2006-2008 COMPREHENSIVE PLAN

RYAN WHITE TITLE I
DENVER ELIGIBLE METROPOLITAN AREA

Developed by:
Evaluation and Assessment Committee
Denver HIV Resources Planning Council
in conjunction with the
Mayor's Office of HIV Resources

January 2006

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ACRONYMS AND DEFINITIONS

ACROYMNS

ACE – AIDS Coalition for Education
ADAP – AIDS Drug Assistance Program
AETC – AIDS Education and Training Center
AIDS – Acquired Immunodeficiency Syndrome
CBO – Community Based Organization
CDC – Centers for Disease Control and Prevention
CDPHE – Colorado Department of Public Health and Environment
CWT – Coloradans Working Together
DEMA – Denver Eligible Metropolitan Area
DHRPC – Denver HIV Resources Planning Council
EAC – Evaluation and Assessment Committee
EMA – Eligible Metropolitan Area
FY – Fiscal Year
HAART – Highly Active Antiretroviral Therapy
HCV – Hepatitis C
HIV – Human Immunodeficiency Virus
HRSA – Health Resources and Services Administration
ID – Infectious Disease
IDU – Injection Drug User
MAI – Minority AIDS Initiative
MDASC – Metro Denver AIDS Services Coalition
MOHR – Mayor's Office of HIV Resources
MCSM – Men of Color who have Sex with Men
MSM – Men who have Sex with Men
N – Number
PLWA – People Living with AIDS
PLWH – People Living with HIV
PLWH/A – People Living with HIV/AIDS
POCL Committee – People of Color Leadership Committee
PTC – Prevention Training Center
RFP – Request for Proposals
RW CARE Act – Ryan White Comprehensive AIDS Resources Emergency Act
SCSN – Statewide Coordinated Statement of Need
STD – Sexually Transmitted Disease

DEFINITIONS

In Care – PLWH/A receiving primary medical care are considered In Care.
Out of Care – PLWH/A who do not access primary medical care for more than a year are considered Out of Care. This includes HIV-infected individuals who have never received care.
Primary Medical Care – primary medical care is defined any of the three forms of service: use of CD4 test, viral load test, or antiretroviral therapy.

Unmet Need – PLWH/A who know their HIV status but are not receiving primary medical care have an unmet need.
Service Gap – all needs for PLWH/A except primary medical care for those who know their HIV status and are not in care.
Health Resources and Services Administration Agency (HRSA) – the federal agency that administers the CARE Act.
Ryan White CARE Act – a federal law that funds services for PLWH/A. CARE Act funds are the payer of last resort.
Ryan White Title I – emergency funds under the CARE Act that go to local areas with a higher number of HIV cases, such as the DEMA, to provide HIV care services.
Core Services – HRSA has defined the following as core services: primary medical care, drug reimbursement, mental health treatment, substance abuse treatment, dental care, and case management.
CAREWare – the reporting system for Ryan White Title I services.

LETTER OF CONCURRENCE

As the Planning Council and Grantee Co-Chairs, we hereby submit the 2006-2008 Comprehensive Plan for the Denver Eligible Metropolitan Area (DEMA). Guided by our DEMA needs assessment, evaluation of the previous comprehensive plan, and an early draft of the Statewide Coordinated Statement of Need for Colorado, the DEMA Title I plan was developed with the assistance and collaboration of a wide array of individuals, including Planning Council and community members, consumers, providers, and other stakeholders.

The goals and strategies outlined in the plan will help define a vision for how the Title I program can work to serve the HIV community in the DEMA, respond to the changing needs of the epidemic, and address the unmet health care needs of those not currently in the system.

The comprehensive plan was formally reviewed and approved by Planning Council members on December 1, 2005. Its contents will continue to be reviewed on a regular basis and refined as necessary.

Accordingly, we concur, without reservation, that this comprehensive plan and the goals and strategies identified within represent the priorities as set forth by the Planning Council and the Mayor's Office of HIV Resources.

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INTRODUCTION

The comprehensive plan guides the Denver HIV Resources Planning Council and the Mayor's Office of HIV Resources in setting goals to maintain and improve services for people living with HIV/AIDS (PLWH/A) over the next three years.

Planning is a primary focus of CARE Act legislation and a critical part of Ryan White Title I programs. The plan reflects the DEMA's vision for delivering HIV/AIDS care services, particularly in light of limited and decreasing resources. The planning process also allows planning councils to examine ways to increase the efficiency of service delivery and to maximize the use of existing funding streams.

Comprehensive plans help answer four basic questions:

1. Where are we now? (What is our current system of care?)
2. Where do we need to go? (What system of care do we want?)
3. How will we get there? (How does our system need to change to assure availability of and accessibility to core services?)
4. How will we monitor our progress? (How will we evaluate our progress in meeting our short and long term goals?)

The comprehensive plan includes data from a variety of sources including DEMA needs assessments and the Statewide Coordinated Statement of Need (SCSN). Those identified needs served as the basis for developing the comprehensive plan and the resulting goals and strategies.

EXECUTIVE SUMMARY

This document represents the comprehensive plan of the DEMA for the years 2006-2008. The DEMA is made up of Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties.

How was the Comprehensive Plan Developed?
The Evaluation and Assessment Committee (EAC) of the Denver HIV Resources Planning Council (DHRPC) guided the development of the comprehensive plan. The plan was developed in collaboration with a wide array of individuals, including Planning Council and community members, consumers, providers, and other stakeholders. Drafted over three months, the working document was made available to Planning Council members at each step of development to assure broad and ongoing review and input. The following committees also played key roles in the process: People of Color Leadership Committee, People Living with HIV/AIDS Committee, and the Metro Denver AIDS Services Coalition.

From the beginning, the process was designed to:

- Gather information from as many different sources as possible
- Ensure that voices of consumers were heard
- Solicit input from other Ryan White, state, and local programs
- Promote Title I cross-collaborative involvement in the development of the Statewide Coordinated Statement of Need and the Title II comprehensive plan

The plan uses data from the following primary sources:

- Epidemiological data through December 2004 provided by the Colorado Department of Public Health and Environment (CDPHE)
- 2005 comprehensive needs assessment
- 2004 needs assessment
- 2003 comprehensive needs assessment
- Draft 2005 Statewide Coordinated Statement of Need
- HIV Prevention in Colorado 2003-2004: An Assessment of Need
- Draft Title II comprehensive plan

Guided by the above information, as well as the previous comprehensive plan and HRSA guidance, the Evaluation and Assessment Committee identified goals and corresponding strategies that will help the DEMA to maintain and improve services for PLWH/A.

How is the Plan Organized?
Following guidance provided by the Health Resources and Services Administration (HRSA), the plan has four major sections:

1. Where are we now: what is our current system of care?
2. Where do we need to go: what system of care do we want?

3. How will we get there: how does our system need to change to assure availability of and accessibility to core services?
4. How will we monitor our progress: how will we evaluate our progress in meeting our short and long term goals?

What Goals were Identified?
The comprehensive planning process identified six major goals for the DEMA:
1. Ensure the availability and adequacy of critical HIV-related local core services within the DEMA.
2. Eliminate disparities in access to services and related support services among disproportionately affected sub-populations and historically underserved communities.
3. Identify individuals who know their HIV status but are not in care.
4. Address the primary health care and treatment needs of those who know their HIV status and are not in care and the needs of those currently in the HIV/AIDS care system.
5. Coordinate services with HIV prevention programs.
6. Coordinate services with mental health and substance abuse prevention and treatment programs.

SECTION 1 – WHERE ARE WE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?

DESCRIPTION OF THE DEMA

The DEMA consists of 6 counties – Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson; and covers 3760 square miles. The total population for the DEMA is 2,275,587; of whom 7251 are reported to be people living with HIV/AIDS. The DEMA represents 49.5% of the population of the State of Colorado (4,601,403). Denver County has the highest proportion of Latinos (31.7%), Blacks/African Americans (11.1%), and individuals living in poverty (14.3%).

EPIDEMIOLOGICAL PROFILE

Current Local Epidemic

The DEMA accounts for 77% of the HIV/AIDS cases in the State of Colorado. Of the 7251 reported cases of people living with HIV/AIDS in the DEMA, 62.1% are living with HIV and 37.9% have been diagnosed with AIDS. A majority of PLWH/A (91.2%) are male; the remaining 8.8% are female. The following table shows the breakdown of PLWH/A in the DEMA by gender, race/ethnicity, risk behavior and age.

DEMA	Group	Number		Percentage		Total	
		HIV	**AIDS**	**HIV**	**AIDS**	**#**	**%**
Gender	Male	4099	2512	56.5%	34.6%	6611	91.2%
	Female	401	239	5.5%	3.3%	640	8.8%
	Total	***4500***	***2751***	***62.1%***	***37.9%***	***7251***	***100%***
Race/Ethnicity	White	3161	1796	70.2%	65.3%	4957	68.4%
	Black/African American	651	403	14.5%	14.6%	1054	14.5%
	Hispanic/Latino	636	506	14.1%	18.4%	1142	15.7%
	Asian/Pacific	25	12	0.6%	0.4%	37	0.5%
	Native American	27	22	0.6%	0.8%	49	0.7%
	Multiracial	0	12	0.0%	0.4%	12	0.2%
	Total	***4500***	***2751***	***100%***	***100%***	***7251***	***100%***
Risk Behavior	MSM	3026	1857	67.2%	67.5%	4883	67.3%
	IDU	321	232	7.1%	8.4%	553	7.6%
	MSM/IDU	424	244	9.4%	8.9%	668	9.2%
	Heterosexual	283	217	6.3%	7.9%	500	6.9%
	No Identified Risk	420	165	9.3%	6.0%	585	8.1%
	Other	26	36	0.6%	1.3%	62	0.9%
	Total	***4500***	***2751***	***100%***	***100%***	***7251***	***100%***
Age	<13	9	3	0.2%	0.1%	12	0.2%
	13-19	11	2	0.2%	0.1%	13	0.2%
	20-24	85	26	1.9%	0.9%	111	1.5%
	25-29	190	60	4.2%	2.2%	250	3.4%
	30-39	1098	632	24.4%	23.0%	1730	23.9%
	40-49	1924	1248	42.8%	45.4%	3172	43.7%
	>49	1183	780	26.3%	28.4%	1963	27.1%
	Total	***4500***	***2751***	***100%***	***100%***	***7251***	***100%***

The majority of HIV/AIDS cases in the DEMA (76.5%) are in Denver County. 10% of PLWH live in Arapahoe County, 7.2% in Jefferson County, 5.3% in Adams County, 0.9% in Douglas County, and 0.1% in Broomfield County.

To examine how the epidemic is distributed, the numbers of PLWH/A in the DEMA was compared to the overall distribution of the DEMA's population by race/ethnicity. This comparison shows that while Blacks/African Americans represent 5.4% of the population in the DEMA, they represent 14.5% of all PLWH/A.

Future Trends

To consider ways in which new cases of HIV are emerging, the numbers of people newly diagnosed with HIV/AIDS in 2004 was examined. This data show that the nature of the HIV epidemic is changing in the DEMA.

- Among those who were newly diagnosed with HIV in 2004 (N=383), people of color (both Blacks/African Americans and Latinos) represent a disproportionate number of the newly diagnosed. Blacks/African Americans, who comprise 5.4% of the general DEMA population, represented 20.4% of those newly diagnosed in 2004. Latinos, who comprise 19% of the general DEMA population, represented 21.4%, respectively.
- The proportion of women living with HIV is increasing. In 2004, 11.7% of those newly diagnosed with HIV/AIDS were women, as compared to 8.8% cumulatively.
- Other counties in the DEMA (besides Denver) report an increase in HIV/AIDS cases; 14.1% of newly diagnosed cases were in Arapahoe County; 9.1% in Jefferson County; and 6.3% in Adams (compared to 9.8%, 7.1%, and 5.3% cumulatively in 2003).

Other trend indicators include the following:

- The majority of HIV/AIDS cases in the DEMA (70.8%) are PLWH/A 45 years of age and older.
- In terms of risk behavior, men who have sex with men (MSM) continue to make up the majority of newly diagnosed cases (58%) in the DEMA.
- Of the 383 newly diagnosed cases, 205 (53.5%) were new HIV cases, while 178 (46.5%) were new AIDS cases.
- Increases in infection among people of color, infection among women, and dual diagnosis were listed as top emerging trends in the 2005 Statewide Coordinated Statement of Need (SCSN).
- Of great concern are the numbers of individuals who test late in the course of their infection and/or delay getting into care. This is indicated by persons who qualify for an AIDS diagnosis within 12 months of their first positive HIV test. Women, people of color, and those with heterosexual contact risk test later than other groups. A 1999 CDC study reported that Blacks/African Americans in Colorado delayed entering care 3 years and 8 months, 2.6 times later than persons in other states. Clinic experience and data from the 2005 SCSN indicate that this problem persists.
- Denver had the number 1 ranking (15%) of AIDS incidence (number of new cases of AIDS diagnosed each year) for MSM-IDU in 2004 epidemiological data produced by CDC.
- Over the last four years, there has been a consistent 9% year-over-year increase in the number of people accessing Ryan White primary care services (see table below).

Year	Primary Care Client Count	Percentage Increase
2004	2341	9.3%
2003	2180	9.0%
2002	1970	8.9%
2001	1756	--

In the first 6 months of FY 2005, 2084 consumers have utilized primary medical care. Based on the last 4 years of primary medical care trending, the DEMA estimates that 2552 clients will utilize the service by the end of the fiscal year. Additionally, annual CAREWare data for 2004 showed that of the 3559 total clients served, 619 (17.4%) were new clients. These steady yearly increases in both primary medical care and overall service utilization, coupled with declining funds have actually set back support to the equivalent of 1999 funding levels.

Description of the History of Local, State and/or Regional Response to the Epidemic
The DEMA has a long history of responding to the HIV epidemic. The first dedicated AIDS service organization was formed in 1983, and the public ID clinic began caring for patients with the first reported HIV cases in the DEMA.

HRSA funding was first awarded to the DEMA in the form of an AIDS Service Demonstration Grant in 1989, followed in 1990 by the award of an Early Intervention Service Grant. In 1994, the DEMA received its first Title I award.

The State of Colorado has had a names-based HIV reporting surveillance system since 1985. The law mandates that any case of HIV and AIDS be reported by both laboratories and physicians within seven days of diagnosis. This names reporting law has provided sound epidemiological data to help the Planning Council make funding decisions, track emerging trends, and for program planning.

The Denver HIV Resources Planning Council has consistently funded the six HRSA-defined core service categories at a high level (see table below), in some years discontinuing funding to some service categories to sustain support of core services. Six services categories have been discontinued since 1997. In the recent allocation process, 86.8% of FY 2006 funding was allocated to the six core service categories. In 1997, recognizing the efficacy of HAART, the Council made a significant shift of resources to support antiretroviral treatment.

	Percentage Funding by Fiscal Year				
Core Service	**2006**	**2005**	**2004**	**2003**	**2002**
Primary Care	39.38%	32.37%	32.37%	31.33%	31.50%
Drug Reimbursement	11.58% *	23.41%	23.41%	21.42%	23.50%
Dental	13.12%	9.39%	9.39%	9.43%	9.70%
Case Management	11.89%	10.23%	10.23%	10.47%	11.0%
Mental Health	6.27%	5.50%	5.50%	5.52%	4.56%
Substance Abuse	4.56%	3.90%	3.90%	4.0%	3.22%
Total	86.8%	84.8%	84.8%	82.17%	83.48%

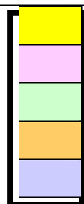
*In FY 2006, the DEMA will contribute to ADAP through its Title II base award.

ASSESSMENT OF NEED
HIV Medical Care Needs
In the 2005 needs assessment survey, consumers (N=311) were asked to check what services they needed the most. The top five most needed services as reported by consumers were: 1) dental care 2) primary medical care 3) food bank 4) prescription drugs and 5) case management.

The following table compares service need across populations participating in the 2005 needs assessment.

Comparison of Service Need Across Populations Participating in 2005 DEMA Needs Assessment Survey

	CONSUMERS								PROVIDERS
	N=311	*N=90*	*N=46*	*N=158*	*N=175*	*N=65*	*N=51*	*N=41*	*N=17*
Service Category	**2005 DEMA Rank**	**African American**	**Latino**	**White**	**MSM**	**MCSM**	**Women**	**IDU**	**Provider**
Dental Care	1	4	2	2	1	1	4	6	6
Primary Medical Care	2	1	1	1	3	2	3	1	1
Food Bank	3	3	2	7	2	2	2	9	9
Prescription Drugs	4	2	4	4	4	4	1	1	2
Case Management	5	4	7	5	6	4	5	3	4
Mental Health	6	9	9	6	5	6	9	6	3
Emergency Housing Assistance	7	8	5	3	8	9	6	6	7
Emergency Financial Aid	8	10	5	9	7	6	8	4	9
Transportation	9	6	8	11	9	6	6	10	8
Health Insurance Continuation	10	6	12	8	10	10	12	11	11
Substance Abuse Services	11	11	10	10	11	11	10	4	5
Client Advocacy	12	12	10	13	12	13	10	13	14
Home Health Care	13	13	14	11	13	12	13	12	11
Hospice	14	14	13	14	14	14	14	14	11



Identified as **first** most needed service
Identified as **second** most needed service
Identified as **third** most needed service
Identified as **fourth** most needed service
Identified as **fifth** most needed service

There are 6 special needs groups within the DEMA:

1. Black/African American – although Blacks/African Americans represent 5.4% of the population in the DEMA, they represent 14.5% of all PLWH/A.
2. Hispanic/Latino – represents 21.4% of newly diagnosed HIV/AIDS cases in the DEMA.
3. MSM – the largest exposure group representing 68.4% of all HIV/AIDS cases in the DEMA.
4. MCSM (men of color who have sex with men) – most disproportionately impacted group when comparing PLWH/A to composition in population.
5. Women of childbearing age (especially of color) – heterosexual transmission represents 6.9% of HIV/AIDS cases in the DEMA.
6. IDU – although the DEMA HIV/AIDS rate among IDU is lower than the national average, this is still an ongoing source of concern.

In the 2005 needs assessment, out of care PLWH/A (N=158) were asked to identify the type of services that would help them enter care and the following table outlines the responses.

Service Needed to Enter Care	**Number**	**Percentage**	**Rank**
Peer Counseling	34	22%	1
Case Management	27	17%	2
Housing	23	15%	3
Counseling	22	14%	4
Substance Abuse Treatment	20	13%	5
Mental Health Counseling	12	8%	6
Transportation Services	10	5%	7
Treatment in Non-AIDS Setting	7	4%	8
Nutritional Counseling	3	2%	9
Total	***158***	***100%***	

Unmet Need Estimate

Unmet need is defined as PLWH/A who know their HIV status but are not receiving primary medical care. The Planning Council estimates that there are approximately 2010 out of care PLWH/A in the DEMA. The method for determining out of care PLWH/A is outlined in the following table.

Input	Value	Data Source
A. Number of people living with AIDS (PLWA), recent time period	2,751 37.9%	Colorado Department of Public Health and Environment (CDPHE) names based reporting as of 12/31/04
B. Number of people living with HIV (PLWH non-AIDS/aware, recent time period	4,500 62.1%	Colorado Department of Public Health and Environment (CDPHE) names based reporting as of 12/31/04
C. Number/percent of PLWA who received the specified primary medical care services in 12-month period	1,986 37.9%	2004 CAREWare data report 2004 DEMA needs assessment Percentage is based on overall demographics
D. Number/percent of PLWH (aware, non-AIDS) who received the specified primary medical care services in 12-month period	3,255 62.1%	2004 CAREWare data report 2004 DEMA needs assessment Percentage is based on overall demographics
E. Number of PLWA who did not receive primary medical services	1,248 17.2%	A – C = E 2,751 – 1,986 = 1,248
F. Number of PLWH (non-AIDS, aware) who did not receive primary medical care	762 10.5%	B – D = F 4,500 – 3,255 = 762
G. Total HIV+/aware not receiving specified primary medical care services (quantified estimate of unmet need)	2,010 27.7%	E + F = G 1,248 + 762 = 2,010

Gaps in Care

An assessment of service gaps in the 2005 needs assessment revealed that consumers had the most difficulty accessing:

1. Dental care
2. Prescription drugs
3. Health insurance continuation
4. Emergency housing assistance
5. Primary medical care

In the 2003 consumer survey, consumers were asked to check which services that they needed but could not get. The top five services that consumers could not get were:

1. Dental care
2. Emergency housing assistance
3. Health insurance continuation
4. Emergency financial assistance and substance abuse services (tie).

A comparison of 2003 and 2005 data reveals that dental care remains the number one service gap for consumers.

Focus group participants and key informant interviews from the 2003 needs assessment identified emergency housing as a significant "service gap." Services most likely reported to have waiting lists were emergency housing and financial assistance and mental health services.

The top five services that respondents from the 2005 Statewide Coordinated Statement of Need listed as having gaps or unmet need among PLWH/A in Colorado are: 1) mental health, 2) prescription drugs, 3) substance abuse services, 4) primary medical care, and 5) health insurance continuation.

Prevention Needs

In the HIV Prevention in Colorado 2003-2004: An Assessment of Need survey, of all the prevention activities listed, HIV testing was considered the most effective (2.5 on a scale of 0 to 3) in helping people to avoid getting or spreading HIV. PLWH/A gave high ratings to medical personnel (2.2), group exercises (2.1), and community events (2.1). When HIV negative respondents were asked what HIV prevention strategies should be offered to help them avoid infection, various types of public information/education (12%) and free condoms (7%) were the most common responses. When HIV positive respondents were asked what HIV prevention activities would help them avoid re-infection, education on topics related to re-infection (14%) was the most common response, then group level interventions (11%) and free condoms (10%).

DESCRIPTION OF THE CURRENT CONTINUUM OF CARE

In FY 2006, the Denver HIV Resources Planning Council funded 13 service categories with Title I dollars and 4 categories with Minority AIDS Initiative (MAI) dollars. With diminishing funding, the Planning Council has had to balance the need for a comprehensive continuum of care while making the most efficient use of resources. The table below shows the service categories that were funded with Title I funds in FY 2006.

Service Category	Rank	Percentage Allocation
Primary Care	1	39.38%
ADAP	2	0.00% *
Local Drug Reimbursement	3	11.58%
Dental Care	4	13.12%
Case Management	5	11.89%
Mental Health	6	6.27%
Substance Abuse Treatment	7	4.56%
Food Bank/Home Delivered Meals	8	2.28%
Emergency Financial Assistance	9	2.28%
Emergency Housing Assistance	10	3.99%
Transportation	11	1.14%
Insurance Continuation	12	1.71%
Client Advocacy	13	1.71%

*The DEMA will contribute to ADAP through its Title II base award. Based upon the FY 2005 Title II award, the ADAP contribution would be $389,742 (equals to 11% of the Title I grant).

It is important to note that the top 6 ranked service categories are the same as the HRSA identified core service categories. More than 86% of all Title I funding is allocated to the provision of core services identified by HRSA: primary medical care, dental care, drug reimbursement, case management, mental health, and substance abuse treatment.

The table below shows the service categories that were funded with MAI dollars in FY 2006.

Service Category	Rank	Percentage Allocation
Substance Abuse Treatment	1	37.0%
Client Advocacy	2	28.5%
Mental Health	3	28.5%
Capacity Building	4	6.0%

These priorities reflect those services identified by consumers in the 2005 needs assessment as ones needed to help them enter care.

RESOURCE INVENTORY

HRSA requires EMAs to put together a resource inventory and profile of provider capacity and capability as part of the needs assessment process. The resource inventory describes current HIV care services in the DEMA, regardless of funding source. The profile of provider capacity and capability builds upon the resource inventory by providing additional information about the availability, accessibility, and appropriateness of services for PLWH.

A 2004 provider survey tool was developed by the Evaluation and Assessment Committee in order to compile the resource inventory and provider profile.

A total of 49 organizations were contacted for the resource inventory and provider profile, of which 41 identified themselves as providing HIV care-related services in the DEMA and were thus included in the results. 17 of the 41 organizations are currently receiving Title I funding (FY 2005). The 41 organizations had the following characteristics:

- 24 organizations have been providing HIV/AIDS care-related services for 10 or more years
- 11 organizations exclusively provide HIV/AIDS services
- 5 organizations providing a variety of services reported having waiting lists, averaging 2 months
- 28 organizations serve all the 6 counties in the DEMA
- 26 organizations target specific populations

PROFILE OF RYAN WHITE CARE ACT FUNDED PROVIDERS BY SERVICE CATEGORY

In FY 2006, the grantee will contract with 15 organizations to provide Ryan White Title I services (including MAI) in the DEMA. Following are some key profile characteristics about the funded organizations:

- Five of the agencies are minority community based organizations (CBOs)
- Two organizations target women
- Three organizations receive MAI funding

- 13 organizations receive Title I funding
- One organization receives both Title I and MAI funding
- 100% of MAI funding goes to minority CBOs

The following table outlines FY 2006 funded organizations by service categories.

Service Category	Organizations Providing Service
Primary Medical Care	Children's Hospital Denver Health Medical Center University Hospital
Local Drug Reimbursement	Children's Hospital Denver Health Medical Center University Hospital
Dental Care	Denver Health Medical Center Howard Dental
Case Management	Colorado AIDS Project Empowerment Program Servicios de la Raza
Mental Health	Colorado AIDS Project Denver Health Medical Center Mental Health Center of Denver Sisters of Color United for Education (MAI) University Hospital
Substance Abuse Treatment	ARTS Colorado AIDS Project Denver Area Youth Services (MAI) Denver Health Medical Center
Food Bank/Home Delivered Meals	Colorado AIDS Project People of Color Consortium Against AIDS Project Angel Heart
Emergency Financial Assistance	Colorado AIDS Project (Single payer system)
Emergency Housing Assistance	Colorado AIDS Project (Single payer system)
Transportation	Colorado AIDS Project Denver Health Medical Center Empowerment Program People of Color Consortium Against AIDS
Insurance Continuation	Colorado AIDS Project
Client Advocacy	It Takes a Village (Title I and MAI) Sisters of Color United for Education (MAI) Women's Lighthouse Project

BARRIERS TO CARE

In order to understand the barriers to care related to service gaps, PLWH/A in the 2003 consumer survey were asked to indicate reasons why they were unable to obtain the 5 top services identified as having gaps. The reasons are presented in the following table.

Service	Reason 1	Reason 2	Reason 3
Dental Care	Cost - 20 (43.5%)	Don't know where to go - 14 (30.4%)	Did not know it was offered - 11 (23.9%)
Emergency Housing Assistance	Not eligible - 15 (46.9%)	Don't know where to go - 7 (21.9%)	Cost - 4 (12.5%) Did not know where to go - 4 (12.5%)
Insurance Continuation	Not eligible - 10 (40%)	Cost - 7 (28%)	Did not know it was offered - 7 (28%)
Substance Abuse Treatment	Did not know it was offered - 10 (43.5%)	Transportation - 6 (26.1%)	Don't know where to go - 6 (26.1%)
Emergency Financial Assistance	Not eligible - 7 (30.4%)	Did not know it was offered - 6 (26.1%)	Don't know where to go - 5 (21.7%)

Surveys results showed that people listed "did not know where to go" and "did not know services were offered" as common problems with accessing services. These findings indicate a need to inform PLWH/A about the range of services, as well as eligibility criteria for obtaining services that are provided under Ryan White Title I. MAI funded priorities reflect an effort in helping consumers learn about services offered through the continuum of care.

In the 2004 provider survey, organizations were asked whether or not they had encountered any barriers in providing services to people living with HIV/AIDS, excluding lack of funding. 26 organizations reported encountering barriers in providing services to PLWH/A. The most frequently reported barriers included:

- Transportation for clients
- ADAP funding issues (it should be noted that significant progress has been made in this area)
- Staffing issues
- Homelessness and housing resources shortages for clients
- Paperwork and release of information issues
- Discrimination and stigma related to HIV/AIDS

Among those individuals identified as out of care in the 2005 survey (those who had received no medical services for their HIV infection during the previous 12 months), the following services were reported as those most needed to help these persons enter care:

- Peer counseling
- Case management
- Housing
- Counseling on side effects of HIV medications
- Substance abuse treatment
- Mental health counseling
- Transportation services

SECTION 2 – WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?

CONTINUUM OF CARE FOR HIGH QUALITY CORE SERVICES

Shared Vision and Values for System Changes

In the DEMA, a continuum of care is defined as a comprehensive set of services available to individuals infected and affected by HIV disease. Because Ryan White funding is designated as the payer of last resort, the continuum of care cannot be exclusive to Ryan White Title I services. Rather, it encompasses the full range of medical and support services within the community, regardless of funding source. As such, the continuum of care promotes collaboration and linkages. A continuum suggests that services must be responsive to changes in the HIV epidemic. The continuum can also be affected by constraints in resources.

The continuum of care includes a set of basic and essential or core services. In the DEMA, the local core services are those defined by HRSA: primary medical care, dental care, drug reimbursement, mental health services, substance abuse treatment, and case management. This reflects a set of services that the DEMA has decided should always be available to PLWH/A in the community. Although resources are limited, the DEMA is committed to maintaining funding to these categories.

The continuum of care is based on a system of shared vision and values. Values refer to the guiding principles or ideas that are used to organize a system of care. Vision refers to the specific qualities of this system. In the DEMA, we envision an integrated continuum of care that provides high quality and coordinated access to a range of services. It is a system that is:

- Client-centered and empowering and in which clients are treated with dignity and respect
- Promotes statewide coordination and collaboration among service providers
- Based on an assessment of community needs and priorities

The following guiding principles are part of the shared values for a HIV system of care in the DEMA:

- Client-centered
- Efficient
- Equitable
- Compassionate
- Culturally competent
- Cost effective
- Improves clients' quality of life
- Balances the need for core services while not neglecting the need for support services

SECTION 3 – HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF AND ACCESSIBILITY TO CORE SERVICES?

GOALS AND STRATEGIES

The comprehensive plan identifies 6 major goals for maintaining and improving services for PLWH/A in the DEMA.

1. Ensure the availability and adequacy of critical HIV-related local core services within the DEMA
2. Eliminate disparities in access to services and related support services among disproportionately affected sub-populations and historically underserved communities
3. Identify individuals who know their HIV status but are not in care
4. Address the primary health care and treatment needs of those who know their HIV status and are not in care and the needs of those currently in the HIV/AIDS care system
5. Coordinate services with HIV prevention programs
6. Coordinate services with mental health and substance abuse prevention and treatment programs

The following 6 tables outline:

- Strategies for accomplishing each identified goal
- Who will be responsible for implementing the various strategies
- When strategies will be implemented
- How each strategy will be evaluated

Goal 1: Ensure the availability and adequacy of critical HIV-related local core services

Strategy	Who Implements	When Implemented	How Evaluated
Conduct consumer-based needs assessment	EAC	Annually	Pre-priorities distribution of report
Consider a cross-Title collaborative training on the needs assessment process	Title I and II collaboration	By 2008	Training conducted
Reflect client-identified needs in resource allocation and reallocation decisions	DHRPC (allocation) MOHR (reallocation)	Annually (allocation) Semi-annually (reallocation)	Results reflected in priorities outcomes and reallocation decisions
Update assessment of provider/care system capacity	EAC	As needed	Report distributed
Effectively use CAREWare capabilities to monitor service utilization and trends	MOHR	Report quarterly to the DHRPC	CAREWare reports
Implement new web-based CAREWare system to improve client management across service categories	Provider agencies MOHR	Ongoing	Decreased duplication of service Decreased client loss to care
Conduct provider site visits to assess/monitor service consistency with Public Health Service guidelines	MOHR	Minimum of 1 time per year with each funded provider	Site visit reports
Focus resources on most needed and core services	DHRPC	During priorities and allocation process	Decisions consistent with needs assessment
Assure timely disbursement of CARE Act funds to service providers	Provider agencies MOHR	Ongoing	Timely billing from agencies, little or no carryover funds
Provide quality management training for all funded service providers	MOHR	Ongoing	Training provided Pre and post tests

Goal 2: Eliminate disparities in access to services and related support services among disproportionately affected sub-populations and historically underserved communities

Strategy	Who Implements	When Implemented	How Evaluated
Assure needs assessment participants are representative of epidemic demographics (for example, over-sample and weight as needed)	EAC	Annually	Representative needs assessment samples
Update assessment of provider/care system capacity	EAC	As needed	Report distributed
Conduct analysis of needs assessment data by severe need and culturally discrete populations	EAC	Annually	Review needs assessment report
Continue to support culturally-guided service delivery competency	MOHR	Ongoing	Through service contracts and RFP language
Identify cultural training resources, provide information to DHRPC and Ryan White funded agencies	DHPRC	Ongoing	Resources distributed
Identify MAI-specific service categories to meet population needs	POCL Committee DHRPC	Annually	DHRPC follows recommendation of POCL Committee
Require that MAI agencies reflect demographics of clients served	MOHR	Annually	Service contract
Provide capacity building/technical assistance to MAI providers	MOHR	Ongoing	Consistency in providers
Provide quality management training for all funded service providers, including working with diverse populations/cultural competency	MOHR	Ongoing	Training provided Pre and post tests
Make more effective use of CAREWare capabilities to monitor service utilization and trends	MOHR	Report quarterly to the DHRPC	CAREWare reports

Goal 3: Identify individuals who know their HIV status but are not in care

Strategy	Who Implements	When Implemented	How Evaluated
Further quantify out of care population	EAC/CDPHE collaboration	Annually	Needs assessment data
Further explore unmet need in the DEMA	EAC	Annually	Needs assessment data
Distribute list of supplemental services that facilitate access to care	Funded providers DHRPC/ACE collaboration	Ongoing	ACE resource directory distribution
Consider additional CAREWare field to capture testing facility data	MDASC MOHR	Ongoing	

Goal 4: Address primary health care and treatment needs of those who know their HIV status and are not in care and those currently in the HIV/AIDS care system

Strategy	Who Implements	When Implemented	How Evaluated
Incorporate language in RFP assuring non-core services demonstrate facilitation of client access to primary care and HAART	MOHR	Upon RFP distribution	Language reflected in RFP
Place high priority on adequately funding primary care and drug treatment services	DHRPC	Annually	Resource allocation outcomes
Evaluate options for getting more clients into primary medical care	MDASC	Ongoing	MDASC report to DHPRC
Promote patient self-management with provision of health care information	Case management and primary care providers	Ongoing	Client ability to use information
Strive for consistency in service provision	MOHR	Ongoing	Service contracts
Include HCV assessment/testing in HIV clinical care settings	Primary care providers	Ongoing	HCV assessment & testing conducted
Promote HIV testing in HCV and STD service settings	DHRPC/CDPHE collaboration	Ongoing	Testing provided
Monitor outcome based goals for treatment	Provider agencies MOHR	Ongoing	MOHR report to DHRPC
Strive to maintain a comprehensive ADAP formulary	DHRPC/Title II collaboration	Ongoing	Periodic review of ADAP formulary

Goal 5: Coordinate services with HIV prevention programs

Strategy	Who Implements	When Implemented	How Evaluated
Continue to collaborate with Coloradans Working Together (CWT) on activities	DHRPC/CWT collaboration	Ongoing	Activity outcomes
Promote availability of Prevention with Positives training for providers	DHRPC/CDPHE/AETC/PTC collaboration	Ongoing	More training provided
Provide Prevention with Positives training for funded providers	MOHR	1 time per year	Training provided
Identify gaps between care and prevention services and develop strategies to address	DHRPC/CDPHE collaboration	Ongoing	Gaps identified Strategies developed
Promote HIV testing in HCV and STD service settings	DHRPC/CDPHE collaboration	Ongoing	Testing provided
Promote provision of prevention case management referral/services for persons who acquire other STDs while in care	DHRPC/CDPHE collaboration	Ongoing	Monitoring of direct service providers

Goal 6: Coordinate services with mental health and substance abuse prevention and treatment programs

Strategy	Who Implements	When Implemented	How Evaluated
Use web-based CAREWare to monitor referral follow through	MOHR	Ongoing	
Document interagency mechanisms for referrals between services	MDASC, Case management collaborative	Ongoing	Service utilization
Incorporate interagency referral mechanisms in new staff orientation	Provider agencies	According to training schedule	Training agenda
Raise awareness of mental health and substance abuse issues	DHRPC	Ongoing	Information shared

SECTION 4 – HOW WILL WE MONITOR OUR PROGRESS: HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT AND LONG-TERM GOALS?

IMPLEMENTATION, MONITORING AND EVALUATION PLAN

Comprehensive planning helps councils make difficult decisions in an increasingly complex health care environment. This includes, for example, the impact of changes at the federal (such as Medicare Part D and Ryan White reauthorization), state, and local levels. As such, this plan is meant to be fluid. An effective monitoring process ensures that the plan adapts to future changes. This may ultimately lead to modifications of goals and strategies when appropriate.

The following mechanisms will be used to ensure that the plan is used as a basis for future program planning and is monitored and evaluated on a regular basis:

- An evaluation plan is outlined for each strategy in order to track progress.
- The Evaluation and Assessment Committee will review the plan at least once per year and make revisions if necessary.
- Planning Council staff will track implementation of the various goals and strategies.
- Council staff will provide comprehensive planning progress reports to the Planning Council twice per year.