HIV Care and Prevention Comprehensive Plan 2009-2011

Developed by Mountain States Group, Inc. in partnership with the Family Planning, STD and HIV Programs of the Idaho Department of Health and Welfare and the Idaho Advisory Council on HIV and AIDS

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The following list of individuals reflects those who have contributed to the work of IACHA:

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INTRODUCTION

Why is the Care and Prevention Comprehensive Plan important?

The Centers for Disease Control and Prevention (CDC) allocates funds for HIV prevention services in response to an application submitted by FPSHP. Integral to this application is a comprehensive HIV prevention plan, which addresses the intervention programs recommended by IACHA to prevent HIV transmission in Idaho. The recommendations made by IACHA help guide FPSHP when seeking HIV prevention program providers in the state.

Health Resources and Services Administration's (HRSA) HIV/AIDS Programs allocate Ryan White Part B (RWPB) funds to provide for the case management and prescription drug needs of people living with HIV and AIDS. FPSHP is responsible for applying for and administering these funds based on a comprehensive HIV care plan developed to substantiate the care needs of people living with HIV in Idaho and direct contracts between the state and care providers.

Striving to maximize resources and recognizing the close ties between HIV prevention and care, IACHA elected to develop a combined comprehensive plan. The HIV Care and Prevention Comprehensive Plan may be used by community-based organizations and state agencies as part of grant applications. Additionally, information contained in the plan help community members to further the knowledge of HIV care and prevention services available and needed in Idaho.

Development of the 2009-2011 Care and Prevention Comprehensive Plan

In October 2006, IACHA approved combining the care and prevention comprehensive plans. Beginning this process, IACHA recommended implementing a combined needs assessment. An IACHA subcommittee worked with FPSHP staff to create an RFP requesting the support of an outside agency to complete a district-specific care and prevention needs assessment as well as to work with district planning bodies to develop strategic plans for the seven Idaho health districts. Idaho State University, Masters of Public Health Program, responded to the RFP and was awarded the contract. In July 2007, Idaho State University began developing focus groups to complete the needs assessment. This process concluded with the submission of the strategic planning reports in December 2008.

In addition, this plan reflects the work of the Statewide Quality Management Committee and attendees of the Providers and Funders Coordination Meeting.

The IACHA Coordinator was responsible for integrating the recommendations of IACHA and FPSHP into the final Care and Prevention Comprehensive Plan. FPSHIP provided continuous oversight of the plan as sections were completed.

IACHA members had a chance to review a draft of the Care and Prevention Comprehensive Plan in September 2008. During the October 2008 IACHA meeting, members had an opportunity to make recommendations to be integrated into the final plan. IACHA reviewed the Plan during their meeting in February 2009 and wrote a letter of concurrence to be attached with the Plan. IACHA will continue to review and edit the Plan as needed during future meetings.

EXECUTIVE SUMMARY

With the support and guidance of IACHA, this combined comprehensive plan addresses the requirements of both CDC and HRSA. The sections of the Care and Prevention Comprehensive Plan are briefly discussed bellow:

Idaho Demographic Background
This section provides statewide and district-specific geographic information. Additionally, this section provides general and HIV-specific demographic information for Idaho and the seven Idaho health districts.

The Idaho Advisory Council on HIV and AIDS
In Section Two, the purpose, function and structure of Idaho's community planning group is delineated.

HIV/AIDS Care Services Planning
Section Three addresses issues specific to providing HIV/AIDS care for people living with HIV/AIDS in Idaho. This section provides a review of the Ryan White HIV/AIDS Treatment and Modernization Act, the way in which Ryan White Part B (RWPB) funds are allocated to various programs and health districts in Idaho and the manner in which RWPB funded programs are monitored. Additionally, Section Three provides a summary of Idaho's Quality Management Program as it relates to providing quality care to people living with HIV/AIDS in Idaho.

Statewide Coordinated Statement of Need
Section Four defines the purpose of the SCSN, identifies the manner it was completed and provides a summary of the final document.

HIV Care Services Recommendations
Section Five provides a summary of the Ryan White HIV/AIDS Treatment Modernization Act as well as a review of the requirements for recipients of Ryan White Part B funds in regards to resource allocation. This section also includes an explanation of the evaluation process for Part B providers and the role of the recently established Statewide Quality Management Committee.

HIV Prevention Community Planning
Section Six provides prevention-specific information, reviewing the Guiding Principles for HIV Prevention Community Planning as defined by CDC, the process of prevention planning in Idaho and the ways in which the planning process are monitored and evaluated.

The Needs Assessment
The work of the Needs Assessment process is captured in Section Five. IACHA determined priority populations based on the review of the 2006 HIV/AIDS Epidemiologic Profile. The top two priority populations served as the target populations for focus groups conducted by Idaho State University. IACHA reviewed the data gleaned from the ISU reports to help determine priorities and unmet needs and gaps in core services.

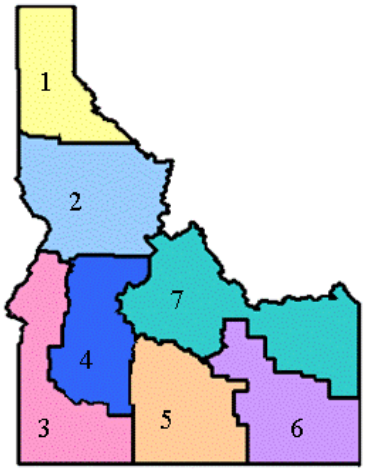
Outreach and Capacity Building Activities
This section provides information regarding Idaho's HIV Prevention programs and testing sites.

Science-Based Prevention Activities/Interventions
IACHA relied on the 2006 HIV/AIDS Epidemiologic Profile to determine priority populations in need of HIV care and prevention services for each of the seven health districts in Idaho. The 2008 HIV/AIDS Epidemiologic Profile is to be published in 2009.

Overarching Goals for HIV CARE and HIV Prevention
This section identifies IACHA's statewide recommendations with corresponding goals and objectives. Additionally, this section references the district specific recommendations made by the regional planning groups.

SECTION I: IDAHO DEMOGRAPHIC BACKGROUND

The Gem State



Idaho has forty-four counties and a land area of 83,557 square miles with agriculture, forestry, manufacturing and tourism being the primary industries. Eighty percent of Idaho's land is either range or forest.

Much of the state's central interior is mountain wilderness and national forest. Nineteen of Idaho's forty-four counties are considered "frontier", with averages of less than six persons per square mile.

Being a rural state, transportation in Idaho is limited to two main highways: Highway I-80 running east and west in the southern part of the state and Highway 95 running north and south along the western border of the state.

Population Information for the State of Idaho

As of 2006, 1,466,465 people are estimated to live in Idaho. The majority of Idaho's residents are non-Hispanic Whites (86.3%). Hispanics (any race) comprise 9.5% of the population.

Economics

Poverty is increasing in Idaho. In 2005, over 10% of families and almost 14% of individuals live below the poverty level, an increase of 3% in both categories from 2003. According to the 2005 Idaho Behavioral Risk Factor Surveillance Survey, almost one-fifth (18.9%) of individuals 19 to 64 years of age are medically uninsured.

Statewide, slightly more females live in poverty (12%) as compared to males (11%). More individuals living in non-metropolitan areas live in poverty (14%) as compared to individuals living in metropolitan areas (12%). Notably, more Hispanics live in poverty as compared to whites (33% and 10% respectively).

HIV and AIDS in Idaho

Of persons reported with HIV (not yet AIDS), the great majority (80%) are male and 81% are white. By age, the highest proportion of HIV cases are diagnosed in 20-29 year-olds (40%) and 30-39 year-olds account for more than 1/3 of cases. The most frequently reported exposure category is MSM, although the proportion is less than half of the total. IDU, MSM/IDU, heterosexual contact and undetermined risk account for notable proportions. Four HIV cases were pediatric cases.

A total of 569 cases of AIDS have been reported in Idaho from 1985 through 2005. An even greater majority of the cases are male and 88% are white. Over half diagnosed cases were among MSM. Other prominent exposure categories are heterosexual contact, IDU and MSM/IDU. Three cases were pediatric. Compared with HIV cases, the age diagnosis is distributed toward older age

groups. Over forty percent of AIDS cases were 30 years old when first diagnosed with HIV/AIDS; almost thirty percent were 40 to 49 years old.

New HIV/AIDS cases have outnumbered HIV/AIDS deaths every year since Idaho's first case in 1984. Prior to the widespread use of protease inhibitors beginning in 1996, deaths averaged 26 per year. Afterward, Idaho averaged 10 fewer deaths per year. With new cases outnumbering deaths, the number of reported persons living with HIV/AIDS in Idaho has increased. As of December 2005, the 866 persons ever reported in Idaho (regardless of whether they were diagnosed in Idaho or moved from another state) are presumed to be still living with HIV/AIDS. Of these, 426 (49%) have an AIDS diagnosis. While the possibility remains of over-counting of presumed living cases due to out-migration or deaths out of state, these figures represent only diagnosed and reported cases. Individuals infected but who are unaware of their HIV infection and have not been tested or reported are part of the true population of interest and mitigate potential over-counting.

Idaho's System of HIV Prevention and Care

The physical barriers of terrain and distance have consolidated Idaho's population into seven natural regions. Idaho's public health delivery system is organized around the seven population centers, with counties grouped into seven districts.

Health District 1

Health District 1, located in the northernmost part of Idaho's panhandle houses 14.1% of Idaho's population. The largest population center of District 1 is within an hour's drive from Spokane, Washington. Most PLWH/A in this district access Community Health Association of Spokane (CHAS) for services. North Idaho AIDS Coalition (NIAC) provides case management for PLWH/A in District 1.

Panhandle Health District is the only state funded provider of HIV counseling, testing, and referral for the region. In 2008, they implemented rapid HIV testing at their main clinic in Hayden, Idaho and will begin rapid testing at all satellite clinics in 2009. Panhandle District Health also provides HIV Partner Services for PLWH/A.

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people diagnosed with HIV/AIDS between 2001 and 2005:

- 15 of the 16 individuals diagnosed with HIV/AIDS between 2001 and 2005 were white males who most frequently reported MSM as the mode of exposure (33%).
- Of those living with HIV/AIDS in 2005, there were more males (76) than females (27).

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people living with HIV/AIDS in 2005 in District 1:

- The highest proportion of both males and females living with HIV/AIDS identified as white (95% and 89% respectively) and were between the ages of 40 and 49 (49% and 41% respectively).
- For males living with HIV/AIDS, the most frequently reported mode of exposure was MSM (53%) followed by IDU (17%).

- Notably, 56% of females living with HIV/AIDS reported heterosexual contact as the primary mode of exposure, followed by IDU (26%).

Health District 2

Health District 2 is located in the northern part of Idaho. Residents of District 2 comprise 7% of Idaho's population. HIV care and prevention services are limited in this district as there is no entity currently contracted to provide case management services. For HIV care services, residents must drive to CHAS in Spokane, Washington, which is at least an hour's drive.

North Central District Health Department, located in Lewiston, provides HIV counseling, testing, and referral services under contract with the state at their main clinic and at satellite clinics. They also provide Partner Counseling and Referral Services for PLWH/A.

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people diagnosed with HIV/AIDS between 2001 and 2005:

- 14 people were newly diagnosed with HIV/AIDS between 2001 and 2005.
- Of the 12 newly diagnosed males, the highest proportion of case were among 20 to 29 year-olds and 30 to 39 year-olds (each 33%).
- The majority of both males and females were white (83% and 100% respectively).
- Half of the males reported MSM as the primary mode of exposure, while 100% of the females reported exposure as heterosexual contact.

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people living with HIV/AIDS in 2005 in District 2:

- The highest proportion of males and females were between 40 and 49 years of age (45% and 75% respectively) and were categorized as white (91% and 88% respectively).
- The most notable mode of exposure for males living with HIV and AIDS was MSM (36%), followed by MSM/IDU (20%) and IDU (16%).
- The most significant mode of exposure for females was heterosexual contact (50%) followed by IDU (38%).

Health District 3

Health District 3 is located in the southwestern part of Idaho. Residents of District 3 comprise 15.9% of Idaho's population. This district has a high proportion of Hispanic residents compared to other health districts in Idaho. HIV case management services are provided by Family Practice Residency whose main office is located in Boise (District 4). PLWH/A in District 3 have the choice of obtaining case management services in Caldwell (District 3) or can travel to Boise (District 4) for case management services.

Southwest District Health Department is the primary provider of HIV counseling, testing, and referral services for the state in this region. They also provide HIV Partner Services for PLWH/A.

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people diagnosed with HIV/AIDS between 2001 and 2005:

- 20 HIV infections (including AIDS) diagnosed between 2001 and 2005, the majority were males (16).
- Of these males, the highest percentages are diagnosed in 30 to 39 and 40 to 49 year-olds (each 38%).
- Half of newly diagnosed females were between 30 and 39 years of age. While most males were white (63%), the majority of the females were Hispanic (75%).
- Notably, the majority of males did not specify a risk category (63%). The primary risk exposure most frequently reported for females was heterosexual contact (50%).
- In 2005, 40 to 49 year olds comprised the highest proportion of males living with HIV/AIDS (48%).

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people living with HIV/AIDS in 2005 in District 3:

- Among females, the highest percentages of cases were between 30 and 39 and 40 and 49 years of age (30% each).
- The predominate race and ethic category for males was white (72%) followed by Hispanic (26%).
- A little over half of females living with HIV/AIDS were white (52%) followed by Hispanic (39%). The greatest number of males reported MSM as the primary risk exposure (40%) followed by IDU (16%) and MSM/IDU (16%).
- Over half (52%) of females reported heterosexual contact as their primary risk category, followed by IDU (13%).

Health District 4

Health District 4, housing the state capital city, Boise, has the largest percentage of Idaho's population (27.2%). Most of the people living with HIV and AIDS in District 4 access the Family Practice Residency HIV Services Clinic in Boise for medical and case management services.

HIV counseling, testing, and referral services and HIV Partner Services are provided under a continuing contract with Central District Health Department. Several other community based providers in the District have been awarded contracts to provide rapid testing outside the clinic setting. These contracts will be up for competitive bid in 2009 for service to begin in 2010.

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people diagnosed with HIV/AIDS between 2001 and 2005:

- 81 people were diagnosed with HIV/AIDS between 2001 and 2005
- The majority of these individuals were males (68) between 30 and 39 years of age.
- Of the 13 females, there was an age split with 31% between 20 and 29 years of age and 31% between 40 and 49 years of age.
- While the majority males were white (88%), the majority of the females were Hispanic (77%).
- Primary exposure for the males was MSM (62%), while the primary exposure for females was heterosexual contact (31%).

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people living with HIV/AIDS in 2005 in District 4:

- The majority of both males and females living with HIV and AIDS in 2005 were between the ages of 40 and 49 years (50% and 47% respectively)and identified as white (83% and 79% respectively).
- Notably, 64% of males reported MSM as the exposure category, followed by MSM/IDU (11%) and IDU (10%).
- The most notable risk category noted by females was IDU (43%) followed by heterosexual (36%).

Health District 5

Health District 5, located in the south central part of Idaho comprises 11.9% of Idaho's population. For people living with HIV/AIDS in District 5, there are two options for HIV care services. Some clients chose to go to the HIV Services Clinic satellite office at Pocatello Family Medicine located in Pocatello, while others chose to travel to Boise to receive their care at HIV Services Clinic at Family Practice Medical Center. Case management services are provided by the South Central Public Health District.

South Central District health is the only agency contracted by the state to provide HIV counseling, testing, and referral services in Health District 5. South Central is also contracted to provide Partner Services.

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people diagnosed with HIV/AIDS between 2001 and 2005:

- 15 individuals diagnosed with HIV/AIDS 2001 and 2005.
- Of the 9 males, most were between the ages of 40 and 49 (56%).
- Of the 6 females, the predominating ages were split with 33% between 20 and 29 years of age and 33% between 30 and 39 years of age.
- The majority of males were white (67%) while the majority of females were Hispanic (67%).
- Primary exposure for males was equally distributed among MSM, IDU and MSM/IDU (22% each).
- Primary modes of exposure for females were divided between heterosexual contact (50%) and risk not specified (50%).

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people living with HIV/AIDS in 2005 in District 5:

- The largest percentage of males (48%) were between 40 and 49 years of age.
- Among females, the largest proportion reported were between the ages of 30 and 39 (33%).
- Among both males and females, the majority were white (80% and 79% respectively).
- The prevailing exposure category for males living with HIV/AIDS was MSM (55%) followed by IDU (17%) and MSM/IDU (5%).
- Over half (58%) of females reported the primary mode of exposure to HIV was through heterosexual contact.

Health District 6

Health District 6 is located in the southeast corner of Idaho. Residents of District 6 comprise 11.4% of Idaho's population. Services for people living with HIV/AIDS are provided by the HIV Services Clinic satellite office at Pocatello Family Medicine. Case management services are provided by the Southeastern District Health Department.

Southeastern District Health provides HIV counseling, testing, and referral services and HIV Partner Services in Health District 6.

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people diagnosed with HIV/AIDS between 2001 and 2005:

- 14 individuals diagnosed with HIV/AIDS between 2001 and 2005, 10 were males and 4 were females.
- The highest percentage of newly diagnosed males and females were between the ages of 20 and 29 (50% and 75% respectively).
- The majority of males were white (80%), while the majority of females were American Indian (75%).
- The primary exposure most frequently reported for males was MSM (50%) followed by MSM/IDU (20%) and heterosexual contact (20%).
- Half of the females reported IDU as the primary mode of exposure, while the other half did not specify a risk.

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people living with HIV/AIDS in 2005 in District 6:

- The highest percentage of males were between 40 and 49 years of age (40%).
- Most females were categorized as either 20 to 29 years of age or 40 to 49 years of age (each 35%).
- Both males and females were predominately categorized as white (80% and 53% respectively).
- The prevailing mode of exposure reported by males living with HIV/AIDS was MSM (55%) followed by ISU (17%) and MSM/IDU (5%).
- The mode of exposure most frequently identified by females was heterosexual contact (47%).

Health District 7

Health District 7 is located in the northeast corner of Idaho along the Montana boarder. Residents of this rural district comprise 12.4% of Idaho's population. People living with HIV/AIDS in this district, may have to travel up to two hours to the HIV Services Clinic satellite office at Pocatello Family Medicine for services. Case management services are provided by the Eastern Idaho Public Health Department.

HIV Counseling, Testing and Referral Services and HIV Partner Services are contracted with Eastern Idaho Public Health Department.

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people diagnosed with HIV/AIDS between 2001 and 2005:

- 7 individuals newly diagnosed with HIV/AIDS between 2001 and 2005, all were males.
- Most (57%) of these males were between 30 and 39 years of age and all were white
- Overwhelmingly, the primary mode of exposure was MSM (86%).

The following is a brief summary of the 2006 HIV/AIDS Epidemiologic Profile for people living with HIV/AIDS in 2005 in District 7:

- 44 of the 55 individuals were males.
- The highest percentage of males living with HIV/AIDS reported were between the ages of 40 and 49 (41%).
- The majority (55%) of the females were between 40 and 49 years of age.
- Among both males and females, most were white (80% and 91% respectively).
- The mode of exposure most predominately reported for males was MSM (59%), while for females it was heterosexual contact (45%).

SECTION II: IDAHO ADVISORY COUNCIL ON HIV AND AIDS

To help understand the Idaho Advisory Council on HIV and AIDS as it currently functions, it may help to review the history of name changes. In 1994, Idaho embraced a community planning process to assist in the development of a plan targeting HIV prevention efforts to those populations at greatest risk for HIV transmission. At this point, the HIV prevention group was known as the Idaho Prevention Planning Group. In 2003, this group expanded to address the care-related needs of people living with HIV and AIDS, thus changing their name to the Idaho Care and Prevention Council. Reflecting a desire to better integrate the spectrum of concerns and issues related to HIV and AIDS, the council once again underwent a name change, becoming the Idaho Advisory Council on HIV and AIDS in October 2007. Thus, Idaho has one statewide community planning group addressing the diverse needs of HIV and AIDS: the Idaho Advisory Council on HIV and AIDS (IACHA).

Purpose and Function

The purpose of IACHA is to strengthen Idaho's HIV and AIDS care and prevention programs. IACHA participates in the development of the comprehensive HIV care and prevention plan that is evidence-based, relevant to Idaho's populations at risk of infection and based on meaningful community input.

IACHA uses a "community planning" process to accomplish its work. Members work in partnership with FPSHP to assess prevention and care needs in the state, determine the populations most at-risk of HIV infection and recommend effective prevention strategies to reach these populations. Most recently, IACHA has become involved with ensuring quality management of HIV and AIDS care through its involvement with the Statewide Quality Management Committee.

IACHA's decisions are based on several sources of data, including an epidemiological profile of who is infected in Idaho, population and district-specific needs assessments and studies of what interventions have proven to be successful in reducing HIV and caring for those living with HIV and AIDS.

IACHA incorporates the views, knowledge and experiences of many individuals and agencies. Ideally, IACHA membership includes persons infected by HIV, persons representing populations at risk of HIV, HIV care and prevention providers, health department representatives, educators and persons with expertise in behavioral science, substance abuse, corrections, health planning, epidemiology and evaluation. IACHA Membership Committee is charged with ensuring inclusion, parity and representation of the membership. IACHA leadership ensures that that every member is included equally in meeting discussions and decision-making.

Structure

According to the IACHA Policies and Procedures, membership may be up to 26 people with membership terms of three years and the option to reapply. The Community Co-Chair is elected by the membership; the FPSHP Co-Chair is appointed by FPSHP. IACHA meets three times per year for two-day sessions. IACHA has five standing committees: Membership Committee, Data Committee, Research Committee, Finance Committee and the Administrative Committee.

The Membership Committee is responsible for the following:

1. Annually analyze and present to IACHA in May the Profile Matrix and IACHA Membership Profile;
2. Monitor the ending terms of IACHA members and instruct the Secretary to mail renewal applications to these members prior to the August application period;
3. Review membership applications and recommend potential members to IACHA in accordance with the IACHA Policies and Procedures and Profile Matrix.
4. Monitor accountability of members through the member accountability tool and mailed reminders to members with unexcused absences;
5. Serve as liaison for members and act as first point of contact for grievances;
6. Present to IACHA ideas for appropriate gifts for departing members; and,
7. Review results of exit interviews of departing members and make recommendations to IACHA for improvements.

The Administrative Committee consists of IACHA Co-Chairs, the secretary and the standing and ad hoc committee chairs. This committee communicates via monthly conference calls and is responsible for the following:

1. Approve conference/training attendance applications;
2. Schedule meetings and phone conference as needed for interim committee progress reports, with such meetings arranged for /facilitated by the secretary (contracted administrative consultant) at the direction of the Co-Chairs;
3. Develop agendas and meeting logistics;
4. Resolve conflicts of Interest issues;
5. Assess meeting evaluations; and,
6. Address time sensitive matters.

The Data Committee shall review and analyze data to make recommendations regarding IDHW Care and Prevention Programs by doing the following:

1) Work with IDHW Care and Prevention Program Coordinators to access and review data (starting with existing data sets currently captured by state programs;
2) Based on report dates of federal funders (CDC and HRSA), create annual work plan with goals to provide each program with specific data needs and recommendations for upcoming grant applications and requests for proposals (RFPs);
3) Determine trends in data one small step at a time;
4) Review existing data available to augment state required data collection;
5) Create reporting mechanism to provide ongoing data information and recommendations to IACHA and Statewide Quality Management Committee; and
6) Research and review data as related to the Needs Assessment.

The Research Committee shall review best practices for both Care and Prevention Programs as assigned by IACHA by doing the following:

1) Work with IDHW Care and Prevention Program Coordinators to determine if current activities used are within best practice standards;
2) Determine best practice standards and the requirements of funders (HRSA and CDC);
3) Make recommendations that will ultimately be reflected in RFPs for both Care and Prevention Programs;

4) Create reporting mechanisms to provide ongoing information and recommendations to IACHA and Statewide Quality Management Committee; and
5) Provide information as related to the Needs Assessment.

The Finance Committee shall review program budgets and available funding to provide cost analysis to IACHA and Care and Prevention Program Coordinators by doing the following:

1) Work with IDHW Care and Prevention Program Coordinators to review expenditures and future program budgets;
2) Explore available capacity building opportunities for Care and Prevention Programs;
3) Possibly explore other funding opportunities for Care and Prevention Contractors;
4) Create reporting mechanisms to provide ongoing information and recommendations to IACHA and Statewide Quality Management Committee; and
5) Research and provide information on available funding resources as related to the Needs Assessment.

Although not standing committees, the membership formed the following committees at various times in the past year to support the development of the Plan:

1. Needs Assessment Committee to help develop questions to be asked at focus groups and guide the development of the RFP requesting an assistance of an outside agency.
2. Structural Committee to review create a timeline to address the reporting needs of CDC and HRSA to coordinate with IAHCA meetings, develop a new structure to integrate the Data, Finance and Research Committees, update the IACHA Policies and Procedures and transition the IACHA Manuals from hard copy binders to electronically accessible manuals.
3. Quality Management Exploratory Committee to address the new HRSA requirements regarding quality management of HIV/AIDS care (this committee ultimately was augmented and replaced by the Statewide Quality Management Committee).

Member Support

FPSHP provides all IACHA members an IACHA Membership Manual that provides electronic links and/or printed copies of the following:

- More in-depth information on community planning
- IACHA Policies and Procedures
- CDC Community Planning Guidance
- Current Idaho HIV/AIDS Epidemiologic Profile and STD statistics
- Current HIV Prevention Comprehensive Plan
- IACHA Membership Directory

FPSHP and IACHA Co-Chairs support the ongoing training, knowledge development and participation of all IACHA members by ensuring the following:

- All new members receive an IACHA orientation prior to the January meeting
- The Administrative Committee ensures that new members have mentors for their first year of service
- The Co-Chairs and additional IACHA members attend the HIV Prevention Leadership Summit annually

- National and regional technical assistance experts meet with IACHA on specific community planning issues at least annually
- National studies, guidance and other materials related to community planning, HIV prevention and HIV/AIDS care are disseminated to members on a regular basis
- An FPSHP liaison is assigned to IACHA committees as needed to arrange for any specific technical assistance or support needs of these groups
- Reports on the prevention and care services funded in Idaho are provided to IACHA at least annually
- A review of how Idaho HIV/AIDS prevention and care funds are allocated, by population and intervention type, is presented to IACHA annually

Member Involvement

IACHA members are actively involved in all aspects of community planning. Members develop the IACHA Policies and Procedures, recruit and approve new members, participate in the development of meeting agendas, chair the meetings and lead working committees.

Together, IACHA members examine applicable data; prioritize Idaho's populations most at risk of HIV infection and select the most effective interventions and care programs to reach these groups. After these decisions are made, IACHA members review the state's comprehensive HIV prevention plan and funding application to ensure their priorities are incorporated. IACHA then evaluates its planning process and sets goals for continuous improvement.

Care and Prevention Integration Efforts

As mentioned previously, HIV/AIDS care and prevention integration efforts began in 2002. However, the decision to integrate the care and prevention comprehensive plans and all planning efforts was formalized during the October 2006 Idaho Care and Prevention Council (currently, Idaho Advisory Council on HIV and AIDS) meeting. During this meeting, the RWPB Coordinator, BeBe Thompson and HIV Prevention Program Specialist/Evaluator, Teri Carrigan, recommended the creation of one integrated Comprehensive Care and Prevention Plan and one Care and Prevention Needs Assessment. IACHA members approved this recommendation.

The first step in the process of integrating care and prevention efforts was to work with Idaho State University (ISU) to conduct a needs assessment of HIV care and prevention services for each of the seven districts in Idaho. Following the completion of the Needs Assessment, ISU was responsible for conducting strategic planning groups in each health district to develop district-specific HIV care and prevention strategic plans. The Needs Assessment Reports and Strategic Planning Reports of each district have been integrated into the HIV Care and Prevention Comprehensive Plan (and can be seen in their entirety as attachments to this document) in order to better address the unique and diverse characteristics of the state.

SECTION III: HIV/AIDS CARE SERVICES PLANNING

Guidelines for Ryan White HIV/AIDS Treatment Modernization Act

The Ryan White HIV/AIDS Program was enacted in 1990 and reauthorized in 1996 and 2000. Reflecting the changing epidemic, the Ryan White HIV/AIDS Treatment Modernization Act of 2006 was passed changing the way in which Ryan White funds can be used. The new law emphasized providing life-saving and life-extending services for people living with HIV/AIDS. Part B of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 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 (ADAP) award, ADAP Supplemental grants and grants to States for Emerging Communities-those reporting between 500 and 999 cumulative reported AIDS cases over the most recent 5 years. All funding is distributed via formula and other criteria.

Part B funds may be used to fund 75% core medical services which include the following: outpatient and ambulatory health services, ADAP, AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost sharing assistance, home health care, medical nutrition therapy, hospice care, community-based health services, substance abuse outpatient care and medical case management (includes treatment adherence services).

The remaining 25% must fund support services that are needed for individuals with HIV/AIDS to achieve their medical outcomes. Support services include the following: respite care for persons caring for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services.

Resource Allocation

FPSHP allocates 84 percent of its cooperative agreement funds to support core and supportive medical services through contracts with six agencies throughout Idaho. RWPB Program funds provide for the following core medical services: HIV-related medications, ambulatory outpatient medical services including laboratory services, medical case management, oral health care, health insurance premium and cost sharing assistance. Additionally, RWPB Program funds provide medical transportation services. Idaho utilizes some of its base funding to supplement the ADAP earmark in order to meet the HIV-related medication cares needs of eligible clients.

FPSHP contracts with Treasure Valley Laboratory for the provision of HIV-related medications to ADAP eligible clients throughout Idaho. Currently, Treasure Valley Labs and IDHW are working to create an import module to allow all lab results to be entered directly into CAREWare.

Administrative Mechanism and Evaluation of Service

In regards to fiscal monitoring, the RWPB contractors submit monthly fiscal reports generated from the CAREWare software program. The report identifies each client by a unique identifier and reports the date, number of service units, and type of service provided. This report is submitted within 30 days following each reporting month and is accompanied by an invoice, which corroborates the information from the CAREWare report. In the event the CAREWare fiscal report does not align with the agency's invoice, the agency is contacted to correct the

discrepancy. During the annual site visits, random chart reviews are conducted in order to assure accuracy of service delivery and services reimbursed.

The FPSHP Manager participates in quarterly budget reviews with the Division of Health's budget analyst. The review monitors progress of the utilization of grant funds and allows for the redistribution of funds within budget categories, if deemed appropriate. FPSHP ensures federal regulations are followed in the event funds are redistributed.

Program monitoring is achieved by annual site visits from the RWPB Coordinator to each contractor to monitor compliance with state and federal RWPB requirements. The contractor is sent an on-site monitoring visit form to be completed and submitted prior to the scheduled site visit. This information is incorporated into the monitoring of contract activities and requirements. Program areas monitored include the documentation of client HIV/AIDS diagnosis, client financial eligibility, insurance status, timeliness of client re-certification; security measures to ensure confidentiality, training and qualifications of staff conducting case management services. Written site visit reports are sent to the contractors within fourteen days of completion of the site visit.

In place of an ADAP Advisory Committee, Sky Blue, MD has been contracted by FPSHP since April 2007 to provide consultation to the FPSHP's ADAP and RW Care Program. The Idaho ADAP attempts to provide access to all new HIV drugs that have been approved by the FDA and brought to market. The program's goal is to ensure that Idaho ADAP clients have access to the most current treatments available. Many drug companies do not allow access to patient assistance programs if a drug is not on a state's formulary, so it is imperative to include as many HIV drugs on the formulary as possible without endangering the budget. While it is difficult to accurately estimate the amount of rebates the state will receive in a given fiscal year, Idaho looks at prior year's expenditures and rebates received to glean an estimate of what percentages of drug costs come back to us in the form of rebates.

When a new drug is approved for the market, Dr. Blue and the RWPB Coordinator informally discuss the addition of the medicine to the state's formulary. With Dr. Blue's understanding of the possible uses and need for the medication and the states responsibility for ensuring cost containment, a process is determined for adding the new med to the formulary. The process ranges from prior authorization of a new regimen by Dr. Blue, a medical review of the case before approval, and/or contact by Dr. Blue to all ADAP prescribing physicians to discuss and review the new medications soon to be available before the drugs are made available for order by the state ADAP.

Currently FPSHP is working to upgrade to CAREWare from stand alone systems to linked remote access with real time data entry. The linked system will create a real-time data entry setup and eliminate duplicate client records. This is extremely critical for accurate quality management data. In addition, the system has an option to create custom forms. In an effort to reduce case manager workload, streamline access to services for clients, and reduce overall paperwork flow, HIV Services Clinic, HOPWA and RWPB Program are working together to create a combined Case Management Intake and Recertification forms.

Quality Management Program

Legislative requirements found in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 direct grantees to develop, implement and monitor clinical quality management programs to ensure that service providers adhere to established HIV clinical practices and quality improvement strategy.

Initially, Idaho responded to this requirement by seeking support from IACHA. IACHA developed a Quality Management Exploratory Committee to explore how best to develop a quality management program for the State of Idaho. This committee ultimately was augmented and replaced by the Statewide Quality Management (QM) Committee, which met for the first time in July 2008.

The Statewide QM Committee continued to develop the Quality Management Plan, to address the following issues:

1. A review of the QM infrastructure available in Idaho
2. A description manner in which stakeholders will participate and communicate in the QM Program
3. A description of QM goals and implementation plan
4. A description of QM performance measurement of data
5. A description of QM capacity building efforts
6. A description of manner in which the QM Program will be evaluated
7. A description of the manner in which the QM Plan will be updated
8. An appendix with glossary of applicable terms and acronyms

For a more complete understanding of the QM Program, please review the Statewide Quality Management Plan that can be found as an attachment to this document (see Appendix H).

SECTION IV: STATEWIDE COORDINATED STATEMENT OF NEED

While the complete report of the Statewide Coordinated Statement of Need (SCSN) is included as Appendix D, the following provides a brief summary of the SCSN.

The Purpose of the SCSN

The Idaho 2009 SCSN provides a collaborative way to identify and address significant issues related to the needs of PLWH/A and to maximize coordination, integration and effective linkages across the Ryan White HIV/AIDS Program Parts B and C grantees and other state, federal and private funders.

Participants in the SCSN Process

The following agencies and representatives participated in the Providers and Funders Coordination meeting:

- Bebe Thompson representing FPSHP's RW Part B
- Teri Carrigan representing FPSHP's HIV Prevention
- Dr. Skye Blue from HIV Services
- Gary Rillema from the District 7 health department and regional planning group
- Tom Machala from the District 5 health department and regional planning group
- Sherry Cook from HOPWA
- Judy Thorne from the Northwest AIDS Education and Training Center
- Jaime Perry representing HIV Services Clinic and Safety Net for AIDS Program
- John McGimpsey from Breaking Boundaries

Description of Data and Information Used in the Process

During the past three years, RWPB Programs in collaboration with the Idaho Advisory Council on HIV and AIDS (IACHA) have engaged in various activities to determine the needs of PLWH/A in Idaho. The following table describes these activities:

DATA COLLECTION ACTIVITY	RESPONSIBLE PARTY and DATE
Survey of RWPB Services Utilized (in Spanish and English)	- Conducted by the RWPB Programs in Fall 2008 - To be reviewed by IACHA during the February 2009 meeting
Needs Assessment of Each of the Seven Health Districts (using focus groups of PLWH/A and MSM)	- Conducted by Idaho State University through contract with RWPB Programs in Fall 2007 - Reviewed and analyzed by IACHA in January 2008
Development of Strategic Plans for Each of the Seven Health Districts	- Conducted by Idaho State University through contract with RWPB Programs in Spring 2008 - Reviewed and analyzed by IACHA in October 2008
Latinos and HIV Knowledge (District 3)	- Conducted by Idaho State University, Centro De Comunidad Y Justicia, HIV Services Clinic, Boise State University and Northwest AIDS Education and Training Center in 2008.

Panel of Women with HIV	- Presented during the October 2007 IACHA meeting - Summarized by IACHA at the October 2007 meeting
Funders & Providers Coordination Meeting	- Meeting held in December 2008
Clearwater Research, Inc Needs Assessments	- High Risk Heterosexual Needs Assessment in 2005 - MSM Needs Assessment in 2004 - IDU Needs Assessment in 2003

Description of Identified Services and Gaps

Based on input from the above mentioned data collection activities, the following were the most commonly mentioned concerns in regards to care of PLWH/A in Idaho:

1. Stigma
2. Availability of Medical Providers
3. Payment for Services/Medications
4. Provider Education and Capacity Building
5. Community HIV Education

In the 2008 RWPB Services Utilized, clients were asked to rank the core and support services in order of importance to them. While there are some limitations to this information, the data provides important insight into the services most valued by PLWH/A in Idaho who are in care. They are as follows:

1. HIV/AIDS Medications/ADAP
2. Medical Visits (including HIV monitoring and screening labs)
3. HIV Specialty Care Clinics
4. Dental Care
5. Case Management
6. Emergency Financial Assistance
7. HIV/AIDS support group

Gaining access to medical care may be initially challenging for PLWH/A, but maintaining access requires more than identifying payer sources. Many others barriers to maintaining access to medical care exist, including, but not limited to, transportation, insurance (public or private), cost of co-pays/deductibles, stigma, confidentiality, child care, availability of providers, employment issues with scheduling time from work and understanding the complexity of using other payer sources. Medical case managers work diligently with clients to overcome these barriers.

PLWH/A Not Receiving HIV-Related Medical Care

Of the 46% (422) who are HIV+/aware and not receiving specified medical care services, 40% (178) of Persons Living With AIDS are not in care and 52% (244) of Persons Living With HIV (not AIDS) are not in care.

SECTION V: HIV CARE SERVICES RECOMMENDATIONS

Priority Care Services for 2009-2011

The Idaho Statewide Coordinated Statement of Need (SCSN) identifies a number of significant issues that were perceived statewide as well as a number that were more specific to certain geographical areas. The following is a non-prioritized list of these.

1. Stigma

   Issue: Stigma is a statewide barrier reflecting the stigma clients have identified in focus groups. Fear of being known as the "HIV doctor" prevents dentists from providing care for people with HIV. Additionally, due to stigma, clients may not seek medical care, thus preventing access to care.

   Goals:

   1) Lobby state legislature for funding for statewide HIV campaign
   2) Keep regional planning groups intact by providing funding

2. Availability of Medical Providers

   Issue: As there are only two HIV specialists for the state of Idaho and few primary care doctors who are willing to treat HIV+ clients, many HIV positive clients are unable or have difficulty accessing specialty HIV care. Additionally, some providers do not have prescribing knowledge regarding HIV medications and are not trained in HIV mental health needs, thus are unable to properly diagnose mental health problems.

   Goals:

   1) Engage in recruiting outside sources for care
   2) RFP for services (case management in Southwest and Southeast Idaho)
   3) Continue to educate clinicians (through NWAETC)
   4) Make access to HIV medical/case manager education easier with statewide tele-health networking
   5) Get to know providers and issues at the local level and fund regional planning groups

3. Payment for Services/Medications

   Issue: Idaho has not been immune to the economic downturn experienced by the majority of the country. Without adequate insurance coverage, many more clients will be forced to access care through public funds. If clients lack proper insurance coverage, providers may be leery of providing services. Additionally, Idaho's ADAP has a very limited formulary that does not meet all of the medication needs of an uninsured HIV+ person. Coordination of payment sources is critical.

   Goals:

   1) Incorporate other private funders into mix
   2) Continue to research and provide data to state legislature move toward purchasing insurance coverage with ADAP money
   3) Address coordination of payor sources on an ongoing basis

4. Provider Education and Capacity Building

Issue: There is simply a lack of providers trained in the specific needs of PLWH throughout Idaho. This includes not only HIV specialty care, but also case managers, dentists, metal health counselors, among others. While there may be providers willing to see HIV+ clients, they may not always have adequate training to provide quality care. Of the providers who do work with PLWH, many times agencies or clinics are underfunded, and understaffed, which can often lead to burnout and turnover in staff. Staff turnover can create fragmented systems of care and frustration for clients attempting to access quality care and resources.

Goals:

1) Continue to educate clinicians and support staff (through NWAETC)
2) Continue to work on building capacity of available providers
3) Streamline available funding sources and data systems to reduce staff workload

5. Community HIV education

Issue: There is limited HIV education available in public schools and in communities in Idaho. Focus groups indicate a desire for consistent messages regarding HIV.

Goals:

1) Get representation from the Department of Education on IACHA
2) Support and provide funding for efforts of regional planning groups
3) Seek funding for statewide media campaign from state legislature

After reviewing the SCSN report during the February 2009 IACHA meeting, the members voted to write letter of concurrence, which was sent to HRSA.

SECTION VI: HIV PREVENTION COMMUNITY PLANNING

Guiding Principles for HIV Prevention Community Planning

As a recipient of CDC's federally-funded HIV Prevention Projects funds, Idaho is required to support an HIV prevention community planning body. According to CDC's 2003-2008 HIV Prevention Community Planning Guidance, community planning bodies are expected to improve HIV prevention programs by "strengthening the 1) scientific basis, 2) community relevance and 3) population-or risk-based focus of HIV prevention interventions in each project area."

Serving as the community planning body for the state of Idaho, IACHA integrates the Guidance into the IACHA Policies and Procedures. The following examples illustrate the ways in which the Guidance has been incorporated into the IACHA Policies and Procedures:

1. IACHA members will have access to and review the HIV/AIDS Epidemiologic Profile to identify and prioritize at-risk populations to help determine appropriate prevention interventions.
2. IACHA members will help develop a community services assessment to help determine gaps in services.
3. IACHA will write submit letters to CDC written by IACHA Co-Chairs, of concurrence or non-concurrence with the annual HIV Care and Prevention Comprehensive Plan.
4. The membership of IACHA shall be consistent with IACHA purposes and membership roles. The membership of IACHA shall also reflect the criteria of Parity, Inclusion and Representation (PIR) as described in the CDC Supplemental Guidance on HIV Prevention Community Planning to the extent that these criteria are compatible with the group's purpose and roles.
5. The health department Co-Chair must be a FPSHP representative and the other must be a community representative. A prospective Co-Chair must have served for a minimum of one year as an IACHA member before being eligible to be considered for election as a Co-Chair. IACHA will strive to select Co-Chairs with geographical and gender balance.

HIV Prevention Community Planning Process

According to the IACHA Policies and Procedures, membership may be up to 26 people with membership terms of three years and the option to reapply. The Community Co-Chair is appointed by the membership; the FPSHP Co-Chair is appointed by FPSHP. IACHA meets three times per year for two-day sessions. To help develop the Care and Prevention Comprehensive Plan, related tasks are assigned to IACHA's five standing committees: Membership Committee, Data Committee, Research Committee, Finance Committee and the Administrative Committee.

Monitoring and Evaluation of HIV Prevention Community Planning

Concluding each of the three yearly IACHA meetings, attending members complete a meeting evaluation. The evaluation includes questions asking members to rank the meeting content, facilitation and accommodations. In addition, the following question is included:

> "According to the CDC Guidance, IACHA must ensure parity in community planning meetings (*parity* implies that all members have equal opportunity to provide input and have equal voice voting and in decision-making). With this in mind, how do you rate degree to which you felt you had the chance to voice your opinion and be a part of the

decision-making processes in this meeting (with 1 being the least amount of parity and five being the highest degree of parity)?"

To evaluate the community planning process, IACHA members are asked to complete The Community Planning Membership Survey found in the HIV Prevention Community Planning: An Orientation Guide. Attached to this survey is a demographics survey designed to determine membership composition. Results of these surveys are presented to the members at the May/June IACHA meeting. The members have a chance to reflect of the results and make recommendations for changes. Specifically the membership demographics influence the Membership Committee when making recruitment recommendations.

Funding for Regional Planning Groups

To support continued efforts of regional planning groups, FPSHP has arranged for Mountain States Group to hold and distribute funds to approved planning groups and act as point of contact for Regional HIV/AIDS Planning Groups. Regional HIV Planning Groups must be recognized as a functioning group by the IACHA administrative committee, each of the seven health department jurisdictions may have one recognized HIV planning committee. Planning committees organized under the 2008 Strategic Planning Project will be recognized as the functioning committee for their region. Each planning committee is eligible to receive funding through an application process, if they elect to continue as a group and actively meet in 2009. Regional HIV Planning groups may apply for funds to support HIV/AIDS planning meetings or special events (e.g. National HIV Testing Day, World AIDS Day or other HIV awareness day). The funding application must list dates and times of meetings/events, full names of meeting attendees and contact information (phone number or email), detail of how funding will be utilized. Funds will be released by MSG to Regional HIV Planning Groups once approved by the IACHA administrative committee.

SECTION VII: NEEDS ASSESSMENTS

The Purpose According to CDC's HIV Prevention Community Planning Guidance

According to the 2003-2008 HIV Prevention Community Planning Guidance, community planning groups are required to complete an assessment of HIV prevention needs. This assessment serves as an integral starting point for the development of the comprehensive HIV prevention plan. Needs assessments adapted to particular areas, populations and organizations enable planners to make informed decisions about the adequacy, availability and effectiveness of specific services that are available to the target audience.

The Process for the Development of the Needs Assessment in Idaho

In June 2007, IACHA took the first step in preparing for the needs assessment process, setting priority populations using Epi Profile (see Section VII for more detailed information about this process). IACHA then established a temporary Needs Assessment Committee to work with the FPSHP staff to help direct the needs assessment process. With guidance from the Needs Assessment Committee, FPSHP produced an RFP requesting an outside agency to conduct the Needs Assessment. Reflecting the desires of IACHA, the Needs Assessment Committee maintained that the RFP require that the contracting entity provide district specific information for the previously set priority populations.

Idaho State University (ISU) responded to the RFP and contracted with the state to conduct a needs assessment in each of the seven health districts in Idaho. According to the contract, ISU planned to conduct two focus groups in each of the seven health districts; the focus groups would be with HIV positives and MSM, as these were the two highest priority populations for each district. The Needs Assessment Committee worked with FPSHP to establish questions that would be asked each focus group. Reflecting the dedication of IACHA to address both HIV care and prevention, questions for the HIV+ focus groups included both care and prevention related topics.

FPSHP worked with local health districts and community based organizations to setup local administrative units (LAUs). Several IACHA members happened to also serve as contacts for the LAUs. This connection helped legitimize the needs assessment process and increase local support for the efforts.

Participants in the Process

The goal was to have ten participants on each focus group in each district.

<u>District 1</u>

Recruitment of participants in the District 1 area was the responsibility of the district contact, North Idaho AIDS Coalition (NIAC). The district contact took charge of the recruitment process and was very involved in ensuring sufficient participants were registered prior to the focus group session. The HIV session only contained three individuals. The MSM group contained all eight individuals who had registered.

District 2

In District 2, recruitment of participants was the responsibility of the district contact, North Central District Health Department located in Lewiston, Idaho. The contact at this agency disbursed recruitment flyers that were supplied by this project to possible participants. Only three HIV positive individuals called to register. Ten people participated in the MSM focus group.

District 3

Recruitment of HIV positive individuals in District 3 was coordinated through the use of recruitment flyers supplied by this project. Five HIV positive individuals participated in the HIV positive focus group. Recruitment MSM focus group participants was coordinated primarily through the Gay Men of Canyon County. This social group meets twice a month on Sundays at a local coffee house in Nampa, Idaho. In order to maximize possible participation, the MSM focus group for this district was scheduled during one of their regularly scheduled social events. Potential participants were targeted through flyers provided by the research team for one month prior to the scheduled focus group and on Craig's List (www.craigslist.com), in the Men Seeking Sex with Men section. Through both of these recruiting efforts, the final number of MSM participants was ten, the maximum allowed.

District 4

Focus group participant recruitment in District 4 was the responsibility of the district contact, Allies Linked for the Prevention of HIV/AIDS (a.l.p.h.a.), located in Boise, Idaho. The contact at this agency disbursed recruitment flyers that were supplied by this project to possible participants. The HIV positive group had seven registered participants the day prior to the focus group session. There were ten participants in the MSM group.

District 5

Recruitment of participants in the District 5 area was the responsibility of the district contact, South Central District Health Department. Recruitment for District 5 proceeded very slowly and was met with difficulty. Discussion of this concern with the district contact revealed that stigma in the area associated with both HIV and MSM populations were a major barrier to recruitment. For this reason, the research team elected to conduct for individual phone interviews. Ultimately, there were six HIV positive individuals involved in the focus group, three in person and three over the phone. However, despite efforts by the district contacts, there were no MSM recruits and the MSM focus group was cancelled. Additional effort at recruiting for an MSM focus group was undertaken in November by the project coordinator. Personal contact was made with the leader of a local GLBT group who promised assistance in recruiting MSM through distribution of flyers provided by the project coordinator. Another MSM focus group was scheduled, but despite these efforts, no MSM were recruited and the focus group was cancelled.

District 6

In District 6, recruitment of participants was the responsibility of the district contact at the Southeastern District Health Department located in Pocatello, Idaho. Recruitment in District 6 proceeded very slowly. As of the day before the focus group session, there were only two participants registered for both the HIV and MSM focus group sessions. Because of these low recruitment numbers, the research team and the FPSHP discussed cancelling the sessions However, in the interest of collecting what ever data was possible, both parties agreed to

continue with scheduled plans and conduct the groups in District 6. On the day of the focus groups, FPSHP made personal contact with the local HIV/AIDS prevention program, Genesis Project and urged leadership to assist with last minute recruitment efforts. This encouragement was very effective in urging the local group to assist with recruitment and an additional eight MSM were recruited and participated in the MSM focus group held that same evening.

District 7

The Eastern Idaho District Health Department Recruitment was responsible for recruiting participants in the District 7 area. Recruitment in District 7 proceeded slowly. As of two days before the sessions, there were only two participants registered for both the HIV positive and MSM focus group sessions. Because of these low recruitment numbers, the research team and FPSHP discussed cancelling the sessions. However, in the interests of collecting any available data, both parties agreed to continue with scheduled plans and conduct the groups in District 7. Additional recruitment efforts were made by contacting current registered participants and encouraging them to invite any personal contacts who fit the specifications of the group they were attending. Through these efforts, an additional three MSM participants were recruited.

Description of Data and Information Used in the Process

Upon completion of the focus groups, ISU compiled Needs Assessment reports for each focus group in each of the seven health districts. IACHA members reviewed the reports and discussed the findings during the January 2008 IACHA meeting to determine priority needs of MSM and HIV positive individuals at the district-level and on a statewide-level. The following is a brief summary of the Needs Assessment Report for each of the seven health districts.

District 1

Several primary themes emerged from discussions with HIV positive and MSM groups in District 1 including the following:

1. *Awareness.* The participants felt strongly that Northern Idaho is hiding from the reality of HIV and AIDS in their area. They want a program to build awareness that HIV is not only a big city concern, but it is also a concern in small town, rural Idaho.
2. *Lack of medical services for HIV positive*. Both groups felt frustrated by the lack of medical services available to them in Idaho. Almost all participants crossed the Idaho border into Spokane, Washington, for all dental, medical and psychological care. While it is only a thirty-minute drive, participants felt that Idaho was not willing to take care of them. Additionally, participants expressed the desire to have local physicians and nurses receive continuing education regarding HIV and AIDS.
3. *Stigma.* The issue of stigma came up repeatedly throughout both groups. Participants of both the HIV positive group and MSM group felt uncomfortable within their own communities. Neither group felt that they were fully accepted in the community at large.
4. *Education needed for youth and community.* Participants of the HIV positive and MSM focus groups desired education regarding HIV and AIDS transmission in the high schools and in the community. Both groups agreed that the coupling of no consistent safe sex message and the lack of fear of contracting HIV are working against the young population and their sexual practices.

District 2

Several primary themes emerged from discussions with HIV positive and MSM groups in District 2 including the following:

1. *Lack of Services.* The HIV positive focus group participants talked about the lack of services, both medical and social and they felt as if no one cared and no one wanted to talk about the issue of HIV and AIDS. This group also appeared to present confusion on what services should be available and what insurance options were out there. Participants were not always in agreement on services available locally, but all agreed that there is not enough support. The MSM focus group participants mirrored the feelings of the HIV positive group by discussing isolation and a lack of medical and social support. Although these feelings were more muted, participants still agreed that District 2 was being left behind in the shuffle. Participants were unaware of local efforts promoting prevention.
2. *Stigma.* Stigma was repeated by both groups as a major barrier to prevention and access to care. According to the MSM group, homosexuality among men is still very secret. Additionally, few, if any, of the men had a doctor in Idaho, choosing to travel to Pullman, Washington, where there was a "gay friendly" doctor. The HIV positive group also discussed stigma from the medical community as a major barrier to medical services in Idaho. The HIV population almost exclusively drives to Spokane, Washington for all medical care.
3. *Lack of Community Education and Support.* Both groups want to start a dialogue in their communities regarding the reality of HIV in Northern Idaho as they see the community pretending that HIV does not exist.

District 3

Several primary themes emerged from discussions with HIV positive and MSM groups in District 3 including the following:

1. *Lack of affordable insurance.* The HIV positive group participants were generally satisfied with local medical care and their physicians, but expressed concern regarding other issues such as access to affordable insurance.
2. *Stigma.* The HIV positive group discussed HIV-related stigma. Participants discussed perceived fear from friends and physicians afraid of contracting HIV through casual contact with them. Participants voiced their desire to be seen as normal individuals in the community, not just as HIV positive individuals. They believed that more education regarding HIV is necessary to reach this goal.
3. *Influence of internet.* The MSM group discussed ways in which the internet plays a role in the gay community. They regarded the internet as a resource for anonymous sex and "hook-ups". Participants felt as though the internet was a medium where unsafe behaviors, such as going "bareback", were advertised by their gay peers, creating a sense of normalcy around not using protection.
4. *Lack of education.* MSM focus group participants also voiced concerns regarding the lack of education in the community, both among gay and heterosexuals, regarding HIV prevention. Participants brought up several misconceptions regarding HIV that hinder regular condom use and voiced concern over the education being provided in the local high schools. Participants felt that education, in the schools and in the community, must address condom negotiation.

District 4

Several primary themes emerged from discussions with HIV positive and MSM groups in District 4 including the following:

1. *Satisfaction.* In general, participants of the HIV positive focus group were content with their medical care, the services available and the way they are treated in their community. While participants still felt uncomfortable with curious questions from other residents, they did not feel strong stigma behind the curiosity. Additionally, participants felt the most negativity from their own gay community regarding their HIV status, something that the research team has not heard in other districts.
2. *Lack of education.* HIV positive participants talked about the need for education in the community and in the schools as they felt that there is no common prevention message in the community. They believed that parents need education on HIV prevention and how to teach their kids this message and that MSMs are ill informed regarding HIV care and prevention. Additionally, they spoke about a lack of understanding surrounding the HIV testing protocols in Idaho that is preventing residents from seeking routine testing. Participants in the MSM focus group reiterated the need for community education. While education in the schools is important, they want to see a broader message that targets parents, college students and the community at large. Participants do not feel as if Idaho is taking HIV serious enough and is ready to start tackling the problem.
3. *Social factors in the MSM population.* The MSM group had concerns regarding certain behaviors seen in the homosexual community that other districts have discussed such as drugs, alcohol, promiscuous behavior and the lack of fear of HIV. However, they also had concerns regarding social factors that affect gay men specifically, such as the lack of appropriate relationship models and the lack of education for gay youth on how to date and negotiate sex. These men were concerned that the heterosexual youth are getting appropriate messages, but the gay youth are being ignored.
4. *Misunderstandings about HIV testing and services.* Participants discussed misunderstandings in the gay community regarding anonymity of test results. Participants felt that these misconceptions are major barriers to more individuals getting routine testing. Additionally, participants were concerned that services are not readily known in the community. While those attending the group were aware of a few services, they felt that their friends and others would not know where to be tested or where to get free condoms.

District 5

Despite efforts by the district contacts, there were no MSM recruits and the MSM focus group was cancelled.

Among the HIV positive participants, not all were dissatisfied with the care that they had been receiving or the assistance offered through the state. In fact, several participants spoke fondly of local physicians who care for all of their non-HIV related needs. Of note, however, is that while satisfied, many were concerned that others in the community who might be in need of the same assistance were unaware of their options. On the other hand, some participants have struggled to get any help and were deeply dissatisfied with the availability of assistance and health insurance.

The primary themes emerged from discussions with HIV positives in District 5 include the following:

1. *Stigma.* Participants discussed the stigma surrounding both HIV status and sexual orientation. Stigma, according to the participants, has hindered the development of HIV support groups and has hindered support in general for those struggling with the disease.
2. *Lack of education.* Education was emphasized as a need at the community level, among local physicians and nurses and in the schools. Education was consistently mentioned as something that participants feel is missing from local efforts.

District 6

Recruitment for this district was difficult and only two individuals participated in the HIV positive group. Therefore, the participants asked a valid and important question: "Where are all of the other HIV positive individuals?" Both participants mentioned that they personally did not know any other HIV positive individuals in the area and they themselves were very hesitant to reveal their HIV status publicly. The 2006 Idaho HIV/AIDS Epidemiologic Profile reported 72 persons living with HIV and AIDS in District 6 in 2005. The current Ryan White Part B caseload in District 6 is 30 cases.

The primary themes emerged from discussions with HIV positives and MSM in District 6 include the following:

1. *Dissatisfaction with level of care.* The focus group session for HIV positive individuals expressed that they were satisfied with the care they were receiving and did not have specific suggestions for improving care or access to care.
2. *Stigma.* The major underlying issue that came up through the session was not care as much as local attitudes and perceived stigma that the HIV positive participants felt regarding their HIV status.
3. *Lack of education.* Most of the men felt that there is a growing sentiment among their peers that HIV is a manageable disease that is not life-threatening or as debilitating as it once was. They thought this sentiment was reinforced and perhaps promulgated, in the marketing messages by pharmaceutical companies' advertising for HIV medications that "it's okay to be HIV positive." Participants felt unsafe sex and the practice of going "bareback" (not using a condom) is increasing.
4. *Social factors in the MSM population.* The MSM participants also discussed the issue of monogamy within the gay community. As many gay men have either left religious affiliations and/or felt alienated from religion, participants thought gay men may tend to consider monogamy as a religious principle and reject it. Other participants felt that monogamy may simply be more difficult between two men because men, as compared to women, have a more casual attitude toward sexual encounters.
5. *Lack of education.* MSM participants regarded prevention education in the community, specifically for men younger than eighteen or older than thirty-five as an important need. In regards to men younger than eighteen, participants discussed the need to address sex education in the local high schools, believing that the high schools are doing an inadequate job of educating teens in preventing STDs and HIV, especially among gay youth. Currently, as perceived by the participants, few gay men feel comfortable enough to be openly gay until after high school graduation, resulting in repressed sexuality among youth and unsafe promiscuous behavior in older adults.

6. *Lack of prevention and testing programs for older gay men.* Gay men older than thirty-five perceived a general lack of access to prevention programs and HIV testing in the area for men their age and older. The Genesis Project at Idaho State University focuses its attention on gay men ages eighteen to thirty-five, but men older than this, as perceived by the participants, are being ignored. Therefore, participants expressed the desire to expand efforts in the area to encompass all gay men in all walks of life. Outside of the Genesis Project, participants were unaware of other locations for testing.

District 7

The primary themes emerged from discussions with HIV positives and MSM in District 7 include the following:

1. *Minimal HIV care.* The HIV positive focus group expressed satisfaction with the services that were being provided through the local district health office, but also felt as though these services were inadequate in meeting all of their needs, including those for social and emotional support. Participants held good opinions of the staff at the district offices, but did not feel as though the district offices in general were seeking additional resources for them or were even concerned with the local HIV positive community at large.
2. *Stigma.* HIV positive participants agreed that local attitudes and HIV related stigma have strongly hindered the development of an HIV support group and the promotion of an AIDS walk. They perceived this stigma as stemming from local religious beliefs, influencing general opinion. Additionally, participants felt as though the district office and Idaho, in general desire to ignore the HIV positive individuals in hopes that they might "go away." They called for more local efforts targeted at meeting their needs or at promoting HIV prevention and testing. Additionally, MSM participants perceived local attitudes as unwelcoming of gay men and, therefore, many gay men choose to keep their sexual identity private. Additionally, the issue of being a closeted gay man influences how one seeks prevention information, may influence safe sexual practices and limit HIV testing. Participants did not think that local gay men would access HIV testing from the local health district offices out of fear of being "outed".
3. *Lack of medical providers.* As there are no local physicians capable of treating their HIV related illnesses, HIV positive participants must travel to Pocatello for all HIV related care. Participants felt that this access to medical care was insufficient as the office is only open two days per month. The participants were concerned about where they could go if they got sick on the other days of the month. Additionally, participants expressed concern about accessing and paying for medical insurance and medications.
4. *Lack of education due to religious influence.* Participants repeatedly referred to local religious beliefs and attitudes as having a strong influence on issues ranging from homosexuality to promotion of the HIV prevention message. Participants perceived a lack of adequate sex education in the local high schools, despite the need to have youth who are sexually active armed with appropriate prevention knowledge. They also perceived a lack of visibility and availability to prevention information for the community at large, especially for those hindered by approaching the district health offices for information.

Statewide

Upon reviewing the seven district-specific Needs Assessment Reports, IACHA sought to find themes common among each of the districts. IACHA concluded that the most significant statewide needs are in regards to providing HIV education (to both the community at large and in the school system) and to address the stigma facing the homosexual community and people living with HIV and AIDS.

Additional Needs Assessments

In addition to the ISU Needs Assessment conducted in 2007, the FPSHP staff identified additional sources of information and data. The following needs assessments were conducted. The High Risk Heterosexual, HIV+, and Men Who have Sex with Men assessments were conducted by Clearwater Research, Inc. Key points are highlighted under each assessment section. Please see the Mountain States Group's "Resources" website for complete reports.

1. 2008 RWPB Services Utilized Survey

Participating clients ranked the core and support services in order of importance to them. While there are some limitations to this information, the data provides important insight into the services most valued by Idaho's HIV+ who are in care, which are as follows:

1. HIV/AIDS Medications/ADAP
2. Medical Visits (including HIV monitoring and screening labs)
3. HIV Specialty Care Clinics
4. Dental Care
5. Case Management
6. Emergency Financial Assistance
7. HIV/AIDS support group

2. High Risk Heterosexual Needs Assessment (2005)

Participants acknowledged the following concerns:

1. *HIV Attitudes and Knowledge*
    - 88% believed HIV was a concern in small, rural communities; however, 54% felt they were less likely than others to contract HIV. Moreover, 18% felt that someone in their social group was more likely than others to contract HIV.
    - Vast majority demonstrated a high degree of HIV prevention knowledge.
2. *HIV Testing*
    - Over one-third of respondents reported they had never been tested for HIV
    - The main reasons for not testing included feeling at low risk for HIV or not worried about HIV.
    - Half of those that had been tested indicated that they were tested within the last year.
    - Ten percent of those that had been tested indicated it had been over five years since their last test.
    - *Sexual Activity and Behavior*
    - 45% of respondents had more than one partner in the past year
    - The majority of respondents (62%) seldom or never use condoms when engaging in sex

- Only 22% talked to partners frequently about HIV; only 28% talk frequently about safer sex
- 50% did not know the HIV status of at least one of their partners.
- 45% had casual or unplanned sex while under the influence of drugs or alcohol.

3. *Injection Drug and Needle Use*
   - Nearly 20% of respondents reported using an injectable drug administered either by needle or syringe.
   - Of those who reported needle use, 39% shared needles in the past 12 months.
4. *Self-Satisfaction and Social Networks*
   - 70% of those surveyed said they were, on the whole, satisfied with themselves.
   - 77% reported that there were people in their life they could count on when things go wrong
   - Nearly one-fifth of respondents indicated they were not satisfied with themselves and 16% felt they did not have people to count on when things go wrong.

3. MSM Needs Assessment (2004)
Participants acknowledged the following concerns:

1. Sexual Orientation "Openness"
2. Internalized Homophobia
3. Ongoing Sexual Relationships
4. Casual Sexual Relationships
5. General Sexual Behavior
6. HIV (Attitudes and Testing) and STDs
7. Service Provision and Need

4. IDU Needs Assessment (2003)

5. HIV-Knowledge and Attitudes in Idaho Hispanic Communities Survey
In 2008, Idaho State University, Centro De Comunidad Y Justicia, HIV Services Clinic, Boise State University and Northwest AIDS Education and Training Center partnered to complete a survey of HIV-knowledge and attitudes in Idaho Hispanic communities in District 3. The project was designed to assess perceptions among Hispanics in Idaho about HIV in regards to related risk factors, knowledge and attitudes in order to identify barriers to early presentation and testing for HIV, develop culturally appropriate strategies and educational materials for clinicians who provide HIV care, treatment, and services for this population. In May 2008, Judy Thorne and Sam Byrd presented the results of this project to the members of IACHA. This survey indicated the following:

- Those with more education tend to regard themselves as less at risk
- Nearly half (49%) of respondents indicated that they had ever had an HIV test and the majority (74%) indicated they would want to be tested if HIV testing had been available at the time of interview.
- The vast majority of all participants believe HIV/AIDS is a problem in the Latino community.
- The majority (95%) of all respondents believe that HIV causes death.

Description of Identified Services and Gaps

The Community Resource Inventory was updated in June 2007 with IACHA members from each Health District identifying district-specific HIV care and prevention services. Ryan White funding provides resources to address identified service gaps, enabling PLWH/A without other payer sources to access medical care and other services not available through other programs.

Idaho has a significant gap in care services in Health District two, where case management services are not available, clients must travel two hours to receive primary medical care at CHAS, and stigma is extremely high. In 2008, Idaho's Family Planning, STD and HIV Programs released a request for proposal to solicit potential providers of HIV Medical Case Management in Health Districts 1 and 2. A provider responded for District 1, but despite attempts from program staff and Idaho's Housing Opportunities for Persons with AIDS (HOPWA) program was unable to locate an agency in District 2 willing to submit a proposal in response to the request for proposals.

Some capacity building activities have occurred and further training is planned in District 2. Rapid Test training and technical assistance was provided to the University of Idaho student group, "Inland Oasis". Additionally, Dr. Blue (Idaho's State HIV Medical Director), in correlation with NWAETC, will provide training to the medical staff at Gritman Medical Center in Moscow in April 2009. These training activities provides not only greater outreach to PLWH who are unaware and PLWH who are aware and not in treatment, but additionally, a good foundation for either of these groups to potentially provide medical case management activities in the future.

A second issue that arises when talking about care is the lack of available support groups for HIV+ persons. Recruitment and retention in groups is difficult at best. The lack of success of support groups may well include all of the barriers to care identified by PLWH and providers in some proportion. Some health districts have unique barriers related to social, political, and religious issues. As was noted in the recruitment and information gathering phase of the statewide needs assessments, some areas of the state had a great deal more difficulty recruiting PLWH and MSM for the focus groups.

Although much of Idaho's system of care is linked together in some form, data tracking systems are not entirely linked together. Idaho still uses stand alone data systems for the majority of case management sites; although, the RWPC clinic and their satellite are linked together giving each access to all medical information needed to provide good care. The state RWPB program has dedicated funding to linking the systems together and upgrading to a real-time data system. In the meantime, it remains difficult to ensure that all who need the data have access to it.

Ryan White Grantees in Idaho have developed a system to minimize the overlap in services and funding. During the last three years, Part C and Part B program staff have focused on identifying funding streams and allocating payment to allow the most efficient use of available funding for uninsured PLWH in Idaho. The RWPB program will continue to sponsor an annual providers meeting to build upon the process to ensure the best efficiencies.

VIII. OUTREACH AND CAPACITY BUILDING ACTIVITIES

Through a collaborative partnership between Idaho State University/Boise; El Ada Community Action Partnerships; and FPSHP, Idaho has been able to provide mobile HIV testing/health screenings for some of our most difficult to reach, at-risk populations in Districts 3 and 4 since August 2007. The at-risk populations identified have been transient individuals and individuals in day shelters, women and children's shelters, and teenage gathering places. Individuals within these groups may have previously identified as HIV+, but may not be in care due to a lack of resources or information. Besides rapid testing, mobile users are given resource information, educational packets, and free blood pressure checks and glucose screenings. They are referred to the closest health care provider for further care as needed.

Some capacity building activities have occurred and further training is planned in District 2. Rapid Test training and technical assistance was provided to the University of Idaho student group, "Inland Oasis". Additionally, Dr. Blue (Idaho's State HIV Medical Director), in correlation with NWAETC, will provide training to the medical staff at Gritman Medical Center in Moscow in April 2009. These training activities provides not only greater outreach to PLWH who are unaware and PLWH who are aware and not in treatment, but additionally, a good foundation for either of these groups to potentially provide medical case management activities in the future.

Idaho's HIV Testing Sites

Idaho's HIV Prevention Program provides funding to a number of sites to provide testing and HIV prevention information. The following is a list of these testing sites:

DH1:
Panhandle District Health (primarily rapid testing)
Port of Hope - Substance Abuse Clinic
Four County Jails: Benewah, Bonner, Shoshone, Kootenai
Two Juvenile Detention Centers: Bonner, Kootenai
NIAC - HIV/AIDS Organization
Benewah Women's Center - Crisis Center/Support
Shoshone Women's Center - Crisis Center/Support
Free rapid testing at four satellite clinics on National HIV Testing Day and World AIDS Day

DH2:
Inland Oasis (MOA)
Inland Oasis Office in Moscow - Saturday testing hours

DH3:
Southwest District Health (conventional testing, Hepatitis C and Syphilis testing at some sites)
Farmway Village - Migrant clinic
Valley Crisis - Women's Crisis Center
Port of Hope
Canyon/Quad County Drug Court
Hope's Door - Women's Shelter

Lighthouse Mission - Shelter
Terry Reilly - Medical Clinic
Hispanic Cultural Center
Free testing at the following events: Latino Health Fair, National HIV Testing Day

DH4: Three agencies provide free rapid testing:

1) El Ada - community based organization, targets homeless and low income men and women, testing offered at their Boise office and at various sites and events
   Mobile Van - stops at Boise locations frequented by homeless and low income
   Vixen Video - adult video shop
   Vineyard Church
   Free testing offered at Mama Jam event and Valley County Flea Market
2) Family Practice Residency - HIV Services Clinic offers free rapid testing at:
   Ada County Juvenile Detention
   Family Services Center - Substance Abuse/Mental Health/HIV Case Management (Serves Hispanic population)
3) a.l.p.h.a. - HIV prevention community based organization provides testing at downtown Boise location, Boise State University, and community events including Gay Pride

DH5: South Central District Health offers free rapid testing at the following sites:
Twin Falls County Jail
Walker Center – substance abuse treatment in-patient facility in Gooding and outpatient in Twin Falls
Snake River Juvenile Detention Center
MiniCassia County Jail
Free testing during awareness events

DH6:
Southeastern District Health offers either free rapid or conventional tests at the following sites:
Bannock County Jail
Charlie's Bar - Pocatello
Genesis Project - Community Level Intervention targeting MSM
Four Directions Treatment Center - Substance Abuse Treatment on the Fort Hall Reservation
Colonial Inn - Bar in Blackfoot
Free testing on National HIV Testing Day

DH7: Eastern Idaho Public Health offers free rapid or conventional tests at the following sites:
Community Work Center - Work Release Program
Bonneville County Jail
Alcohol Rehabilitation Center
PFLAG - friends of lesbians and gays organization
Harbor House - Women's Shelter
Drug Court

SECTION IX: SCIENCE-BASED PREVENTION ACTIVITIES/ INTERVENTIONS

Priority Populations for 2009-2011

Upon review of the 2006 HIV/AIDS Epidemiologic Profile, IACHA set HIV prevention priority populations for each of the seven health districts in Idaho. As mandated by CDC, HIV positive persons are ranked as priority population number one. District priority populations were ranked for each health district as follows:

District 1

The following are the prioritized populations for District 1:

1. HIV+
2. MSM (Specifically White men)
3. HRH (Specifically men and women)
4. IDU (Specifically those over the age 40+ and/or youth)

* UNR—Significant concern needing more data

District 2

The following are the prioritized populations for District 2:

1. HIV+
2. MSM (Specifically White men)
3. IDU
4. HRH

* UNR—Significant number

District 3

The following are the prioritized populations for District 3:

1.1 HIV+MSM
1.2 HIV+ Hispanic men and women
1.3 HIV+ Risk not specified
2.0 MSM
2.1 MSM/IDU
3.0 Hispanic families
3.1 Hispanic men
3.2 Hispanic women
4.0 IDU men and women

District 4

The following are the prioritized populations for District 4:

1. HIV+
2. MSM (Specifically ages 20–49)
3. IDU
4. HRH

* UNR—Need more information

District 5

The following are the prioritized populations for District 5:

1. HIV+
2. MSM
3. IDU
4. HRH (Specifically Hispanic women)

District 6

The following are the prioritized populations for District 6:

1. HIV+
2. MSM (Specifically White men, ages 20-49)
3. IDU
4. HRH (Specifically Native American and Black/African American women)
5. MSM/IDU

District 7

The following are the prioritized populations for District 7:

1. HIV+ (Specifically White men, ages 20-40)
2. MSM (Specifically men, ages 20-40)
3. IDU
4. MSM/IDU
5. HRH (men and women)

* Focus needed on Hispanic population

Interventions for 2009

Due to FPSHP receiving a cost-extension from CDC for the 2009 contract year, all health education/risk reduction (HE/RR) and health communication/public information (HC/PI) interventions were extended for a fourth and final year of funding. These programs were based on Idaho's Comprehensive Plan for HIV Prevention 2007-2008.

Interventions for 2010-2011

During 2007 a needs assessment, of the top two priority populations for each district, was conducted by ISU as described in Section VII. In 2008, with guidance from ISU, regional planning groups used both epidemiological information and the outcome of needs assessments to develop HIV care and prevention strategic plans. The strategic plans are included in Appendix C.

In fall 2008, the IACHA Research Committee was given the task of reviewing prevention interventions. Their instruction was to take into consideration the prioritized populations, the needs assessments (of HIV positives and MSM in all districts and Hispanics living in District 3) and the district-specific strategic plans and make recommendations to the larger IACHA membership. The Research Committee members decided to limit recommended interventions to those that had evidence of effectiveness.

During the February 2009 IACHA meeting, the Research Committee provided an overview of the Committee's recommendations of intervention programs. The Committee based selections on the following criteria:

a) How best does the intervention address target populations as identified by IACHA?
b) Using the CDC's three criteria categories, which interventions indicate the best evidence of success?
c) Which interventions have training available (online, in person, manuals, etc.)?

The Committee noted that some interventions serve more than one target group and that all interventions must be adapted to better fit the needs of Idaho.

The following is a list of the HIV Prevention Intervention recommendations (with correlated risk group) made by the IACHA Research Committee and approved by IACHA:

1. All Groups:
    a. **HIV CTR:** Health Districts benefit from and are recommended to continue with HIV counseling, testing, and referral including HIV rapid testing as an intervention

    b. **Health Communication Public Information (HC/PI)**
    HC/PI interventions are planned HIV/AIDS prevention messages delivered through one or more channels to target audiences to influence knowledge, attitudes, beliefs, and/or behaviors of individuals and communities. HC/PI can accomplish any one or more of the following: build general support for safe behavior, support personal risk-reduction efforts, raise awareness, increase knowledge, refute myths and misconceptions, suggest and enable action, inform persons at risk for infection how to obtain specific services, increase support for and/or demand for services, and help build organizational relationships.

    HC/PI programs should use multiple approaches to motivate and involve people and communities. Using health communication methodologies is not sufficient to guarantee change. Plans for creating sustained behavior change should include information/communications in combination with other prevention strategies.

    HC/PIs can be delivered through any one of the following methods:

    Presentations/Lectures: These are information-only activities conducted in group settings; often called “one-shot” or “HIV 101” education interventions

    Health/Community Fairs: To set up information tables or booths which may include interactive activities for the purpose of disseminating information verbally and written to the general public and/or high-risk populations. Health/community fairs raise awareness and assist in building relationships within a community. This intervention may be used as a vehicle to recruit persons for other services/programs.

    Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-,or statewide) audience.

    Print Media: These formats also reach a large-scale or nationwide audience and include any printed material, such as newspapers, magazines, pamphlets and “environmental media” such as billboards and transportation signage.

    Hotline: Telephone service (local or toll-free) offering up-to-date information and referral to local services (e.g., counseling/testing and support groups).

Clearinghouse: Interactive electronic outreach systems using telephones, mail and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.

c. **Safe in the City**
This is an HC/PI with potential for testing interventions.

2. HIV Positives:
   a. **Comprehensive Risk Counseling and Services (CRCS)**
   CRCS is intensive, individualized client-centered counseling for adopting and maintaining HIV risk-reduction behaviors. CRCS is designed for HIV-positive and HIV-negative individuals who are at high risk for acquiring or transmitting HIV and STDs and struggle with issues such as substance use and abuse, physical and mental health, and social and cultural factors that affect HIV risk. This program is based on best practices and recommended by CDC.

   b. **Safety Counts**
   This intervention for out-of-treatment, active injection and non-injection drug users is aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings, and makes referrals to HIV and HCV counseling and testing, medical and social services.
   http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/safetycounts.htm

   c. **Choosing Life: Empowerment, Actions, Results (CLEAR)**
   This is an in-person delivered intervention with 18 one-on-one sessions targeting young HIV+ substance users and seeking to improve health and sexual decision making.
   http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/CLEAR.htm

   d. **Healthy Relationships: Prevention for Positives**
   This is a group level intervention for HIV positive people, targeting heterosexual men and women and MSM. The Research Committee recommends this intervention for the Boise area only.
   http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/HealthyRelationships.htm

3. MSM:
   a. EXPLORE
   This intervention targets HIV-seronegative men who have sex with men. The goals of the intervention include the following:
   - Prevent the acquisition of new HIV infection
   - Reduce unprotected anal intercourse, serodiscordant unprotected anal intercourse, and serodiscordant unprotected receptive anal intercourse

http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/EXPLORE.htm

b. **Mpowerment Project**
This multi-component intervention includes 2 types of formal outreach, informal outreach, peer-led small groups, and a small ongoing publicity campaign.
http://www.cdc.gov/hiv/resources/reports/hiv_compendium/section1-16.htm

4. High Risk Heterosexuals:
   a. **Project Respect: Two Models of Effective, Individual, Client-focused HIV Prevention Counseling Intervention**
   This intervention targets heterosexual men and women at STD clinics ages 14 and over. The focus is to reduce risky sexual behaviors through one-on-one counseling sessions (two "brief" or four "enhanced" sessions).
   http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/respect.htm

   b. **SISTA**
   This intervention targets African American women through weekly group sessions. It seeks to empower women to make healthy sexual decisions.
   http://www.cdc.gov/hiv/resources/reports/hiv_compendium/section1-9.htm

   c. **Street Smart**
   Street Smart is a multisession, skills-building program designed to help groups of runaway youth reduce unprotected sex, number of sex partners, and substance use. This intervention targets runaway youth, ages 11 to 18.
   http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/streetsmart.htm

5. Injection Drug Users:
   a. **Choosing Life: Empowerment, Actions, Results (CLEAR)**
   This is an in-person delivered intervention with 18 one-on-one sessions targeting young HIV+ substance users and seeking to improve health and sexual decision making.
   http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/CLEAR.htm

   b. **Street Smart**
   Street Smart is a multisession, skills-building program designed to help groups of runaway youth reduce unprotected sex, number of sex partners, and substance use. This intervention targets runaway youth, ages 11 to 18.
   http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/streetsmart.htm

   c. **Safety Counts**
   This is an intervention for out-of-treatment, active injection and non-injection drug users that is aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings, and makes referrals to HIV and HCV counseling and testing, medical and social services.

http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/safetycounts.htm

6. Youth:
    a. **Street Smart**
    Street Smart is a multisession, skills-building program designed to help groups of runaway youth reduce unprotected sex, number of sex partners, and substance use. This intervention targets runaway youth, ages 11 to 18.
    http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/streetsmart.htm

    b. **Focus on kids (FOK)**
    Targets high risk youth through eight small-group sessions of risk reduction intervention. The second component is a single session with the individual youth and parent. Parent monitoring and commitment is emphasized. District 3 prioritized Hispanic families as 3.0. This may be a way to address this priority by targeting HR Hispanic (though this intervention specifically targets African American youth) youth and their parents in this intervention. It can be delivered in Community housing settings for FOK and Impact may be also presented in participant's homes.
    http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/FOK-ImPACT.htm

7. Latino(a)s/ Spanish-Speakers:
    a. *¡Cuidate!* A culturally-based program to reduce HIV sexual risk behavior among Latino youth
    This is a group level intervention that targets Spanish and English speaking Latino youth while incorporating culturally relevant information to encourage safer sex behaviors. This intervention utilizes both abstinence and safer-sex approaches.
    http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/!cuidate!.htm

    b. Project SAFE (Standard Version)
    This intervention targets African American and Hispanic women diagnosed with a STD in public health clinics. It seeks to reduce sexual risk behaviors though three small group sessions delivered by an ethnically matched facilitator.
    http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/SAFE.htm

    c. VOICES/ VOCES: Video Opportunities for Innovative Condom Education and Safer Sex
    This intervention targets African American and Latino Men and seeks to encourage safer sex behaviors. This intervention is provided in a clinic setting with a small, group-level intervention of one session using videos specific to cultural group and is available in English and Spanish. The groups are culturally (ethnic and gender) specific. http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/voices.htm

8. High Risk Negatives:
    a. **Comprehensive Risk Counseling Services**

    b. **Safety Counts**

This is an intervention for out-of-treatment, active injection and non-injection drug users that is aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings, and makes referrals to HIV and HCV counseling and testing, medical and social services.
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/safetycounts.htm

9. People being released from correctional facilities:
    a. **Project Start**
    This intervention was designed specifically for young men (18-29 years) leaving prison focusing on sexual risk, with reincarceration as a secondary outcome.
    http://www.cdc.gov/hiv/topics/research/projectSTART/index.htm

The recommendations of the Research Committee will help inform FPSHP as they prepare requests for proposals (RFPs) that will be released in August 2009. The RFPs will be for prevention programs that will begin January 1, 2010.

SECTION X: OVERARCHING GOALS FOR HIV CARE AND HIV PREVENTION

Over the past several years, IACHA, FPSHP and collaborative partners have worked hard to conduct needs assessments and surveys aimed at determining how best to address the needs of providing HIV care and prevention programs in the state of Idaho. For district-specific goals, please review the strategic plans that are attached to this Plan.

ISSUE: STIGMA

Stigma is a statewide issue reflecting the many barriers to prevention and care services that clients and providers have identified. Stigma presents in many different forms and each health district may experience differing stigma sources based upon economic, religious, race and ethnicity, and community HIV knowledge levels. Strategies for addressing HIV/AIDS stigma should include comprehensive interventions targeting policy makers, the community, and individuals.

A. GOAL: Develop and fund statewide HIV media campaign. Ongoing thru 2011		
Action Steps	**Responsible Entity**	**Timeline**
1. Develop strategies and activities to educate decision-makers for 2010 legislative sessions. • Involve private employers or affiliated nonprofits of IACHA members. • Develop a structural intervention through RFP's for Health Communications and Publication Information (HCPI). • Involve Regional Strategic Planning Groups. Invite representatives to IACHA May meeting to discuss this opportunity. • Collaborate with District 4's Strategic Planning Group. • Determine other groups that will be involved on a community planning level.	IACHA membership	Contact Regional Planning Groups by March 30, 2009. Complete by November 2010
2. Research stigma interventions and media for best practices.	IACHA Research Committee	January 2010, with interim updates.
3. Increase access to pharmaceutical company education grants and activities and develop lists for IACHA and Strategic Planning Groups.	Ryan White Part B Program	First list to be developed by August 2009.

B. GOAL: Address stigma issues with providers and clients.		
1. Determine methods and resources to educate clients, providers and health educators about dealing with all levels of stigma.	Providers of HIV Care Services and Testing, FPSHP staff, RW Grantees, IACHA's Administrative Committee (by engaging Regional Planning Groups)	IACHA Administrative Committee will contact Regional Planning Groups by March 30, 2009 to advise them of available funds and support. Efforts will be ongoing.

ISSUE: INSUFFICIENT HIV KNOWLEDGE

This is a statewide concern among patients, providers and their communities. Patients often lack basic knowledge of HIV and standards of care; providers often lack basic knowledge of HIV and are not aware of current standards of care; community members often lack basic knowledge of HIV that contributes to levels of stigma experienced by clients statewide. In addition, focus groups in all seven districts mentioned need for consistent message in schools and in Idaho communities.

C. GOAL: Increase HIV and Other STD Education in Schools.		
Action Steps	**Responsible Entity**	**Timeline**
1. Get a member from the Department of Education on IACHA.	IACHA and FPSHP	By August 2009.
2. Offer support, tools and expertise to the Department of Education (DOE) to teach Sexual/Health HIV in Idaho schools. Also, encourage collaboration of DOE with Regional Planning Groups	IACHA Administrative Committee and DOE's IACHA member representative	Ongoing
3. Provide funding for Regional Planning Groups.	HIV Prevention Program	Send letter to Regional Planning Groups by March 2009
***D. GOAL: Develop and fund statewide HIV media campaign.* (See Goal A; steps 1, 2, 3.)**		

ISSUE: LACK OF PROVIDERS AND SUPPORT SYSTEMS

There are few HIV specialists and few primary doctors in Idaho doctors willing to treat HIV+ clients. Additionally, some providers do not have prescribing knowledge regarding HIV medications and are not trained in HIV mental health needs, thus are unable to properly diagnose mental health problems. Finally, participants of focus groups and surveys repeatedly expressed desire for HIV support groups.

E. GOAL: Increase Number of HIV Providers and HIV Support Groups		
Action Steps	**Responsible Entity**	**Timeline**
1. Develop RFP for services (case management in Southwest and Southeast Idaho).	FPSHP Part B	Summer 2009
2. Continue to educate clinicians.	NWAETC	Ongoing
3. Make access to HIV medical/case manager education easier with statewide tele-health networking.	FPSHP Part B	Ongoing
4. Get to know providers and issues at the local level and fund regional planning groups.	FPSHP Part B	July 2009
5. Conduct grant writing workshop	HIV Prevention Program	July 2009
6. Select evidence-based interventions	HIV Prevention Program	July 2009

ISSUE: ADDRESS NEED FOR HIV TESTING

Due to stigmatization, many seek testing locations other than at the local health departments. In addition, testing site locations need to be better advertised to make communities aware of their existence.

F. GOAL: Increase HIV Testing Sites		
Action Steps	**Responsible Entity**	**Timeline**
1. In the next competitive application, request more funds to bring rapid testing to high risk populations at more alternate test sites (non-clinical).	HIV Prevention Program	September 2009
2. Train providers to do better planning on how and where to reach high-risk populations.	HIV Prevention Program	February 2010
3. Train providers to implement improved outreach and recruitment strategies.	HIV Prevention Program	February 2010
4. a) Use state funds to help train a trainer for "Social Network Strategies Training". b) Offer training to testing providers and continue to offer it each year.	HIV Prevention	A. Completed in 2009 B. Buy in March 2009 and pilot in 2010
5. Work towards normalizing HIV testing by promoting the CDC recommendations for screening - this also will require asking for more funds from CDC or through other federal, state or non-governmental organizations.	HIV Prevention, Regional Planning Groups, Community Based Organizations.	Ongoing
6. Encourage all providers to tag-on or take advantage of national testing campaigns	HIV Prevention, IACHA	Ongoing

ISSUE: HIGH QUALITY AND COORDINATED SYSTEM OF CARE

Ideally, a high quality system of care begins with consistent and appropriate HIV education, access to prevention activities, interventions and messages, and extending through providing quality, sustainable, accessible care services for those already infected with HIV. In an era of sparse and inadequate school based sex education, reduced prevention funding, increasing HIV+ numbers, reduced resources while need continues to grow, and stigma and isolation for populations at risk and PLWH, coordination of existing services is crucial to maintaining and improving the existing systems.

G. GOAL: Increase Coordination of Services		
Action Steps	**Responsible Entity**	**Timeline**
1. Continue to discuss and improve coordination of funding activities	FPSHP, HOPWA, HIV Services Clinic, and other appropriate entities.	Ongoing
2. Continue annual HIV care providers meeting	RWPB, QM Coordinator.	Annually
3. Expand coordination to other providers of STD services, other public or private health care organizations, private fundraisers, and strategic planning groups	IACHA, FPSHP, Strategic Planning Groups	Ongoing
H. GOAL: Create Additional Linkages for Care and Prevention Data Needs		
Action Steps	**Responsible Entity**	**Timeline**
1. Continue project to link HIV care data systems together	RWPB, HIV Services Clinic, IDHW	Review progress at August 2009 meeting
2. Expand surveillance programs role in coordinating data sources and ensuring timely, accurate and quality data	IDHW, Health Departments, IACHA	Ongoing Monthly Meetings, BI Annual Site Visits, IACHA Meetings
3. Monitor and update Statewide Quality Management Plan and provide outcome results	Statewide QM Committee, Part B Providers, Part C Providers, IACHA, FPSHP	Identified timelines in QM Plan

ISSUE: LACK OF ADEQUATE PAYMENT SOURCES FOR HIV POSITIVE CARE NEEDS

Gaps in available medical care and quality of care may be linked to lack of adequate payment sources for services provided. Ryan White Part B and C have limited funding to meet the core medical and support services of patients.

I. GOAL: Increase and Coordinate Available Funding Sources		
Action Steps	**Responsible Entity**	**Timeline**
1. Incorporate other private funders into annual providers meeting	RWPB, QM/CP Coordinator	Annual Meeting Date
2. Provide data to Idaho State Legislature in coordination with substance abuse regional advisory Councils and Wellness Center. IACHA will write thank you letters to legislators on behalf of their constituents.	IACHA	Develop approach at August, 2009 meeting for next legislative session.
3. Move toward purchasing insurance coverage with ADAP funds	RWPB, ADAP, IACHA Data Committee	RWPB and IACHA Data Committee to provide update at August 2009 meeting

ISSUE: TRANSPORTATION TO MEDICAL CARE

This is a statewide concern due to the long distances that many clients must travel to receive care. Additionally, public transportation is nonexistent or very limited throughout the state.

J. GOAL: Improve Access to Transportation to Medical Care		
Action Steps	**Responsible Entity**	**Timeline**
1. Engage Regional Planning Groups to conduct Gap Analysis for community specific transportation needs.	Administrative Committee to discuss and reach agreement on an approach and present to IACHA at August, 2009 meeting.	Report during August 2009 meeting.
2. Explore telehealth as an alternative approach for accessing care.	Lynsey and Bebe	Report during the August 2009 meeting

MONITORING OF GOALS

During the May 2009 IACHA meeting additional goals, action steps with corresponding responsible entities, and timeline may be identified and integrated into the plan. The ultimate responsibility for monitoring of the comprehensive plan falls upon the community planning body. The Community Planning Contract with Mountain States Group has been amended to include monitoring of the district strategic plans and oversight of the funding targeted toward those groups. The community planning liaison will be responsible for completing these duties. A summary of completed goals and activities will be sent as an attachment to both the care and prevention grant applications after review and approval by IACHA members. The goal is to incorporate the combined comprehensive plan into a proposed annual work plan.