

Idaho Statewide Coordinated Statement of Need

2012

The Idaho Statewide Coordinated Statement of Need was 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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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Part 1. The SCSN Development Process

To determine the needs of people living with HIV/AIDS in Idaho and to complete the tasks as designated by the Statewide Coordinated Statement of Need (SCSN), Idaho's Department of Health and Welfare's Family Planning, STD and HIV Programs (FPSHP) worked closely with the state planning body, the Idaho Advisory Council on HIV and AIDS (IACHA). Together, FPSHP and IACHA identified missing data elements, developed needs assessments and surveys, reviewed resulting data and set goals.

IACHA is a community-based group comprised of PLWH/A and individuals representing various risk groups. Staff FPSHP serve as members and technical assistance providers to IACHA. In addition, IACHA receives consistent technical assistance from representatives of the Ryan White Part C (RWPC) clinic in Boise (the Wellness Center), Housing Opportunities for Persons with AIDS (HOPWA), the Northwest AIDS Education Center (NWAETC) and the Department of Education.

Identifying and Accessing Missing Data

MSM:

Reviewing the Epi Profile, IACHA members recognized the great burden of HIV on MSM. Consequently, IACHA's Research Committee worked with the HIV Prevention Program to organize a focus group of young gay men in Boise (ages 18-29) in February 2011. The outcome of the focus group was less than desired: seven men registered; four participated. IACHA's Research Committee and the HIV Prevention Program also made efforts to administer an MSM survey online, but due to insufficient funding and time, the survey was not completed.

In October 2011, IACHA organized a panel of HIV+ individuals to answer HIV care and prevention related questions. Seven MSM participated representing 5 of the 7 health districts.

IDU:

Beginning in fall 2011, IACHA's Data Committee recommended that the HIV Prevention program conduct a needs assessment of IDU and MSM/IDU due to the following reasons:

1. A needs assessment of IDU has not been completed in Idaho since 2003
2. According to the Epi Profile for 2005-2009, IDU as a risk group individually represents 8% of new infections, but when combined with MSM/IDU, represent nearly 19% of newly diagnosed individuals

Following this recommendation, IACHA's Research Committee in collaboration with the HIV Prevention Program began to develop a survey to be distributed to IDU (both MSM and non-MSM). This survey was further refined during the February 2012 IACHA meeting. IACHA members continue to work with the HIV Prevention Coordinator to improve this survey and determine the best mode of distribution.

Ryan White Consumers:

In January 2012, IACHA and the Ryan White Part B Program developed and disseminated a survey to ___ consumers of HIV services (including consumers in all areas of Idaho, all health departments, consumers receiving HIV medical care through the Veterans Administration and recipients of Ryan White Part B, Part C and ADAP programs). In total __ consumers responded to the survey. Please see **Appendix X** for HIV Consumers Report.

Providers:

In December 2011, IACHA and the Ryan White Part B Program developed and disseminated a survey to 39 providers of HIV services (including Medical Case Managers, Part C Clinic staff, mental health providers, private HIV specialists, the state HOPWA administrator, health department staff, hospitals, Emergency Rooms, Epidemiologists, Federally Qualified Health Centers, Community Based Organizations, and Community Action Programs). In total, 24 providers responded to the survey. Please see **Appendix X** for HIV Providers Report.

Prioritization of Populations:

Regional Planning Groups (RPGs) in each health district were asked to prioritize populations. RPGs use the prioritization tool developed by the Data Committee and information available in the Epi Profile to determine final prioritization rankings (see Page __ for the final results).

RPGs in Districts 1, 2, 4, 5, 6 and 7 finalized their ranking. The IACHA Administrative Committee finalized the ranking for District 3.

Resource Inventory:

Per contract, agencies providing Medical Case Management services were required to submit resource directories to the state. The resource directories provided information about services as defined by the Ryan White program. The Quality Management Coordinator and Ryan White Coordinator combined the directories into a statewide document.

Quality Management Program Data:

Co-chairs of IACHA's Research Committee, Data Committee and Finance Committee also serve on the Idaho Quality Management Committee. This link helps maintain communication between the two committees. IACHA reviewed the 2011 Quality Management data during the February 2012 meeting.

Pulling Information Together

During the February 2012 IACHA meeting, workgroups formed to review the data as described above to develop goals for the HIV Care and Prevention Comprehensive Plan and identify needs for the SCSN. The state provided the groups with guidance to identify disparities in care, access to services and service gaps. The groups focused on the following tasks:

1. Review data from a consumer perspective and identify service gaps and priorities
2. Review data from a provider perspective and identify service gaps and priorities
3. Review data to identify service gaps in various regions in Idaho

Each group provided a summary of their work and identified recommended goals to be included in the SCSN and Comprehensive Plan.

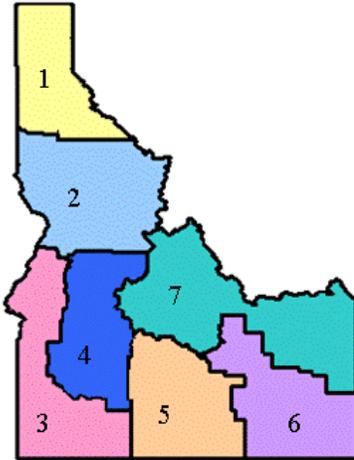
A fourth group met during the IACHA meeting to continue to refine the IDU needs assessment and address state survey requirements.

Following the February IACHA meeting, the IACHA Coordinator, FPSHP staff and IACHA Administrative Committee reviewed the recommendations and began to piece together the Comprehensive Plan goals and SCSN. Prior to the May 2012 IACHA meeting, members have had a chance to review the Comprehensive Plan and SCSN to make final recommendations. The finalization of the Comprehensive Plan and the SCSN are scheduled for early June 2012, with a final copy of the SCSN submitted to HRSA by June 1, 2012 and the Comprehensive Plan submitted to HRSA and CDC by June 15, 2012.

Part 2. Description of People Living with HIV/AIDS in Idaho

General Demographics of Idaho

The U.S. Census Bureau estimated the Idaho population to be 1,567,582 in 2010. Idaho ranks 39 in the nation in population, with less than 1 percent of the U.S. population.



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. 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 (as noted in map).

The following table illustrates the distribution of the population by gender and age. Note that over one-third of Idaho’s population is 24 years of age or younger.

Table 1: Distribution of Population by Gender and Age— Idaho

Age Group	Male	%	Female	%	Total	%
≤14	180,037	23%	171,887	22%	351,924	23%
15-19	58,173	7%	56,771	7%	114,944	7%
20-24	59,718	8%	53,991	7%	113,709	7%
25-29	57,133	7%	54,211	7%	111,344	7%
30-39	99,952	13%	95,350	12%	195,302	13%
40-49	99,142	13%	97,931	13%	197,073	13%
>49	221,763	29%	239,742	31%	461,505	30%
Total Population	775,918	100%	769,883	100%	1,545,801	100%

Source: Estimates for 1990-1999 are bridged-race intercensal population estimates of the July 1 resident population. Estimates for 2000-2009 are Vintage 2009 bridged-race postcensal population estimates of the July 1 resident population. These estimates were prepared by the Census Bureau in collaboration with NCHS.

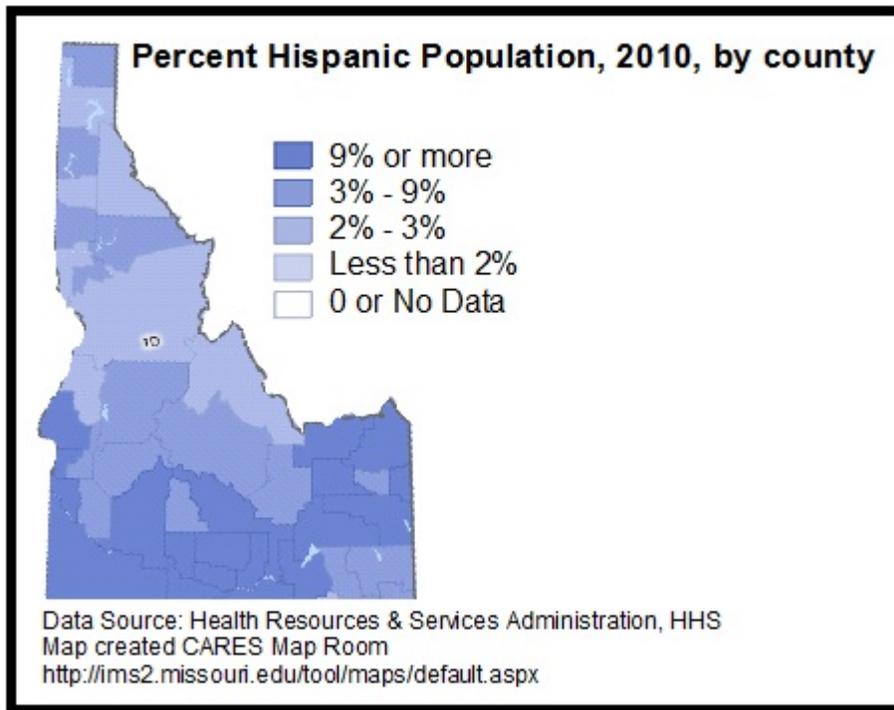
The following table illustrates the distribution of the population by gender and ethnicity. In Idaho, Hispanics comprise 11% of the population. Comparatively, Hispanics comprise 16.3% of the U.S. population (according to the U.S. Census Bureau, 2010 Census).

Table 2: Distribution of Population by Ethnicity— Idaho

Ethnicity	Male	%	Female	%	Total	%
Hispanic or Latino	87,499	11%	77,786	10%	165,285	11%
Not Hispanic or Latino	688,419	89%	692,097	90%	1,380,516	89%
Total Population	775,918	100%	769,883	100%	1,545,801	100%

Source: Estimates for 1990-1999 are bridged-race intercensal population estimates of the July 1 resident population. Estimates for 2000-2009 are Vintage 2009 bridged-race postcensal population estimates of the July 1 resident population. These estimates were prepared by the Census Bureau in collaboration with NCHS.

The following map shows the more densely Hispanic populated areas of Idaho to be in the southern part of the state.



The following table illustrates the distribution of the population by gender and race. Among both males and females, the majority of Idahoans are white.

Table 3: Distribution of Population by Race— Idaho

Race	Male	%	Female	%	Total	%
American Indian/Alaska Native	13,303	2%	13,329	2%	26,632	1.7%
Asian or Pacific Islander	10,766	1%	12,432	2%	23,198	1.5%
Black or African American	9,045	1%	10,193	1%	19,238	1.2%
White	741,656	96%	735,077	95%	1,476,733	95.5%
Total Population	775,918	100%	769,883	100%	1,545,801	100%

Source: Estimates for 1990-1999 are bridged-race intercensal population estimates of the July 1 resident population. Estimates for 2000-2009 are Vintage 2009 bridged-race postcensal population estimates of the July 1 resident population. These estimates were prepared by the Census Bureau in collaboration with NCHS.

The following table illustrates the distribution of the population by health district. Health District 4, which includes the state capital (Boise) is the largest district in Idaho.

Table 4: Distribution of Population by Health District— Idaho

Health District	Population	Percent
District 1	213,662	13.8%
District 2	104,496	6.8%
District 3	251,013	16.2%
District 4	429,647	27.8%
District 5	179,994	11.6%
District 6	167,290	10.8%
District 7	199,699	12.9%
TOTAL	1,545,801	100%

The HIV/AIDS Epidemic in Idaho

Cumulative HIV and AIDS Diagnoses:

At 3.7 per 100,000, the Idaho rate is far below the estimated rate of 19.4 for the 37 U.S. states with mature HIV reporting systems in 2008. Rates of HIV infection (including concurrent AIDS diagnosis) have decreased in Idaho since the early 1990s, but appeared to increase substantially in the most recent two years for which data are available. In Idaho, 1,254 persons ever reported (regardless of whether they were diagnosed in Idaho or moved from another state) are presumed to be living with HIV/AIDS. For further details, see Table 5.

HIV Diagnoses:

A total of 459 residents were first diagnosed with HIV in Idaho from 1984–2009 and have not yet received an AIDS diagnosis.

- The majority (81%) of HIV cases were male and White (80%)
- By age, the highest proportion of HIV cases were diagnosed in persons aged 20-29 years (42%), though persons aged 30-39 years accounted for almost one-third of diagnoses

- The most frequently reported exposure category was MSM, although the proportion was less than half of the total.
- Five were pediatric cases.

For further details, see Table 5.

AIDS Diagnoses:

A total of 666 residents were first diagnosed and reported with AIDS in Idaho from 1984–2009.

- The majority (85%) were male and White (85%)
- Forty percent were aged 30–39 years at their AIDS diagnosis
- Over half of diagnosed cases were among MSM
- Three cases were pediatric

From 2008 to 2010, the number of new HIV cases was relatively flat, while there was a notable increase in the number of AIDS diagnoses over the three-year time period.

For further details, see Tables 5 and 6.

Table 5. HIV (not AIDS) and AIDS Cases by Year of Report— Idaho, 2008–2010

Note: Highlighted sections signify populations of significance

Year of Report								
Sex	2008		2009		2010		TOTAL (2008-2010)	
	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
TOTAL	37	29	41	33	32	51	110	113
	66		74		83		223	

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update

Table 6. Characteristics of Cumulative Non-duplicated Idaho Resident HIV & AIDS Diagnosed through 12/31/2009.
 Note: Highlighted sections signify populations of significance

	Disease/Condition			
	HIV		AIDS	
Sex	#	%	#	%
Male	373	81%	569	85%
Female	86	19%	97	15%
Total	459	100%	666	100%
Race/Ethnicity				
Hispanic	56	12%	69	10%
American Indian/Alaska Native	8	2%	10	2%
Asian/ Pacific Islander	3	1%	3	0%
Black	20	4%	17	3%
White	366	80%	562	84%
Unknown	6	1%	5	1%
Total	459	100%	666	100%
Age group at first diagnosis				
<13	5	1%	3	0%
13-19	13	3%	5	1%
20-29	192	42%	159	24%
30-39	141	31%	269	40%
40-49	81	18%	155	23%
Over 49	27	6%	75	11%
Total	459	100%	666	100%

Source: 2010 HIV/AIDS Epidemiologic Profile

Mode of Exposure:

Of the 1254 people who have been diagnosed with HIV or AIDS between 1984 and 2009, the primary modes of exposure are as follows:

- Over half (56%) of males living with HIV/AIDS in Idaho had MSM mode of exposure classification.
- Among men, IDUs accounted for 10% and the dual-category MSM/IDUs were an additional 14%.
- Over half of females living with HIV/AIDS had heterosexual or presumed heterosexual¹ mode of exposure.
- Both males and females had notable proportions of unidentified risk.

For further details, see Table 7.

¹ Includes only females answered “yes” to sex with male and “no” to IDU

Table 7. Presumed Living HIV/AIDS Cases by Sex and Mode of Exposure—Idaho, 2009

Note: Highlighted sections signify populations of significance

Exposure Category	Males		Females		Total	
	#	%	#	%	#	%
Adult						
MSM	575	56%	NA	-	575	46%
IDU	103	10%	62	27%	165	13%
MSM/IDU	148	14%	NA	-	148	12%
Hemophiliac	4	0%	1	0%	5	0%
Heterosexual contact	56	5%	94	41%	150	12%
Presumed heterosexual contact	0	0%	30	13%	30	2%
Transfusion/transplant	4	0%	2	1%	6	0%
Risk not specified	129	13%	28	12%	157	13%
Pediatric						
Mother with/at risk HIV	3	0%	8	3%	11	1%
Transfusion/transplant	0	0%	0	0%	0	0%
Other/undetermined	2	0%	5	2%	7	1%
TOTAL	1024	82%	230	18%	1254	100%

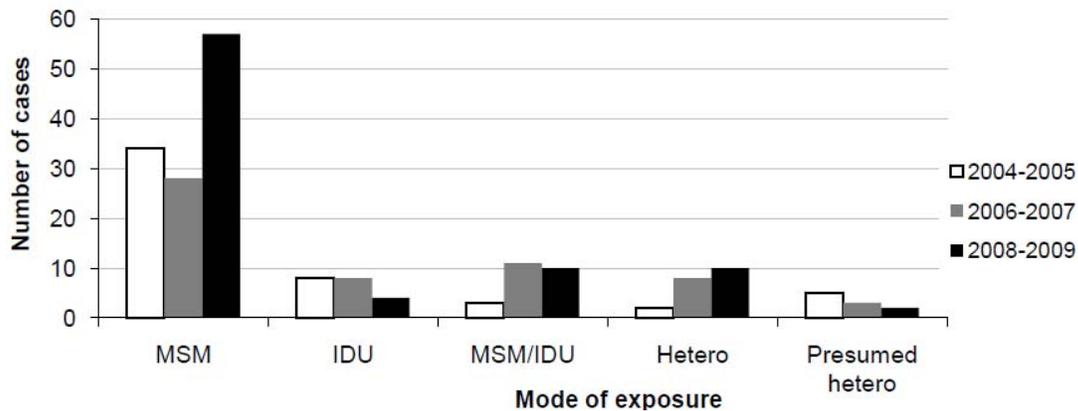
Source: 2010 HIV/AIDS Epidemiologic Profile

Recent trends regarding mode of exposure include the following:

1. The trend among MSM and MSM/IDU appeared to increase from 2007 to 2009
2. Heterosexual mode of exposure increased, but when combined with the presumed heterosexual category, the trend was somewhat flat, with 10 cases in 2004–2005 and 11 cases in 2008–2009

For further details, see Figure 1.

Figure 1. Two-Year Aggregate HIV/AIDS Diagnoses by Selected Mode of Exposure—Idaho, 2004-2009



Source: 2010 HIV/AIDS Epidemiologic Profile

HIV/AIDS Distribution by Health District:

Overall, in Idaho, the rate of reported persons presumed living with HIV/AIDS is 82.3 per 100,000. Health District 4 had the highest rate of reported persons presumed living with HIV/AIDS as well as the highest actual numbers of persons living with HIV/AIDS (for further details, see Table 8).

Recent trends observed by District Regional Planning Groups include the following:

3. North Idaho MSM groups are largely underground
4. North Idaho and Spokane, Washington area are seeing increased IDU with increased heroin use
5. In Districts 2 and 5, it is believed that many MSM are late-testers with infection occurring in earlier age
6. In District 6, it is believed that many people within the age range of 20-39 are late-testers with infection occurring in earlier age
7. Among clients case managed by the Part C clinic and District 6 Medical Case Managers, 15 cases of HIV positive clients were co-infected with Hepatitis C

Table 8. Presumed Living HIV (not AIDS) and AIDS by District of Residence at Report—Idaho, 12/31/2010
 Note: Highlighted sections signify populations of significance

Health District	Diagnosis Category		Total	Percentage	Rate of Total (per 100,000)
	HIV	AIDS			
District 1	64	85	149	12%	70.0
District 2	40	45	85	7%	80.6
District 3	67	93	160	12%	62.9
District 4	277	261	538	42%	123.0
District 5	55	63	118	9%	63.3
District 6	73	62	135	10%	79.6
District 7	54	55	109	8%	53.1
TOTAL	630	664	1,294	100%	82.3

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update

Gender:

Overall, both HIV and AIDS in Idaho is much higher numbers in males as exemplified in the following data:

- More males than females were living with HIV/AIDS in Idaho at the end of 2007
- Males outnumbered females at a ratio of 5.5:1 (at the national level, this ratio is 2.7:1, according to the CDC 2008 HIV Surveillance Report)
- From 2005-2009, 84% of new HIV and AIDS diagnoses were among males; 16% were among females
- The 2010 HIV total number of males reported (28) was 7 times the number of females (4)
- From 2008 to 2010, the number of newly reported AIDS diagnoses among males was greater than those among females by a multiple of 3.9

- The two-year aggregate rates of HIV/AIDS diagnoses increased sharply among males, rising 57% from 3.9 per 100,000 in 2004–2005 to 6.1 per 100,000 in 2008–2009.

For more information, see Tables 9 and 10 and Figure 2.

Table 9. HIV (not AIDS) and AIDS Cases by Sex and Year of Report— Idaho, 2008–2010

Note: Highlighted sections signify populations of significance

Sex	Year of Report							
	2008		2009		2010		TOTAL (2008-2010)	
	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
Male	31	24	36	24	28	42	95	90
Female	6	5	5	9	4	9	15	23
TOTAL	37	29	41	33	32	51	110	113
	66		74		83		223	

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update

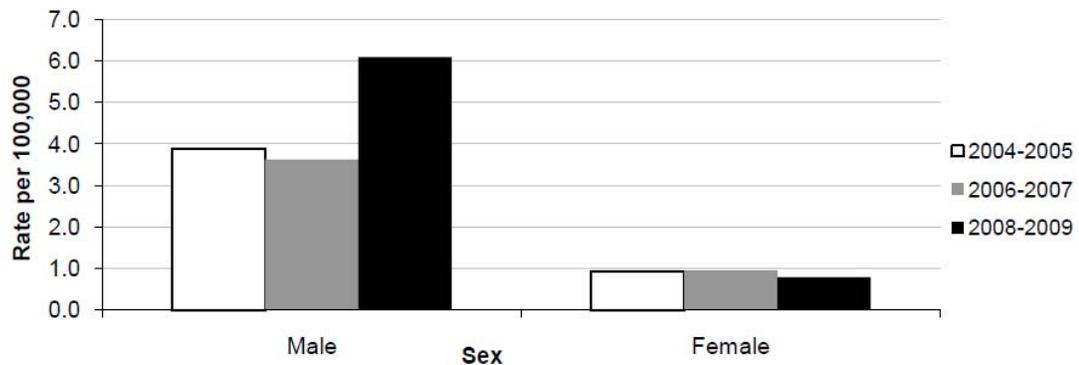
Table 10. Cumulative HIV and AIDS Diagnoses in Idaho through 12/31/2009

Note: Highlighted sections signify populations of significance

Sex	HIV		AIDS		HIV/AIDS Combined	
	#	%	#	%	#	%
Male	373	81%	569	85%	942	84%
Female	86	19%	97	15%	183	16%
TOTAL	459	100%	666	100%	1125	100%

Source: 2010 HIV/AIDS Epidemiologic Profile

Figure 2. Two-Year Aggregate Rate of HIV/AIDS Diagnoses by Sex—Idaho, 2004-2009



Source: 2010 HIV/AIDS Epidemiologic Profile

Late Testers:

In Idaho, the trend of individuals diagnosed with AIDS within 1 year of HIV diagnosis has been variable since the late 1980s. AIDS was diagnosed within 1 year in 36% of individuals diagnosed with HIV during 2005–2009. This is similar to national proportion of 32% and 38% reported by CDC in the 2008 HIV Surveillance Report and the June 2009 Morbidity and Mortality Weekly review article (*Late Testing-34 States, 1996–2005*), respectively.

- In regards to individuals diagnosed with AIDS within 1 year of HIV diagnosis, there was no appreciable difference observed between males and females.
- Hispanics and Whites had similar proportions consistent with the overall total (38% of Hispanics were diagnosed with AIDS within 1 year; 36% of Whites were diagnosed with AIDS within 1 year)
- Of the four American Indians diagnosed between 2005-2009, three-quarters were diagnosed with AIDS within 1 year
- Individuals with Heterosexual or Unspecified modes of exposure were a higher proportion late testers than other adult exposure categories
- Districts 4, 6, and 7 had the lowest proportion of late testers by district.

Race/Ethnicity:

1. Hispanic:

- The number of HIV (not AIDS) diagnosis reports among Hispanics was variable between 2008–2010
- During 2008-2010, Hispanics constituted 35 of the 193 HIV and AIDS cases (18%)
- During 2008-2010, Hispanics constituted 25 of the 113 AIDS cases (22%)
- Whether looking at the combined HIV/AIDS figures or the AIDS-only figures, Hispanics represent a significant proportion of the HIV/AIDS burden as they represent only 11% of the Idaho total population

2. White

- During 2008-2010, Whites constituted 131 of the 193 HIV and AIDS cases (68%)

Trends in diagnoses among other race/ethnic categories were minimal. For further details, see Table 11.

Table 11. HIV (not AIDS) and AIDS cases by race/ethnicity and year of report— Idaho, 2008–2010

Race/Ethnicity	Year of Report					
	2008		2009		2010	
	HIV	AIDS	HIV	AIDS	HIV	AIDS
Hispanic - any race	2	8	7	8	1	9
American Indian/AK	1	1	0	0	2	0
Asian/Pacific	0	0	0	0	0	1
Black	1	1	1	3	0	4
White	3	19	30	20	26	33
Other	0	0	0	1	0	0
Unknown	0	0	3	1	3	4
TOTAL	7	29	41	33	32	51
	66		74		83	

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update

Age Group:

HIV diagnoses increased in three different age groups during 2002– 2007 as described below:

- Cases increased by 80% among 20-29 year olds
- Cases increased 72% among 40-49 year olds
- Cases increased 100% among persons aged 50 and over (although the number in this age group were few compared to 20-29 and 30-39 year olds)

Part 3. Description of the Needs of People Living with HIV/AIDS in Idaho

Current Provisions

Ryan White Part B (RWPB) FY 2012 contracts with providers allow for the following services:

- 1) Medical Case Management
- 2) Emergency Financial Assistance
- 3) Medical Transportation

Although RWPB has only allocated funding to the above listed services, additional Ryan White-funded services may exist in various health districts through Ryan White Part C, HOPWA Programs, or other local funding sources.

Service Priorities

In the Consumer survey, respondents ranked the importance of Ryan White services. Dividing the state into three regions, the results are as follows:

Northern Region (Districts 1 and 2)

- # 1: HIV medical care
- # 2: Payment for ARVs
- # 3: (the following includes critical Ryan White services regarded as having equal importance):
 - Payment for other medications
 - Medical case management
 - Dental care
 - Mental health care
 - Social support groups
 - Help paying for health insurance premiums/co-pays
 - Education about preventing HIV transmission
 - Help paying for HIV diagnostic and monitoring labs
 - Help paying for housing/emergency food

Southwest Region (Districts 3, 4 and 5)

- # 1: HIV medical care
- # 2: Payment for ARVs
- # 3: (the following includes critical Ryan White services regarded as having equal importance):
 - Payment for other medications
 - Medical case management
 - Dental care
 - Mental health care

- Help paying for health insurance premiums/co-pays
- Outpatient substance abuse service
- Education about preventing HIV transmission
- Help paying for HIV diagnostic and monitoring labs
- Help paying for housing/emergency food
- Payment for transportation to medical care

Southeast Region (Districts 6 and 7)

1: HIV medical care

2: Payment for ARVs

3: (the following includes critical Ryan White services regarded as having equal importance):

- Payment for other medications
- Medical case management
- Dental care
- Help paying for HIV diagnostic and monitoring labs
- Help paying for housing/emergency food
- Payment for transportation to medical care

Based on results from the survey of providers, the following services are most critical to HIV care in Idaho:

1. Doctor Visits/labs
2. HIV drug assistance
3. Medical Case Management
 - i. Without being linked to the MCM, the client cannot receive services or know that services are available
 - ii. Provide standardized training for MCMs to ensure ability to help clients navigate eligibility requirements
4. Medical Transportation
5. Addiction and Mental Health services
6. Oral health

Gaps in Services

In the Consumer survey, respondents identified services that they needed but did *not* receive. Dividing the state into three regions, the gaps in services are as follows (a higher ranking indicates a greater need; “AND” indicates an equal ranking):

Northern Region (Districts 1 and 2)

1. Get emergency payments for housing
2. Attend a support group
3. Get emergency food voucher AND See an eye doctor

4. Get help applying for Medicaid AND Get help applying for Medicare AND Get help applying for private insurance AND Talk to HIV+ per advocate

Southwest Region (Districts 3, 4 and 5)

1. See an eye doctor
2. Get help with health insurance premiums/co-pays AND See a dentist
3. Get emergency payments for housing
4. Get help applying for Medicaid AND Get help applying for private insurance

Southeast Region (Districts 6 and 7)

1. Attend a support group
2. See a dentist
3. See an eye doctor
4. Get help applying for a Medicare drug plan AND Get help applying for disability AND Get help applying for private insurance AND Get help paying for utilities AND See a mental health counselor AND Talk to HIV+ per advocate

According to respondents of the provider survey, the following list represents gaps in Ryan White services (in no particular order):

- Homeless services
- Substance abuse/addiction services
- Transportation to medical appointments
- Payment for medical care
- Number of primary care providers
- Assistance with health insurance premium/co-pay

A panel of HIV+ individuals (MSM from 5 of the 7 health districts in Idaho) made the following recommendations:

1. Provision of eye care needs to be addressed
2. Provision of dental care needs to be addressed
3. Clients need to be made aware of their rights to choose providers (i.e. Medical Case Management, mental health, etc.)
4. Clients need help from medical providers to arrange transportation
5. IACHA needs to consider developing a speakers' bureau to provide HIV messages throughout the state
6. Increase focus on HIV education in schools
7. The HIVUSA-Idaho video needs to be more widely distributed in Idaho

Part 4. Issues of Individuals Who are Living with HIV but Not in Care

Calculating Unmet Need

Calculating the need of people living with HIV/AIDS, but not accessing care is a critical component of community planning. While getting an accurate estimate is a challenge (due to the fact that we cannot track the movement of people living with HIV/AIDS in and out of Idaho), the following table provides information about people living with HIV/AIDS in care by gender, race/ethnicity and health district. This method compares the number of PLWH/A with the number of PLWH/A enrolled in Ryan White medical case management (MCM) and/or receiving care at the Wellness Center (Ryan White Part C Clinic).

Upon review of the following table during the February 2012 IACHA meeting, members concluded the following:

- Females are 7.5 percent more likely to be engaged in Ryan White Care Systems than males
- Hispanics are twice as likely to be engaged in care, than any other race
- PLWH/A residing in primarily rural and frontier health districts are seriously under-represented in Ryan White Care systems, while those living in Health District 4 (a metropolitan area) are over-represented in care
- Demographics based on age were removed because age at diagnosis does not change over time, leading to skewed results.

Please note that Column E indicates the degree to which a specific population is or is not represented in Ryan White based care. A *negative* percentage may indicate under representation and a *positive* percentage may indicate the specific population is well represented (for example, females are accessing care 7.5 percent more than -----).

Table 12. PLWH/A in Care by Gender, Race/Ethnicity, Age, and Health District (2010)

<i>Column A</i>	<i>Column B</i>	<i>Column C</i>	<i>Column D</i>	<i>Column E</i>
Demographics	PLWH/A as of 12/31/10*	Part B MCM and Part C Enrollment as of 12/31/10**	Percent (%) PLWH/A enrolled in MCM	(+/-) %
Gender	Number	Number	Percent (%)	
Male	1,057	520	49.2%	-0.2
Female	237	135	56.9%	+7.5
Total	1,294	655	50.6%	
Race/Ethnicity				
White	1006	500	49.7%	+0.3
Black/African-American	85	43	50.5%	+1.1
Hispanic	145	83	57.24%	+7.8
Asian/Pacific Islander	10	3	30.0%	-19.4%
American Indian/Alaskan Native	26	12	46.1%	+3.3%
Multi-Race	5	11	63.6%	+14.2
Other/Unknown	17	3		
Total	1,294			
Health District				
1	149	61	40.9%	-8.5%
2	85	12	14.1%	-35.3%
3	160	582	83.38%	+34.4%
4	538			
5	118	40	33.8%	-15.6%
6	135	49	36.2%	-13.2%
7	109	52	47.7%	-1.7%
Total	1,294	655		
Column C/Column B = Column D %		(Column D) (49.4%) = Column E		
* Living in Idaho at time of initial report		**Number of Clients in Care from 2010 RDR (RWPB report)		

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update

Activities to Improve Unmet Need Calculation

The activities we are implementing to improve the unmet need calculation include:

1. Match HIV/AIDS data with death certificates from the Bureau of Vital Records and Health Statistics (BVRHS) using the LinkPlus software to perform a probabilistic match using selected variables to identify matches. New death information will improve the

unmet need calculation by allowing greater accuracy determining the number of persons presumed living with HIV. The proposal, submitted by RW Programs?, is now in the approval process at BVRHS.

2. Match HIV/AIDS data with Ryan White/HRSA clinic client data from The Wellness Center. The Wellness Center 2009 data for HRSA-sponsored HIV medical care clinics in all of Southern Idaho, including the Treasure Valley, which is Idaho's most heavily populated area. Wellness Center data will be used to identify access to medical care, which might not have been received through HIV surveillance because of limitations of laboratory reporting criteria for HIV viral load and CD4 results.
3. Assess the impact of increasing reporting limits to include below-limit viral load results and CD4 results in excess of current AIDS-defining criteria. The results of the assessment will be used to request additional funding for the HIV surveillance capacity; which such a change would require.

Outreach Activities to Determine Unmet Need

1. Medical Case Management in Health Districts 2 and 5:
Following a break in Medical Case Management services in Districts 2 and 5, the RWPB Program funded outreach activities FY 2010 to help link clients with new Medical Case Management providers.
2. Ryan White Program Brochure:
During the FY2011 funding year, the RWPB Program, in collaboration with Ryan White Part C Clinics in Washington and Idaho, developed a Ryan White Program Brochure describing the services available, the location of services, and contact information of service providers throughout Idaho and Washington. Targeting newly diagnosed HIV positive individuals and PLWH/A not in care. Brochures were sent to the following service provider types:
 - All Idaho Health District HIV MCMs and Disease Investigation Specialists
 - Major hospital emergency department social workers and discharge planners
 - HIV Prevention funded testing and prevention service providers
 - Private HIV medical providers known to the Ryan White Part B and C Programs

The brochure is set to be sent to the following list of providers as funding allows:

- Clinics and hospital emergency room staff in each of the seven health districts
- All Federally Qualified Health Centers located in the state
- Homeless and domestic violence shelters
- Mental health facilities
- Substance use treatment programs
- Communities of Faith
- University health clinics

A Spanish Language version of the brochure is being translated and will be sent out to providers identified in the above list as funding allows as well.

3. Collaboration:

Idaho continues to collaborate with Ryan White and non-Ryan White providers as needed to ensure PLWH/A in Idaho have access to care, payment for services, and quality care services.

Factors Influencing Unmet Need

Respondents of the Ryan White Program Consumer Survey identified barriers to HIV care following their HIV diagnosis. In particular, the survey asked, “What would have helped you get HIV medical care sooner after testing?” Among respondents diagnosed with HIV within the last five years, the majority (79%) claimed, “Nothing-I got help right away.” However, several of these respondents did identify the following barriers:

1. Help with addressing anxiety/fear (13.8%)
2. Knowing how important early care was for my health (10.3%)
3. Knowing who to call/where to go (10.3%)

Additionally, survey respondents identified barriers they had faced when receiving HIV-related care services. Highlights per district are as follows (respondents were able to identify more than one selection):

Northern Region (Districts 1 and 2):

- Did not know where to go for services (28%)
- Fear of disclosing HIV status (26%)
- Cost of needed medical services (23%)

Southwest Region (Districts 3, 4 and 5):

- Cost of needed medical services (23%)
- Cost of drug treatment (17%)
- Fear of disclosing HIV status (17%)

Southeast Region (Districts 6 and 7):

- Fear of disclosing HIV status (23%)
- Lack of transportation to medical care (20%)
- Cost of drug treatment (20%)
- Cost of needed medical services (20%)
- Did not financially qualify (20%)

Among respondents of the HIV Provider Survey, 38% of providers indicated that an insufficient number of primary care providers limit the services they provide (38%). Related to this barrier, comments from providers fell into the following themes:

- Uninsured clients living in north Idaho have to go to Washington for care
- Limited primary care providers who serve PLHW/A
- Distance to primary care providers
- Fear of confidentiality being breached

Part 5. Description of Needs of Individuals who are Unaware of Their HIV Status

Identifying individuals, who are unaware of their HIV status or are aware of their status but not in care, is of primary importance to the FPSHP, HIV Prevention and Care Programs. HIV community based organizations, Regional Strategic Planning Groups, and members of IACHA, are committed to researching, designing and implementing strategies to reach individuals of highest risk, those of moderate to low risk, and historically underserved communities to educate and provide linkage to testing, referral to care and service, and ensure those referred have accessed care.

The strategy incorporates methods to determine those who are unaware of their status, (testing), informing individuals of their status, referring them into care (disease investigation) and following up to ensure that positive individuals have accessed care (prevention, disease investigation and care).

FPSHP is committed to the following goals:

- Goal 1.** Increase the number of individuals aware of their HIV status by increased testing of groups at highest risk
- Goal 2.** Increase the number of newly diagnosed HIV positives linked to Care by determining necessary system level changes involving testing agencies and local disease investigation specialists and care providers
- Goal 3.** Provide training opportunities to increase the capacity and number of HIV prevention and care providers
- Goal 4.** Increasing the number of HIV positive individuals in care by working with the state surveillance program and other providers to improve the state unmet need calculation to target activities to PLWH/A not in care
- Goal 5.** Increase access to Care and improve health outcomes for PLWH/A with support of Medical Case Management and access to HIV medications
- Goal 6.** Reduce new HIV infections by implementing Prevention with Positives activities in care settings

Idaho's Ryan White Programs coordinate on nearly every activity. Again, given the lack of funding resources, geographic distances, and lack of providers, collaboration and coordination is required in order to meet the needs of each program.

Part 6. Specific Priorities Regarding Underserved Populations

MSM

1. Support Group: According to Consumer Survey
2. Speakers Bureau- provide HIV education and put real face to HIV
3. According to HIV+ Panel (all MSM)- need for support of healthy relationships/ role models for gay relationships
4. Lack of legislature to provide legal legitimacy and protection to all relationships. Idaho's "Add the Words" campaign is currently striving for this legislative change.

Hispanic

Perhaps late testers

Women

IDU

In October 2011, IACHA's Data Committee reviewed the Epi Profile and the various needs assessments conducted in Idaho in the last 10 years. The Data Committee noted that according to the Epi Profile for 2005-2009, IDU as a risk group individually represents 8% of new infections, but when combined with MSM/IDU, there are close to 19% of newly diagnosed individuals who are IDU. Additionally, the Data Committee noted that a needs assessment of IDU had not been completed in Idaho since 2003. With about 20% of newly diagnosed HIV+ clients being IDU related, the Data Committee recommended that a needs assessment be developed targeting IDU and IDU/MSM...

According to the consumer survey, barriers faced by IDU or "possible IDU" (meaning that HIV risk was not specified) include the following:

1. Cost for needed medical services (21.4%)
2. Fear of disclosing HIV status (21.4 %)
3. Did not know where to go for services (17.9%)

Homeless

As of February 2012, there are 41 people on the HOPWA wait list (with waitlists in 3 of the 5 regions in Idaho).

Rural Idaho

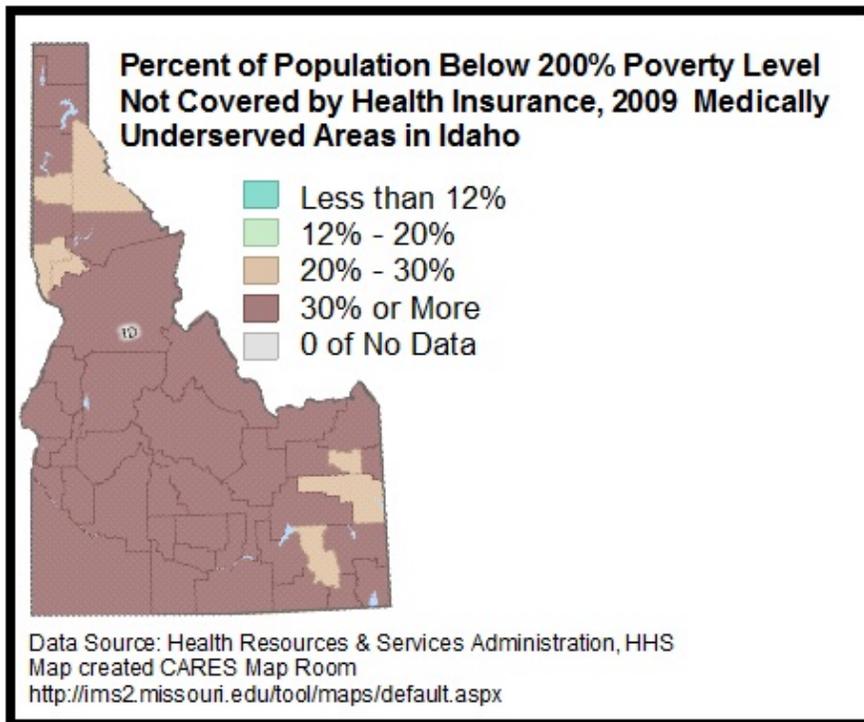
As noted earlier, Idaho is a rural state with limited transportation, physical barriers of terrain and distance and low population densities in many of the 44 counties. As such, clients have limited access to mental health, dental and primary care providers in the rural areas of Idaho.

In North Idaho, clients must travel a minimum of two hours to Spokane, Washington to see a care provider. Clients in Lewiston are limited to a (HIV??) provider who visits once a month. Clients living in Twin Falls are limited to the once-a-month visit of the HIV specialist and pharmacist.

Uninsured

Respondents to the Idaho Ryan White Consumers Survey were asked to indicate the number of times they had seen a doctor in the past 12 months. While not statistically significant, one pattern did surface in our sample: Respondents with private or employer-sponsored health insurance were more likely to visit a doctor one or two times than those with insurance or some combination of Medicaid and/or Medicare.

The majority of Idahoans living below 200% of poverty are not insured as noted in the map below.



Comparing the general public to those receiving Ryan White care,

Table 13. Idaho Population Compared with PLWH/A Poverty Levels, and Insurance Coverage (2009)

Column A	Column B	Column C	Column D	Column E	Column F
2009 Co-Morbid and Demographic Data	Idaho Population Numbers	Percent of Total Morbidity	HIV Positive In Care Numbers	Percent of Total Morbidity	+/- Percent ¹
Idaho Poverty Levels					
≤ to 100% FPL	208,980	13.72%	264	45.9%	+33.7%
101 – 200% FPL	326,190	21.41%	160	27.8%	+4.9%
201 – 299% FPL	331,929	21.78%	78	13.6%	-8.7%
≥ 300% FPL	656,619	43.09%	66	11.5%	-31.1%
Unknown	0	0	7	1.2%	+1.2%
Total	1,523,718	100%	575	100%	
Insurance Coverage					
Private ³	472,000	30.9%	188	32.7%	-3.5%
Medicare	205,772	13.5%	116	20.2%	+7.7%
Medicaid	204,222	13.4%	74	12.9%	+3.0%
Other Public	412,476	27.0%	7	1.2%	-24.6%
No Insurance	231,905	15.2%	188	32.7%	+17.1%
Other/ Unknown	0	0	7	1.2%	+1.2%
Total	1,526,375	100%	575	100%	
Column C – Column E = Column F standard deviation.					
¹ This is the percent deviation from the rates of individual measures in the general population.					
² Diagnosed concurrently or after HIV diagnosis. Individuals may have had multiple STD report.					
³ Includes Private Insurance and Employment Based Insurance Coverage.					

Incarcerated Individuals

Part 7. Description of Shortfalls in Healthcare Workforce

Training Needs

Training needs as identified as “very important” in the HIV providers survey:

1. Addressing stigma in the community
2. Standardized MCM
3. HIV/AIDS prevention for positives
4. Medication adherence for HIV positives
5. Conducting hepatitis interventions

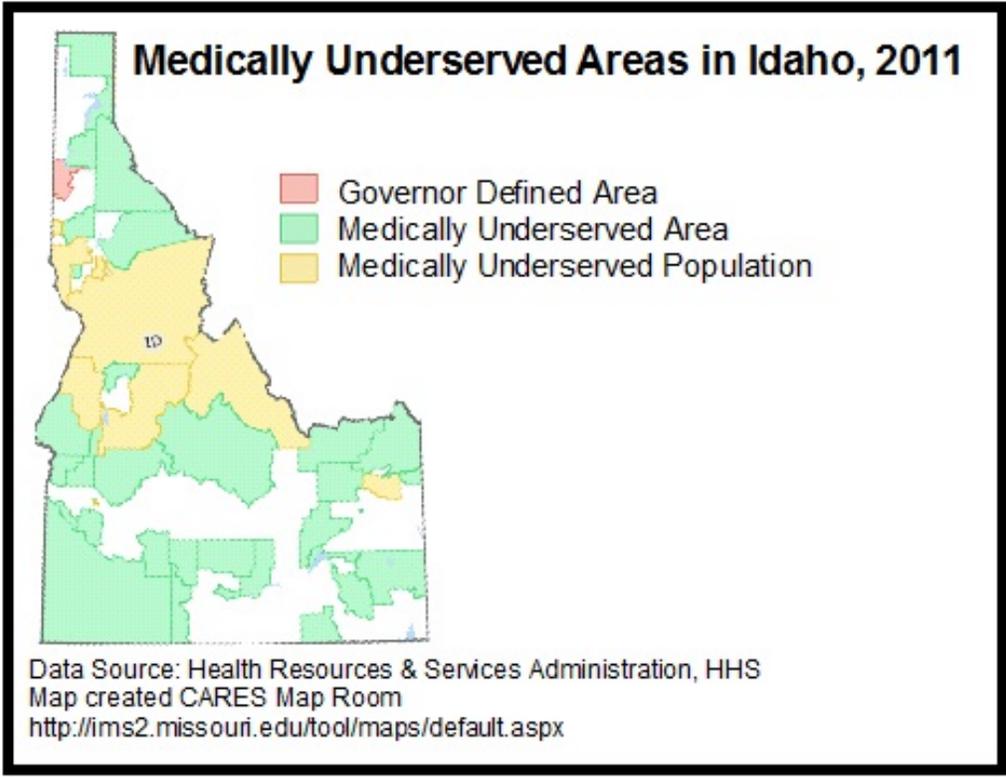
In regards to addressing cultural diversity, 27% of providers indicated that their agencies do not currently address cultural diversity.

Medically Underserved

The designation of areas or populations as medically underserved is based on an index of the following four variables:

1. Ratio of primary care physicians per 1,000 population
2. Infant mortality rate
3. Percent of the population with incomes below the poverty level
4. Percent of the population age 65 and over

Within Idaho, several areas of the state are considered medically underserved, shown in the map below.



Lack of HIV Training for Providers

Part 8. Broad Goals