. These goals are presented according to four major administrative areas: systems, planning, evaluation, and service. The administrative goals and objectives are designed to be long-term and to span the two-year period of this plan. They will be fully reviewed and updated again in 2016 in preparation for the *Integrated HIV Prevention and Care Plan* for 2017-2021. Unless otherwise indicated, responsibility for achieving the stated goals rests with the Part A grantee.

|  |  |
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| **Category** | **1. Systems** |
| **Purpose** | To ensure that the key systems of care are unique and coordinated in an effort to reduce duplication of effort and maximize resources. |
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| **Goal** | **1.1. To improve coordination between major Ryan White Program grantees.** |
| **Objective** | **1.1.a.** To maintain Part A representation on the Part B Comprehensive HIV Services Planning and Advisory Council. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Membership Committee |
| **Notes** | -- |
| **Objective** | **1.1.b.** To continue to elicit participation from Parts B, C, and F on the Ryan White Part A Planning Council. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Membership Committee |
| **Notes** | -- |
| **Objective** | **1.1.c.** To re-establish the quarterly “All Parts” meetings to facilitate regular communication between Parts A, B, C, and F. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | Prior to 2014, “All Parts” meetings had been convened by the Part B grantee. |
| **Objective** | **1.1.d.** To annually review the eligibility requirements for all Part A, B, and C service components to ensure consistency. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and staff from Parts B and C |
| **Notes** | -- |
| **Objective** | **1.1.e.** To annually review the benefit information for all Part A, B, and C service components to identify and eliminate any overlapping services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and staff from Parts B and C |
| **Notes** | -- |
| **Objective** | **1.1.f.** To coordinate the skills-building training efforts of the Part A, B, and C grantees with the advice of the Part F grantee. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and staff from Parts B , C, and F |
| **Notes** | -- |
| **Objective** | **1.1.g.** To assist the Part B grantee in the creation of the Statewide Coordinated Statement of Need (scheduled to be updated once every three years). |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and staff from Part B |
| **Notes** | -- |

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| **Objective** | **1.1.h.** To collaborate with the Part B grantee to develop coordinated and consistent 6- and 12-month recertification processes. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | As of early 2015, income is calculated differently by each grantee, and the recertification periods are not aligned. |
| **Objective** | **1.1.i.** To coordinate contract compliance efforts with the Part B and C grantees. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, QM Committee, and staff from Part B |
| **Notes** | This objective would be limited to contractor in common and relates to the exhaustive annual site visits required for Part A providers (see Administrative Objective 3.2.c.). |

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| **Category** | **2. Planning** |
| **Purpose** | To ensure that the planning process is structured, inclusive, coordinated, and continual. |
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| **Goal** | **2.1. To maintain an active and engaged Ryan White Part A Planning Council.** |
| **Objective** | **2.1.a.** To maintain the membership level of the Ryan White Part A Planning Council at 90% of full capacity (or better) on average each year. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Executive Committee |
| **Notes** | -- |
| **Objective** | **2.1.b.** To ensure that the priorities, allocations, and directives of the Planning Council are reflected in the actual delivery of Part A services in the Indianapolis TGA. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **2.1.c.** To share with the Planning Council any relevant changes in Medicaid and Medicare policies that may affect planning and priority setting. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |

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| **Goal** | **2.2. To engage in structured and on-going efforts to obtain input from clients in the design and delivery of services.** |
| **Objective** | **2.2.a.** To ensure that at least one-third of the official Ryan White Part A Planning Council membership is composed of unaffiliated HIV-positive persons. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Membership Committee |
| **Notes** | The goal related to this objective is taken directly from the National Monitoring Standards – Universal (April 2013). |
| **Objective** | **2.2.b.** To retain the Consumer Access Committee as a standing committee within the Planning Council structure. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | The goal related to this objective is taken directly from the National Monitoring Standards – Universal (April 2013). |

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| **Goal** | **2.3. To maintain a dynamic Comprehensive Plan for the Indianapolis TGA.** |
| **Objective** | **2.3.a.** To plan an exhaustive needs assessment with the input of consumers, providers, and community members to be conducted every three years. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Needs Assessment Committee |
| **Notes** | -- |
| **Objective** | **2.3.b.** To conduct an exhaustive needs assessment every three years to elicit input from consumers, sub-grantees, other providers, key informants, and community members. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Needs Assessment Committee |
| **Notes** | -- |
| **Objective** | **2.3.c.** To analysis and incorporate the results for the most recent exhaustive needs assessment into the Comprehensive Plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, PC Needs Assessment Committee, and PC Systems of Care Committee |
| **Notes** | -- |
| **Objective** | **2.3.d.** To obtain and incorporate the results of any relevant outcome measure assessments into the Comprehensive Plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, MCPHD Epidemiologist, and PC Systems of Care Committee |
| **Notes** | Examples of such assessments include consumer satisfaction surveys and clinical quality reviews. |

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| **Objective** | **2.3.e.** To obtain and incorporate updated epidemiological information into the Comprehensive Plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, MCPHD Epidemiologist, and PC Systems of Care Committee |
| **Notes** | -- |
| **Objective** | **2.3.f.** To incorporate descriptions of relevant changes in available services and the HIV service delivery system (including changes made necessary by the implementation of the Affordable Care Act) into the Comprehensive Plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Systems of Care Committee |
| **Notes** |  |

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| **Goal** | **2.4. To ensure that the Comprehensive Plan for the Indianapolis TGA reflects other recognized strategies and planning documents for HIV care.** |
| **Objective** | **2.4.a.** To incorporate any relevant changes in the most recent edition of the Planning Council’s approved Standards of Care into the Comprehensive Plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Systems of Care Committee |
| **Notes** | -- |
| **Objective** | **2.4.b.** To incorporate any relevant changes in the most recent edition of the Statewide Comprehensive Plan and the Statewide Coordinated Statement of Need (prepared by the Part B grantee) into the Comprehensive Plan for the Indianapolis TGA. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, PC Systems of Care Committee, and staff from Part B |
| **Notes** | -- |
| **Objective** | **2.4.c.** To explicitly incorporate the key objectives of the National HIV/AIDS Strategy into the Comprehensive Plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Systems of Care Committee |
| **Notes** | http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf |
| **Objective** | **2.4.d.** To explicitly incorporate the applicable objectives of DHHS’s Health People 2020 campaign into the Comprehensive Plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Systems of Care Committee |
| **Notes** | https://www.healthypeople.gov/2020/topics-objectives/topic/hiv/objectives |

|  |  |
| --- | --- |
| **Goal** | **2.5. To issue a new, fully updated Comprehensive Plan for the Indianapolis TGA every three years.** |
| **Objective** | **2.5.a.** To complete the necessary review of goals and objectives as written in the current Comprehensive plan at least 90 days prior to the expected release of the new plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Systems of Care Committee |
| **Notes** | For example, if the next plan is scheduled to be issued in March 2017, then the review should be completed by December 2017. |
| **Objective** | **2.5.b.** To incorporate all changes into a draft revision for review at least 30 days prior to the expected release of the new plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Systems of Care Committee |
| **Notes** | -- |
| **Objective** | **2.5.c.** To obtain approval of the updated Comprehensive Plan from thePlanning Council prior to its release. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and Planning Council |
| **Notes** | -- |

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| --- | --- |
| **Category** | **3. Evaluation** |
| **Purpose** | To ensure that the expenditure of funds has achieved the desired, positive outcomes for the grantee and the program participants. |
|  |  |
| **Goal** | **3.1. To document the effect of funded interventions on the health outcomes of the target population.** |
| **Objective** | **3.1.a.** To annually update the benchmark health indicators to be used in measuring the health outcome improvements of Part A participants. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC QM Committee |
| **Notes** | -- |
| **Objective** | **3.1.b.** To collect client-level service utilization data in a structured and uniform manner to facilitate analysis of health outcomes. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and Marion County CIS staff |
| **Notes** | This process involves both the RISE database used internally by the grantee and the CAREWare instances used by the grantee and the sub-grantees. |
| **Objective** | **3.1.c.** To collect available health status information in a structured and uniform manner to facilitate analysis of health outcomes. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | An example of health status information is client-level viral load data for program participants. |
| **Objective** | **3.1.d.** To annually compare current health and service utilization information for participants against the established benchmarks to evaluate the effectiveness of Part A services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC QM Committee |
| **Notes** | This process is the essential function of the Clinical Quality Management Plan. See the most recent CQM Plan for more details regarding the specific benchmarks currently in use (e.g., HAB Group 1 performance measures and HIVQUAL benchmarks). |
| **Objective** | **3.1.e.** To issue an annual Clinical Quality Management report documenting the results of the comparison of participants’ health and service utilization information against the established benchmarks. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC QM Committee |
| **Notes** | -- |
| **Objective** | **3.1.f.** To issue an annual Unmet Need Report documenting the number of status-aware HIV-positive persons in the Indianapolis TGA who appear to be out of care and describing the extent of any disproportionate impact on particular subpopulations. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, PC QM Committee, and PC Consumer Access Committee |
| **Notes** | -- |

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| **Goal** | **3.2. To document that funded sub-grantees deliver quality services according to established guidelines, policies, and standards.** |
| **Objective** | **3.2.a.** To incorporate the most recent edition of the National Monitoring Standards for Part A into the contract of each funded service provider. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **3.2.b.** To incorporate the most recent service-specific Quality Management expectations into the contract of each funded service provider. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |

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| --- | --- |
| **Objective** | **3.2.c.** To conduct an annual comprehensive site visit with each funded Part A service provider. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | This type of site visit is often referred to as an “audit” and includes a complete programmatic, financial, contractual compliance (including compliance with the National Monitoring Standards), and quality management activity review. |
| **Objective** | **3.2.d.** To issue a comprehensive site visit report to each funded sub-grantees documenting achievements and areas requiring improvements within 90 days of the visit. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |

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| **Goal** | **3.3. To gather formal evaluative feedback from service providers, council members, and program participants.** |
| **Objective** | **3.3.a.** To survey funded service providers at least once every three years to elicit quantifiable input regarding the service delivery model. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Executive Committee |
| **Notes** | -- |
| **Objective** | **3.3.b.** To implement an annual process for Part A Planning Council members to evaluate the performance of the Part A grantee. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and Planning Council |
| **Notes** | -- |
| **Objective** | **3.3.c.** To implement an annual process for Part A Planning Council members to participate in a “self-evaluation” of their membership experience. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and Planning Council |
| **Notes** | -- |
| **Objective** | **3.3.d.** To conduct a comprehensive satisfaction survey with program participants at least once every three years to elicit quantifiable input regarding the service quality. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Executive Committee |
| **Notes** | -- |
| **Objective** | **3.3.e.** To conduct quarterly client forums to solicit qualitative input regarding services and the service delivery model. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Client Access Committee |
| **Notes** | -- |

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| --- | --- |
| **Category** | **4. Service** |
| **Purpose** | To ensure that quality HIV-related services are available to all eligible individuals.[[79]](#footnote-79) |
|  |  |
| **Goal** | **4.1. To eliminate disparities in access to HIV services in disproportionately affected sub-populations and underserved communities.** |
| **Objective** | **4.1.a.** To distribute the most recent edition of the Ryan White Services Program brochure through all known HIV case management programs, HIV prevention programs, Disease Intervention Specialists, and Part A-funded providers throughout the Indianapolis TGA. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Consumer Access Committee |
| **Notes** | -- |
| **Objective** | **4.1.b.** To distribute the most recent edition of the Ryan White Services Program brochure widely to other unaffiliated health and social service organizations throughout the Indianapolis TGA. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Consumer Access Committee |
| **Notes** | Unaffiliated organizations are those not typically considered to part of the HIV continuum of care. |
| **Objective** | **4.1.c.** To maintain the Ryan White Services Program website as an accessible source of program information. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Consumer Access Committee |
| **Notes** | -- |
| **Objective** | **4.1.d.** To provide at least one opportunity annually for non-funded providers to learn about Part A services and referral processes. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | Examples of non-funded providers include Department of Correction personnel and township trustees. |
| **Objective** | **4.1.e.** To update the Provider Resource Guide at least once every three years. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, PC Systems of Care Committee, PC Executive Committee |
| **Notes** | The Provider Resource Guide catalogues the known HIV services in the TGA. It is not limited to services funded by the Part A grantee. |

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| **Goal** | **4.2. To inform low-income individuals of the availability of HIV-related services and the respective points of access.** |
| **Objective** | **4.2.a.** To conduct quarterly forums to educate consumers regarding services and the service delivery system in the Indianapolis TGA. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and PC Client Access Committee |
| **Notes** | These may be the same quarterly forums that are used to solicit qualitative input (see Administrative Objective 3.3.e.). The goal related to this objective is taken directly from the National Monitoring Standards – Universal (April 2013). |

|  |  |
| --- | --- |
| **Goal** | **4.3. To ensure that funded providers are well-prepared to deliver Part A services.** |
| **Objective** | **4.3.a.** To conduct quarterly training and educational meetings for funded Part A service providers. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and funded agencies |
| **Notes** | Common topics include eligibility, enrollment, and proper reimbursement procedures. |
| **Objective** | **4.3.b.** To provide an annual training opportunity for funded Part A service providers specifically related to the National Monitoring Standards and the Planning Council’s Standards of Care. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and funded agencies |
| **Notes** | This opportunity may be delivered in conjunction with the quarterly training and educational meetings (see Administrative Objective 4.3.a.). |
| **Objective** | **4.3.c.** To provide an annual training opportunity for funded Part A service providers specifically related to the Quality Management. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, PC QM Committee, and funded agencies |
| **Notes** | This opportunity may be delivered in conjunction with the quarterly training and educational meetings (see Administrative Objective 4.3.a.). |
| **Objective** | **4.3.d.** To support the financial stability of Part A providers by ensuring that payments for services rendered are issued within 30 days of claim submission. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, MCPHD Grants Management staff, and MCPHD Accounts Payable staff |
| **Notes** | -- |

**2015-2017 Universal Service Goals and Objectives**

In order to attain an improved system of care, achievement of the following universal service goals and objectives will be necessary. These goals are taken, in part, from the National Monitoring Standards – Universal[[80]](#footnote-80) and are presented according to two main categories: eligibility determination and access to care. Like the Administrative goals and objectives, these are designed to be long-term and to span the two-year period of this plan. They will be fully reviewed and updated again in 2016 in preparation for the *Integrated HIV Prevention and Care Plan* for 2017-2021. Unless otherwise indicated, responsibility for achieving the stated goals rests with the Part A grantee.

|  |  |
| --- | --- |
| **Category** | **1. Eligibility Determination** |
| **Purpose** | To ensure that funds are used to serve those most in need of assistance. |
|  |  |
| **Goal** | **1.1. To provide eligible services only to eligible individuals.** |
| **Objective** | **1.1.a.** To determine the initial eligibility of all prospective clients according to the guidelines of the grantee, within a predetermined timeframe, and prior to the provision of services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and funded agencies |
| **Notes** | This objective is taken directly from the National Monitoring Standards – Universal (April 2013). |
| **Objective** | **1.1.b.** To require that prospective clients seek alternative means of payment for services prior to or at the time of application for Part A services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and funded agencies |
| **Notes** | Examples of alternative payment sources include Indiana Medicaid, the Part B HIV Medical Services Program, HOPWA, and Section 8. |
| **Objective** | **1.1.c.** To determine the continued eligibility of all active clients according to the guidelines of the grantee prior, within a predetermined timeframe, and at least every six months. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and funded agencies |
| **Notes** | This objective is taken directly from the National Monitoring Standards – Universal (April 2013). |
| **Objective** | **1.1.d.** To confirm the eligibility of existing clients prior to the provision of each service. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and funded agencies |
| **Notes** | This process can be facilitated through the use of CAREWare or through the written referral process. |

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| **Category** | **2. Access To Care** |
| **Purpose** | To ensure that those in need of assistance can access services with as few barriers as possible. |
|  |  |
| **Goal** | **2.1. To provide accessible and affordable services.** |
| **Objective** | **2.1.a.** To provide eligible services to eligible persons regardless of an individual’s ability to pay for the service. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **2.1.b.** To provide eligible services to eligible persons regardless of an individual’s current or past health conditions. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **2.1.c.** To provide services in settings that are accessible to eligible low-income persons. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | An example of an accessible setting would be one located on the city bus route. |
| **Objective** | **2.1.d.** To ensure that military veterans who are otherwise eligible are not deemed ineligible due to the availability of Department of Veterans Affairs (VA) benefits. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **2.1.e.** To explore opportunities to expand the number of participating providers outside of Marion County. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | TGA communities located outside of Marion County are often considered to be underserved because fewer providers are based in the rural counties. |

**2015-2017 Core Service Delivery Goals and Objectives**

In order to attain an improved system of care, achievement of the following core service delivery goals and objectives will be necessary. While the administrative and universal service goals and objectives are framed in terms of broad non-service-specific activities, those for the provision of care are categorized according to the priority service needs. For core services, eight of the thirteen allowed categories have been prioritized for the Indianapolis TGA and are presented herein:

* Outpatient and Ambulatory Medical Care (including laboratory tests)
* Local AIDS Pharmaceutical Assistance Program (LPAP)
* Oral Health Services
* Early Intervention Services (EIS)
* Health Insurance Premium and Cost-Sharing Assistance
* Mental Health Services
* Medical Case Management Services (including treatment adherence)
* Substance Abuse Treatment Services – Outpatient

In general, goals were written to apply to the two-year plan period, while objectives may apply to individual fiscal year periods. All elements will be fully reviewed and updated again in 2016 in preparation for the *Integrated HIV Prevention and Care Plan* for 2017-2021. Unless otherwise indicated, responsibility for achieving the stated goals rests with the Part A grantee.

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| **Category** | **1. Outpatient and Ambulatory Medical Care (including laboratory tests)** |
| **Purpose** | To improve health outcomes through the provision of outpatient medical care for uninsured or underinsured persons with HIV in the Indianapolis TGA. |
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| **Goal** | **1.1. To provide efficient and cost-effective Outpatient and Ambulatory Medical Care benefits for all eligible applicants.** |
| **Objective** | **1.1.a.** To aggressively negotiate the lowest fees possible for covered laboratory tests. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **1.1.b.** To ensure that all providers receive updated DHHS Guidelines for the Use of Antiretroviral upon release. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, PC QM Committee, staff from Part F, and funded medical providers |
| **Notes** | -- |

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| **Category** | **2. Local AIDS Pharmaceutical Assistance Program (LPAP)** |
| **Purpose** | To improve health outcomes through the temporary provision of HIV pharmaceuticals for uninsured or underinsured persons with HIV in the Indianapolis TGA. |
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| **Goal** | **2.1. To provide efficient and cost-effective Local AIDS Pharmaceutical Assistance benefits for all eligible applicants.** |
| **Objective** | **2.1.a.** To ensure that participating pharmacies are Medicaid certified. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **2.1.b.** To ensure 340B pricing from participating pharmacies. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **2.1.c.** To utilize the Part B AIDS Drug Assistance Plan formulary as the LPAP list of covered pharmaceuticals. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and staff from Part B |
| **Notes** | Grantee policy allows for the provision of non-formulary substitutes for formulary medications when requested by the physician for medical reasons. |
| **Objective** | **2.1.d.** To require documentation that arrangements for longer-term access to medications have been initiated prior to the dispensation of medications. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, CC sites, Part A case management providers, and participating pharmacies |
| **Notes** | Examples of documentation include proof of application to Medicaid or the Part B HIV Medical Services Program. |

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| **Category** | **3. Oral Health Services** |
| **Purpose** | Improve health outcomes for persons with HIV through the provision of comprehensive oral health services. |
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| **Goal** | **3.1. To provide efficient and cost-effective Oral Health benefits for all eligible applicants.** |
| **Objective** | **3.1.a.** To ensure that participating providers are Medicaid certified. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **3.1.b.** To establish a formulary of covered dental services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **3.1.c.** To ensure that service costs do not exceed the established per-person limit. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and oral health care providers |
| **Challenges** | -- |
| **Notes** | The per-person limit is established in consultation with the Planning Council. |
| **Objective** | **3.1.d.** To ensure that Part B dental benefits (if applicable) are exhausted prior to service provision. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, staff from Part B, and oral health care providers |
| **Notes** | Some (but not all) HIAP enrollees also receive dental insurance benefits. |

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| **Category** | **4. Early Intervention Services (EIS)** |
| **Purpose** | To improve health outcomes for persons with HIV through the process of early disease detection and expedited entry into care. |
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| **Goal** | **4.1. To identify HIV-positive persons who are not aware of their HIV status.** |
| **Objective** | **4.1.a.** To require EIS providers to target identification efforts to populations and geographic areas with the highest prevalence of HIV infection. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and MCPHD Epidemiologist |
| **Notes** | The areas of highest prevalence are described in the annual Epidemiological Profile. |
| **Objective** | **4.1.b.** To utilize EIS providers who are able to demonstrate the ability to successfully reach the target populations. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |

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| **Goal** | **4.2. To promote coordination with other disease intervention activities.** |
| **Objective** | **4.2.a.** To require EIS providers to strategically coordinate identification efforts with the other HIV prevention programs operating within the Indianapolis TGA. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and EIS providers |
| **Notes** | The Bell Flower clinic is an example of an HIV prevention program operating in the TGA. |
| **Objective** | **4.2.b.** To utilize Minority AIDS Initiative resources to supplement EIS activities in minority communities. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, MAI providers, and EIS providers |
| **Notes** | -- |
| **Objective** | **4.2.c.** To collaborate with philanthropic organizations to encourage funding of complementary programs designed to address the goals of the Part A grantee’s EIIHA strategy. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | The Health Foundation of Greater Indianapolis is an example of a philanthropic organization. EIIHA is the acronym for *Early Identification of Individuals with HIV/AIDS*, and its goals are closely associated with those of the EIS category. |

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| **Goal** | **4.3. To promote immediate entry into care.** |
| **Objective** | **4.3.a.** To require EIS providers to maintain at least one formal referral agreement with an HIV medical or case management provider to facilitate entry into care for newly identified HIV-positive persons. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and EIS providers |
| **Notes** | -- |

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| **Category** | **5. Health Insurance Premium and Cost-Sharing Assistance** |
| **Purpose** | To improve health outcomes by providing financial assistance for eligible individuals living with HIV to obtain or maintain continuity of health insurance coverage. |
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| **Goal** | **5.1. To supplement the Part B Health Insurance Assistance Plan (HIAP) for eligible Part A participants.** |
| **Objective** | **5.1.a.** To assume the premium payments for a portion of Part A participants who are also enrolled in HIAP. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, PC Priority Setting and Resource Allocation Committee, and staff from Part B |
| **Notes** | This objective is achieved through a direct contract with the Indiana State Department of Health. The amount of funding typically dedicated to this objective is insufficient to cover all of the eligible Part A participants. |
| **Objective** | **5.1.b.** To prioritize Part A participants living in communities outside of Marion County for HIAP premium payment assistance. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and staff from Part B |
| **Notes** | See Core Service Objective 1.1.a. |
| **Objective** | **5.1.c.** To reallocate additional funds as necessary to minimize the impact of a Part B waiting list (in the event that one is instituted). |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, Part B staff, Planning Council, PC Client Access Committee, and PC Priority Setting and Resource Allocations Committee |
| **Notes** | Part B has not experienced a waiting list for many years. |

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| **Goal** | **5.2. To engage the private insurance market to expand Health Insurance Premium and Cost-Sharing Assistance possibilities.** |
| **Objective** | **5.2.a.** To offer deductible assistance for those who are privately insured and not enrolled in HIAP. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **5.2.b.** To assess the feasibility of directly purchasing non-Marketplace policies for eligible Part A participants who cannot immediately access coverage through the Marketplace. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | Examples of barriers to immediate access to Marketplace coverage include the closure of the Open Enrollment period for Marketplace policies and ineligibility for HIAP due to previous recertification failure. |

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| **Category** | **6. Mental Health Services** |
| **Purpose** | To improve health outcomes for persons with HIV through the provision of mental health services. |
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| **Goal** | **6.1. To provide efficient and cost-effective Mental Health Services for all eligible applicants.** |
| **Objective** | **6.1.a.** To ensure that participating providers are Medicaid certified. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |

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| **Goal** | **6.2. To ensure the appropriate level of mental health care.** |
| **Objective** | **6.2.a.** To require mental health providers to conduct an exhaustive mental health assessment during the first session with the client. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and mental health providers |
| **Notes** | An initial screening will have been performed by a case manager prior to execution of the referral. Exhaustive assessments can be documented in CAREWare. |
| **Objective** | **6.2.b.** To require mental health providers to conduct mental health re-assessments at six-month intervals following enrollment. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and mental health providers |
| **Notes** | Reassessments can be documented in CAREWare. |
| **Objective** | **6.2.c.** To require mental health providers to refer clients to in-patient treatment when indicated by the assessment results. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and mental health providers |
| **Notes** | -- |

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| **Goal** | **6.3. To promote coordination with case management services.** |
| **Objective** | **6.3.a.** To require mental health providers to include the mental health goals documented by the assigned case manager in the client’s mental health treatment plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and mental health providers |
| **Notes** | Such information can be included in the referral documentation from the case management provider. |

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| **Category** | **7. Medical Case Management Services (including treatment adherence)** |
| **Purpose** | To improve health outcomes for persons with HIV through the provision of medical case management. |
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| **Goal** | **7.1. To ensure access to primary health care.** |
| **Objective** | **7.1.a.** To require medical case management providers to document each participant’s primary health care status. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and medical case management providers |
| **Notes** | CAREWare can be used to document a participant’s primary medical provider, and RISE can be used internally by the grantee to monitor primary care reimbursements made by Part A. |

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| **Goal** | **7.2. To promote medication adherence.** |
| **Objective** | **7.2.a.** To require medical case management providers to deliver explicit medication adherence counseling on a quarterly basis. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and medical case management providers |
| **Notes** | Adherence counseling can be documented in CAREWare. |

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| **Goal** | **7.3. To promote coordination between case management services.** |
| **Objective** | **7.3.a.** To require medical case management providers to participate in activities and trainings arranged or provided by the ISDH HIV Care Coordination Program. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and Part B staff |
| **Notes** | This includes activities designed to facilitate the management of mutual clients such as the monthly AIDS Service Organization meetings. |

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| **Category** | **8. Substance Abuse Treatment Services – Outpatient** |
| **Purpose** | To improve health outcomes for persons with HIV through the provision of substance abuse treatment services. |
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| **Goal** | **8.1. To provide efficient and cost-effective Substance Abuse Treatment Services for all eligible applicants.** |
| **Objective** | **8.1.a.** To ensure that participating providers are Medicaid certified. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |

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| **Goal** | **8.2. To ensure the appropriate level of addiction treatment.** |
| **Objective** | **8.2.a.** To require substance abuse treatment providers to conduct an exhaustive substance abuse assessment during the first session with the client. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and substance abuse treatment providers |
| **Notes** | An initial screening will have been performed by a case manager prior to execution of the referral. Exhaustive assessments can be documented in CAREWare. |
| **Objective** | **8.2.b.** To require substance abuse treatment providers to conduct substance abuse re-assessments at six-month intervals following enrollment. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and substance abuse treatment providers |
| **Notes** | Reassessments can be documented in CAREWare. |
| **Objective** | **8.2.c.** To require substance abuse treatment providers to refer clients to in-patient treatment when indicated by the assessment results. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and substance abuse treatment providers |
| **Notes** | -- |

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| **Goal** | **8.3. To promote coordination with case management services.** |
| **Objective** | **8.3.a.** To require substance abuse treatment providers to include the substance use goals documented by the assigned case manager in the client’s substance abuse treatment plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and substance abuse treatment providers |
| **Notes** | Such information can be included in the referral documentation from the case management provider. |

**2015-2017 Support Service Delivery Goals and Objectives**

In order to attain an improved system of care, achievement of the following support service delivery goals and objectives will be necessary. While the administrative and universal service goals and objectives are framed in terms of broad non-service-specific activities, those for the provision of care are categorized according to the priority service needs. For support services, eight of the sixteen allowed categories have been prioritized for the Indianapolis TGA and are presented herein:

* Case Management (non-medical)
* Emergency Financial Assistance (EFA)
* Housing Services
* Legal Services (including permanency planning)
* Linguistic Services
* Medical Transportation Services
* Outreach Services
* Psychosocial Support Services (including pastoral care and counseling)

In general, goals were written to apply to the two-year plan period, while objectives may apply to individual fiscal year periods. All elements will be fully reviewed and updated again in 2016 in preparation for the *Integrated HIV Prevention and Care Plan* for 2017-2021. Unless otherwise indicated, responsibility for achieving the stated goals rests with the Part A grantee.

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| **Category** | **1. Case Management (non-medical)** |
| **Purpose** | To improve access to services and health outcomes for persons with HIV through the provision of non-medical case management. |
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| **Goal** | **1.1. To ensure access to primary health care.** |
| **Objective** | **1.1.a.** To require Case Management providers to document each participant’s primary health care status. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and case management providers |
| **Notes** | CAREWare can be used to document a participant’s primary medical provider, and RISE can be used internally by the grantee to monitor primary care reimbursements made by Part A. |

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| **Goal** | **1.2. To facilitate engagement in Part A services.** |
| **Objective** | **1.2.a.** To require case management providers to serve as the point of origination for all new Part A service applications. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and Part B staff |
| **Notes** | This includes HIV Care Coordination agencies funded by ISDH. |
| **Objective** | **1.2.b.** To require case management providers to assume the responsibility for the recertification of all eligible enrollees. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and case management providers |
| **Notes** | This includes HIV Care Coordination agencies funded by ISDH. The recertification of eligibility is required every six months. |
| **Objective** | **1.2.c.** To require case management providers to explicitly document the reason for each failure to complete the recertification process. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and case management providers |
| **Notes** | CAREWare can be used to document the client’s recertification status. |
| **Objective** | **1.2.d.** To require case management providers to serve as the primary executor of referrals for other Part A services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and case management providers |
| **Notes** | This includes HIV Care Coordination agencies funded by ISDH. Referrals executed by medical case management providers are also accepted. |
| **Goal** | **1.3. To consistently monitor clients for concurrent diagnoses.** |
| **Objective** | **1.3.a.** To require case management providers to perform a standard mental health screening with each new enrollee at the time of application for Part A services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and case management providers |
| **Notes** | -- |
| **Objective** | **1.3.b.** To require case management providers to perform a standard mental health screening with each enrollee at the time of each recertification for continued Part A services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and case management providers |
| **Notes** | -- |
| **Objective** | **1.3.c.** To require case management providers to perform a standard substance abuse screening with each new enrollee at the time of application for Part A services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and case management providers |
| **Notes** | -- |
| **Objective** | **1.3.d.** To require case management providers to perform a standard substance abuse screening with each enrollee at the time of each recertification for continued Part A services. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and case management providers |
| **Notes** | -- |

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| **Goal** | **1.4. To promote coordination between case management services.** |
| **Objective** | **1.4.a.** To require case management providers to participate in activities and trainings arranged or provided by the ISDH HIV Care Coordination Program. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and Part B staff |
| **Notes** | This includes activities designed to facilitate the management of mutual clients such as the monthly AIDS Service Organization meetings. |

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| **Category** | **2A. Emergency Financial Assistance (EFA) – Utilities** |
| **Purpose** | To improve health outcomes for persons with HIV through the provision of utility assistance. |
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| **Goal** | **2A.1. To provide efficient and cost-effective Emergency Financial Assistance for Utilities for all eligible applicants.** |
| **Objective** | **2A.1.a.** To require EFA providers to strictly limit utility assistance to documented emergency circumstances. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and EFA providers |
| **Notes** | -- |

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| **Goal** | **2A.2. To promote coordination with case management services.** |
| **Objective** | **2A.2.a.** To require EFA providers to include in the client’s service record the stated need for utility assistance as documented by the assigned case manager. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and EFA providers |
| **Notes** | Such information can be included in the referral documentation from the case management provider. |

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| **Category** | **2B. Emergency Financial Assistance (EFA) – Food** |
| **Purpose** | To improve health outcomes for persons with HIV through the provision of assistance to acquire food. |
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| **Goal** | **2B.1. To provide efficient and cost-effective Emergency Financial Assistance for Food for all eligible applicants.** |
| **Objective** | **2B.1.a.** To require EFA providers to strictly limit food assistance to documented emergency circumstances. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and EFA providers |
| **Notes** | -- |

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| **Goal** | **2B.2. To promote coordination with case management services.** |
| **Objective** | **2B.2.a.** To require EFA providers to include in the client’s service record the stated need for food assistance as documented by the assigned case manager. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and EFA providers |
| **Notes** | Such information can be included in the referral documentation from the case management provider. |

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| **Category** | **3. Housing Services** |
| **Purpose** | To improve health outcomes for persons with HIV through the provision of short-term housing services. |
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| **Goal** | **3.1. To provide efficient and cost-effective Housing Services for all eligible applicants.** |
| **Objective** | **3.1.a.** To ensure that other housing assistance (if applicable) is exhausted prior to service provision. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and housing service providers |
| **Notes** | Some (but not all) consumers may also receive assistance from HOPWA or a HUD-based program. |

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| **Category** | **4. Legal Services (including permanency planning)** |
| **Purpose** | To improve access to services and health outcomes for persons with HIV through the provision of legal services. |
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| **Goal** | **4.1. To provide efficient and cost-effective Legal Services for all eligible applicants.** |
| **Objective** | **4.1.a.** To require legal service providers to limit their scope of assistance to only those matters related to health care planning and the acquisition of services for which the client may be denied or unable to access independently. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and legal service providers |
| **Notes** | Examples of health care planning include the preparation of documents pertaining to advanced health care directives, living wills, and powers-of-attorney. |

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| **Goal** | **4.2. To promote coordination with case management services.** |
| **Objective** | **4.2.a.** To require legal service providers to include in the client’s service record the stated need for services as documented by the assigned case manager. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and legal service providers |
| **Notes** | Such information can be included in the referral documentation from the case management provider. |

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| **Category** | **5. Linguistic Services** |
| **Purpose** | To improve access to services and health outcomes for persons with HIV through the provision of linguistic services. |
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| **Goal** | **5.1. To provide efficient and cost-effective Linguistic Services for all eligible applicants.** |
| **Objective** | **5.1.a.** To provide this service using the internal resources of the Part A grantee to the extent possible. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | -- |
| **Objective** | **5.1.b.** To facilitate access to other free translation services in the event that internal resources are not adequate. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | Free assistance is available from LanguageLine Solutions and LUNA Language Services. |

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| **Category** | **6. Medical Transportation Services** |
| **Purpose** | To improve access to services and health outcomes for persons with HIV through the provision of medical transportation. |
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| **Goal** | **6.1. To promote coordination with case management services.** |
| **Objective** | **6.1.a.** To require medical transportation providers to include in the client’s service record the stated need for services as documented by the assigned case manager. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and medical transportation providers |
| **Notes** | Such information can be included in the referral documentation from the case management provider. |

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| **Goal** | **6.2. To diversify the models of Medical Transportation Service provision.** |
| **Objective** | **6.2.a.** To explore additional methods of facilitating transportation to medical care. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee |
| **Notes** | Current methods include bus tickets, fuel vouchers, non-profit transportation services, and for-profit transportation services willing to accept Medicaid reimbursement rates. |

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| **Category** | **7. Outreach Services** |
| **Purpose** | To improve health outcomes for persons with HIV through the process of expedited entry or re-entry into care. |
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| **Goal** | **7.1. To identify persons who are known to be HIV-positive but not actively engaged in care.** |
| **Objective** | **7.1.a.** To require outreach providers to strategically coordinate engagement efforts with the other HIV programs operating within the Indianapolis TGA. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and outreach providers |
| **Notes** | A number of agencies are planning or have launched “linkage to care” projects designed to re-engage those persons who have become “lost to care.” |
| **Objective** | **7.1.b.** To utilize Minority AIDS Initiative resources to supplement outreach activities in minority communities. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee, MAI providers, and outreach providers |
| **Notes** | -- |
| **Objective** | **7.1.c.** To require outreach providers to conduct activities in a manner that will maximize contact with the target population. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and outreach providers |
| **Notes** | For example, contact can be maximized by conducting activities after hours and in locations commonly frequented for recreational purposes by the target population. |

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| **Goal** | **7.2. To promote immediate entry (or re-entry) into care.** |
| **Objective** | **7.2.a.** To require outreach providers to maintain at least one formal referral agreement with an HIV medical or case management provider to facilitate entry (or re-entry) into care for previously identified HIV-positive persons who are not actively engaged. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and outreach providers |
| **Notes** | -- |

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| --- | --- |
| **Category** | **8. Psychosocial Support Services (including pastoral care and counseling)** |
| **Purpose** | To improve health outcomes for persons with HIV through the provision of psychosocial support services. |
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| **Goal** | **8.1. To ensure the appropriate level of support.** |
| **Objective** | **8.1.a.** To require psychosocial support providers to conduct a mental health assessment during the first session with the client. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and psychosocial support providers |
| **Notes** | An initial screening will have been performed by a case manager prior to execution of the referral. Assessments can be documented in CAREWare. |
| **Objective** | **8.1.b.** To require psychosocial support providers to conduct mental health re-assessments at six-month intervals following enrollment. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and psychosocial support providers |
| **Notes** | Reassessments can be documented in CAREWare. |
| **Objective** | **8.1.c.** To require psychosocial support providers to refer clients to mental health treatment when indicated by the assessment results. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and psychosocial support providers |
| **Notes** | -- |
| **Objective** | **8.1.d.** To require psychosocial support providers to refer clients for further mental health evaluation in the event that support plan goals are not achieved within 12 months of service. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and psychosocial support providers |
| **Notes** | -- |

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| --- | --- |
| **Goal** | **8.2. To promote coordination with case management services.** |
| **Objective** | **8.2.a.** To require psychosocial support providers to include the mental health goals documented by the assigned case manager in the client’s psychosocial support plan. |
| **Timeframe** | 1 March 2015 through 28 February 2017 |
| **Responsible Party** | Grantee and psychosocial support providers |
| **Notes** | Such information can be included in the referral documentation from the case management provider. |

**Conclusion**

On 19 June 2015, HRSA issued a joint statement with the Centers for Disease Control and Prevention (CDC) announcing their guidance for a new *Integrated HIV Prevention and Care Plan*. This new plan is to be created collaboratively by the Part A, B, C, and F grantees, and its content is to pertain to the five full calendar years of 2017-2021. The integrated plan will be due to HRSA and the CDC on 30 September 2016. The goals and objectives contained herein will be fully updated in the process of preparing the integrated plan.

The progress achieved toward the 2015-2017 goals and objectives will be documented in a final report to be prepared in the last calendar quarter of 2016 and issued in January 2017, following a process similar to that used in the preparation of the *Ryan White Services Program Part A Goals and Objectives Progress Report* for 2012-2015.

1. Categories marked with an “X” have been prioritized and allocated Part A funds. Those without an “X” have may have been prioritized but have not been allocated Part A funds. The “Health Education and Risk Reduction” category has been allocated Minority AIDS Initiative (MAI) funding. [↑](#footnote-ref-1)
2. United States Census Bureau. (2015). Annual Estimates of the Population of Metropolitan and Micropolitan Statistical Areas: April 1, 2010 to July 1, 2014. U.S. Census Bureau, Population Division. March 2015. Available: <http://en.wikipedia.org/wiki/List_of_Metropolitan_Statistical_Areas#cite_note-PopEstCBSA-2> [↑](#footnote-ref-2)
3. Centers for Disease Control and Prevention. (2015). Enhanced HIV/AIDS Reporting System. Epidemiology Requests DR2459, 2611, and 2676 prepared by Tammie Nelson, Marion County Public Health Department, 19 March 2015, 30 July 2015, and 17 December 2015, respectively. [↑](#footnote-ref-3)
4. Marion County Public Health Department. Taken from *Table 2: Trend in Unmet Need for PLWA and PLWH, Indianapolis TGA: 2011-2013* in theRyan White Part A FY2015 Grant Application prepared by the Health and Hospital Corporation for the Indianapolis TGA. [↑](#footnote-ref-4)
5. Hereinafter referred to as Ryan White or the Ryan White Program [↑](#footnote-ref-5)
6. The Core Based Statistical Area (CBSA) code for the Indianapolis-Carmel MSA is 26900. [↑](#footnote-ref-6)
7. The respective Federal Information Processing Series (FIPS) codes for these ten counties are: 18011, 18013, 18057, 18059, 18063, 18081, 18097, 18109, 18133, and 18145. [↑](#footnote-ref-7)
8. United States Census Bureau. (2015). Population Esimates for Indiana Counties, 2010-2014. U.S. Census Bureau, Population Division. July 2015. Available: <http://www.stats.indiana.edu/population/popTotals/2014_cntyest.asp> [↑](#footnote-ref-8)
9. United States Census Bureau. (2015). Population Esimates for Indiana’s Incorporated Places, 2010-2014. U.S. Census Bureau, Population Division. May 2015. Available: <http://www.stats.indiana.edu/population/sub_cnty_estimates/2014/e2014_places.asp> [↑](#footnote-ref-9)
10. United States Census Bureau. (2014). Annual Estimates of the Resident Polulation by Race, Sex, and Hispanic Orgin: April 1, 2010 to July 1, 2013. U.S. Census Bureau, Population Division. June 2014. Available: <http://www.census.gov/popest/data/counties/asrh/2013/PEPSR6H.html> [↑](#footnote-ref-10)
11. United States Census Bureau. (2010). Demographics & Trends Indianapolis, Marion County & the Indianapolis Region. Department of Metropolitan Development, Indianapolis, Indiana. Retreived February 2015. Available: <http://www.indy.gov/eGov/City/DMD/Planning/Stats/Documents/2010_indy_demographics.pptx> [↑](#footnote-ref-11)
12. United States Census Bureau. (2014). Annual Estimates of the Resident Polulation by Race, Sex, and Hispanic Orgin: April 1, 2010 to July 1, 2013. U.S. Census Bureau, Population Division. June 2014. Available: <http://www.census.gov/popest/data/counties/asrh/2013/PEPSR6H.html>

    [↑](#footnote-ref-12)
13. Centers for Disease Control and Prevention. (2015). Enhanced HIV/AIDS Reporting System. Epidemiology Requests DR2459 and 2676 prepared by Tammie Nelson, Marion County Public Health Department, 19 March 2015 and 17 December 2015, respectively. [↑](#footnote-ref-13)
14. This percentage includes the combined Men Who Have Sex With Men and Injection Drug User (MSM/IDU) risk category. [↑](#footnote-ref-14)
15. Centers for Disease Control and Prevention. (2014). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data – United States and 6 dependent areas – 2012. HIV Surveillance Supplemental Report, 19(3). Available: <http://www.cdc.gov/hiv/pdf/surveillance_Report_vol_19_no_3.pdf>. [↑](#footnote-ref-15)
16. The actual calculation is ((.14/.86) x 5351) = 871. [↑](#footnote-ref-16)
17. Centers for Disease Control and Prevention. (2015). Enhanced HIV/AIDS Reporting System. Epidemiology Requests DR2611 and 2676 prepared by Tammie Nelson, Marion County Public Health Department, 30 July 2015 and 17 December 2015, respectively. [↑](#footnote-ref-17)
18. Centers for Disease Control and Prevention. (2015). Enhanced HIV/AIDS Reporting System. Epidemiology Requests DR2459, 2611, and 2676 prepared by Tammie Nelson, Marion County Public Health Department, 19 March 2015, 30 July 2015, and 17 December 2015, respectively. [↑](#footnote-ref-18)
19. Centers for Disease Control and Prevention. (2010). CDC Analysis provides new look at disproportionate impact of HIV and syphilis among U.S. gay and bisexual men. March 2010. Available: <http://www.cdc.gov/nchhstp/newsroom/msmpressrelease.html> [↑](#footnote-ref-19)
20. Centers for Disease Control and Prevention. (2015). Enhanced HIV/AIDS Reporting System. Epidemiology Requests DR2459, 2611, and 2676 prepared by Tammie Nelson, Marion County Public Health Department, 19 March 2015, 30 July 2015, and 17 December 2015, respectively. [↑](#footnote-ref-20)
21. Centers for Disease Control and Prevention. (2007). HIV/AIDS risk factor reporting alarmingly low. Available: <http://permanent.access.gpo.gov/gpo14631/SampleArticle.pdf> [↑](#footnote-ref-21)
22. Indiana State Department of Health. (2008). 2008 HIV/AIDS Epidemiologic Data, Indiana. Available: <http://www.in.gov/isdh/files/Question_3(1).pdf> [↑](#footnote-ref-22)
23. Centers for Disease Control and Prevention. (2015). Enhanced HIV/AIDS Reporting System. Epidemiology Request DR2676 prepared by Tammie Nelson, Marion County Public Health Department, 17 December 2015. [↑](#footnote-ref-23)
24. Marion County Public Health Department. Taken from the Unmet Need section of theRyan White Part A FY2015 Grant Application prepared by the Health and Hospital Corporation for the Indianapolis TGA [↑](#footnote-ref-24)
25. Centers for Disease Control and Prevention. (2008). HIV Prevalence Estimates—United States, 2006. Morbidity and Mortality Weekly Report. October 3, 2008 / 57(39); 1073-1076. Available: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5739a2.htm> [↑](#footnote-ref-25)
26. Marion County Public Health Department. This figure is based on information in the Ryan White Part A & Minority AIDS Initiative Service Utilization: FY 2014 report which states that 2326 unique clients were served by the RWSP (including MAI but excluding Part C) in FY2014. [↑](#footnote-ref-26)
27. Indiana State Department of Health. (2015). Indiana HIV Services Quarterly Report Summary, Third Quarter: 1 January 2015 through 31 March 2015. [↑](#footnote-ref-27)
28. The latest version of the Indianapolis Transitional Grant Area Provider Resource Guide (2012) is available at <http://www.ryanwhiteindytga.org/wp-content/uploads/2012/07/IndianapolisTGAProviderResourceGuide_Ready-for-Press-4-3-12.pdf> [↑](#footnote-ref-28)
29. A number of additional services were prioritized but not allocated Part A funds. These included the AIDS Drug Assistance Program (ADAP), Home Health Care, Hospice Care, Medical Nutrition Therapy, Child Care Services, Food Bank and Home-Delivered Meals, Health Education and Risk Reduction, and Respite Care. (Note, however, that the grantee has designated its MAI funding, in part, for Health Education and Risk Reduction services.) Five other allowable categories were not prioritized for FY2015: Home and Community-Based Health Services, Referral to Health Care and Supportive Services, Rehabilitation Services, Substance Abuse Treatment – Residential, Treatment Adherence Counseling. The utilization data in this section is derived from the Ryan White Part A & Minority AIDS Initiative Service Utilization: FY 2014 report; it includes MAI but excludes Part C utilization information. [↑](#footnote-ref-29)
30. Stall R, Paul JP, Greenwood G, et al. Alcohol use, drug use and alcohol-related problems among men who have sex with men: the Urban Men’s Health Study. *Addiction* 2001; 96:1589–1601. [↑](#footnote-ref-30)
31. Indiana State Department of Health. (2013). Indiana Tuberculosis Control Program - 2013 Annual Report. Available: <http://www.state.in.us/isdh/files/annualreport2013kcFINALcorrected.pdf> [↑](#footnote-ref-31)
32. Centers for Disease Control and Prevention. (2013). Tuberculosis in Hispanics/Latinos. July 2013. Available: <http://www.cdc.gov/tb/publications/factsheets/specpop/tuberculosis_in_hispanics_latinos.htm> [↑](#footnote-ref-32)
33. Centers for Disease Control and Prevention. (2013). Trends in Tuberculosis —United States, 2012. Morbidity and Mortality Weekly Report. March 22, 2013 / 62(11); 201-205. Available: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6211a2.htm> [↑](#footnote-ref-33)
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36. Centers for Disease Control and Prevention. (2015). CDC Fact Sheet: TB Drug Resistance in the U.S. July 2015. Available : <http://www.cdc.gov/nchhstp/newsroom/docs/TB-Drug-Resistance-Factsheet.pdf> [↑](#footnote-ref-36)
37. Centers for Disease Control and Prevention. (2015). Hepatitis C FAQS for health professionals. May 2015. Available: <http://www.cdc.gov/hepatitis/HCV/HCVfaq.htm#section1> [↑](#footnote-ref-37)
38. Centers for Disease Control and Prevention. (2014). HIV and Viral Hepatitis. March 2014. Available: <http://www.cdc.gov/hiv/pdf/library_factsheets_HIV_and_viral_Hepatitis.pdf> [↑](#footnote-ref-38)
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41. Marion County Public Health Department. (2015). Epidemiology of HIV/AIDS in the Indianapolis Transitional Grant Area: 2014. June 2015. Available: <http://www.ryanwhiteindytga.org/wp-content/uploads/2015/06/DR2468-RWG-Epi-Profile-Presentation_2015-06-04_Final.pptx> [↑](#footnote-ref-41)
42. Centers for Disease Control and Prevention. (2014). Sexually transmitted disease surveillance 2013. December 2014. Available: <http://www.cdc.gov/std/stats13/surv2013-print.pdf> [↑](#footnote-ref-42)
43. Marion County Public Health Department. (2015). Epidemiology of HIV/AIDS in the Indianapolis Transitional Grant Area: 2014. June 2015. Available: <http://www.ryanwhiteindytga.org/wp-content/uploads/2015/06/DR2468-RWG-Epi-Profile-Presentation_2015-06-04_Final.pptx> [↑](#footnote-ref-43)
44. Centers for Disease Control and Prevention. (2014). Sexually transmitted disease surveillance 2013. December 2014. Available: <http://www.cdc.gov/std/stats13/surv2013-print.pdf> [↑](#footnote-ref-44)
45. Marion County Public Health Department. (2015). Epidemiology of HIV/AIDS in the Indianapolis Transitional Grant Area: 2014. June 2015. Available: <http://www.ryanwhiteindytga.org/wp-content/uploads/2015/06/DR2468-RWG-Epi-Profile-Presentation_2015-06-04_Final.pptx> [↑](#footnote-ref-45)
46. Arno, J. Director, Marion County Public Health Department STD Clinic, Personal communication, 25 September 2015. [↑](#footnote-ref-46)
47. This utilization data is derived from the Ryan White Part A & Minority AIDS Initiative Service Utilization: FY 2014 report; it includes MAI but excludes Part C utilization information. [↑](#footnote-ref-47)
48. This utilization data is derived from the Ryan White Part A & Minority AIDS Initiative Service Utilization: FY 2014 report; it includes MAI but excludes Part C utilization information. [↑](#footnote-ref-48)
49. United States Census Bureau. (2014). Income, poverty, and health insurance coverage in the United States: 2013. U.S. Census Bureau, Population Division. September 2014. Available: <http://www.census.gov/newsroom/press-releases/2014/cb14-169.html> [↑](#footnote-ref-49)
50. United States Census Bureau. (2014). 2014 American Community Survey 1-Year Estimates. U.S. Census Bureau, Population Division. Retrieved 17 September 2015. Available: <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_S1703&prodType=table> [↑](#footnote-ref-50)
51. Marion County Public Health Department. (2015). Ryan White Part A & Minority AIDS Initiative Service Utilization: FY 2014. July 2015. [↑](#footnote-ref-51)
52. Taken from the county-level Connect2Help2-1-1 reports for April 2015-March2015. Retrieved September 2015. Available: <http://www.connect2help211.org/community-data/community-reports/> [↑](#footnote-ref-52)
53. Indiana University Public Policy Institute. (2015). Many Families in Indianapolis Not Able to Find Shelter. July 2015. Available: <http://www.chipindy.org/wp-content/uploads/2013/07/HomelessCount_2015_Web.pdf> [↑](#footnote-ref-53)
54. U.S. National AIDS Housing Coalition. (2009). Mobilizing knowledge: Housing is HIV prevention and care. Retrieved 17 September 2015. Available: [www.nationalaidshousing.org/toolkit/Summit%20IV%20findings.ppt](http://www.nationalaidshousing.org/toolkit/Summit%20IV%20findings.ppt) [↑](#footnote-ref-54)
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58. Indiana State Department of Health. (2009). 2008 HIV/AIDS Epidemiologic Data, Indiana – Question 2: What is the scope of the HIV/AIDS Epidemic in Indiana? Retrieved 19 September 2015. Available at: <http://www.in.gov/isdh/23266.htm> [↑](#footnote-ref-58)
59. Clements-Noelle K, Marx R, et al. Highly active antiretroviral therapy use and HIV transmission risk behaviors among individuals who are HIV infected and were recently released from jail. AJPH, 2008; 98(4): 661-665. [↑](#footnote-ref-59)
60. Centers for Disease Control and Prevention. (2015). Enhanced HIV/AIDS Reporting System. Epidemiology Request DR2676 prepared by Tammie Nelson, Marion County Public Health Department, 17 December 2015. [↑](#footnote-ref-60)
61. MAI funds are designated to reduce HIV-related health disparities and improve health outcomes for HIV-positive minorities (specifically, Black and Hispanic persons). The HE/RR component provides individual education and promotes health literacy to decrease the risk of HIV transmission among the target population – with a special focus on incarcerated or formerly incarcerated individuals – by promoting individual behavior change and utilizing behavioral self-appraisals. The Community Liaison is an internal RWSP staff member who is available to assist case managers and other providers in their attempts to locate and reconnect consumers who have become disengaged from care. [↑](#footnote-ref-61)
62. The latest version of the Indianapolis Transitional Grant Area Provider Resource Guide (2012) is available at <http://www.ryanwhiteindytga.org/wp-content/uploads/2012/07/IndianapolisTGAProviderResourceGuide_Ready-for-Press-4-3-12.pdf> [↑](#footnote-ref-62)
63. Centers for Disease Control and Prevention. (2015). Enhanced HIV/AIDS Reporting System. Epidemiology Requests DR2459 prepared by Tammie Nelson, Marion County Public Health Department, 19 March 2015. Some “%” and “Δ“ cells have been manually rounded for illustrative purposes. [↑](#footnote-ref-63)
64. United States Census Bureau. (2014). Annual Estimates of the Resident Polulation by Race, Sex, and Hispanic Orgin: April 1, 2010 to July 1, 2013. U.S. Census Bureau, Population Division. June 2014. Available: <http://www.census.gov/popest/data/counties/asrh/2013/PEPSR6H.html> [↑](#footnote-ref-64)
65. The symbol “Δ” denotes the simple difference between the percentages in FY2013 compared to FY2011. [↑](#footnote-ref-65)
66. Rate per 100,000. For Risk, the rates are calculated using total TGA population rather than the estimated population at risk. [↑](#footnote-ref-66)
67. United States Census Bureau. (2014). Annual Estimates of the Resident Population for Selected Age Groups by Sex: April 1, 2010 to July 1, 2013. U.S. Census Bureau, Population Division. June 2014. Available: <http://www.census.gov/popest/data/counties/asrh/2013/PEPAGESEX.html> [↑](#footnote-ref-67)
68. This row includes the MSM/IDU category. [↑](#footnote-ref-68)
69. The symbol “Δ%” denotes the percent of increase or decrease between the number of cases reported in FY2013 compared to FY2011. [↑](#footnote-ref-69)
70. Centers for Disease Control and Prevention. (2015). Enhanced HIV/AIDS Reporting System. Epidemiology Request DR2611 prepared by Tammie Nelson, Marion County Public Health Department, 30 July 2015. Some “%” and “Δ“ cells have been manually rounded for illustrative purposes. [↑](#footnote-ref-70)
71. United States Census Bureau. (2014). Annual Estimates of the Resident Polulation by Race, Sex, and Hispanic Orgin: April 1, 2010 to July 1, 2013. U.S. Census Bureau, Population Division. June 2014. Available: <http://www.census.gov/popest/data/counties/asrh/2013/PEPSR6H.html> [↑](#footnote-ref-71)
72. Does not include HIV-to-AIDS conversions within the report period. [↑](#footnote-ref-72)
73. Rate per 100,000. In the Risk category, the rates are calculated using total TGA population rather than the estimated population at risk (e.g., gay men for the MSM rate). [↑](#footnote-ref-73)
74. United States Census Bureau. (2014). Annual Estimates of the Resident Population for Selected Age Groups by Sex: April 1, 2010 to July 1, 2013. U.S. Census Bureau, Population Division. June 2014. Available: <http://www.census.gov/popest/data/counties/asrh/2013/PEPAGESEX.html> [↑](#footnote-ref-74)
75. This row includes the MSM/IDU category. [↑](#footnote-ref-75)
76. This table draws upon the same data sources as the preceding Tables A-C as well as Epidemiology Request DR2676 prepared by Tammie Nelson (Marion County Public Health Department) on 17 December 2015. It excludes HIV-to-AIDS conversations in its presentation of new AIDS diagnoses. [↑](#footnote-ref-76)
77. This table represents the final budget for FY2015 including both Part A and Minority AIDS Initiative funds. Categories accompanied by a dollar figure greater than $0 have been prioritized and allocated funds. Those accompanied by a dollar figure of $0 have been prioritized but have not been allocated any funds. Those shaded gray have not been prioritized or funded. [↑](#footnote-ref-77)
78. This table describes the Part A service categories as prioritized for FY2015. The symbol “⯅” indicates a core service. Note that one core service (Home and Community-Based Health Services) and four support services (Referral to Health Care and Supportive Services, Rehabilitation Services, Substance Abuse Treatment – Residential, and Treatment Adherence Counseling) were not prioritized. Also note that items 5 and 20-25 were not allocated funding by the Planning Council based on either a lack of identified need or the existence of another readily available provider (such as Indiana Medicaid). The Council did, however, chose to prioritize these services in the event that any should emerge as an unmet need for funding during the grant year. [↑](#footnote-ref-78)
79. When crafting the goals and objectives for this category, the grantee intentionally focused on service awareness and provider training. [↑](#footnote-ref-79)
80. National Monitoring Standards for Ryan White Part A and B Grantees: Universal – Part A and B (April 2013);

    see <http://hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf> [↑](#footnote-ref-80)