2009-2011
Comprehensive Plan

Denver Transitional Grant Area

January, 2009

Denver HIV Resources Planning Council
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Letters of Concurrence

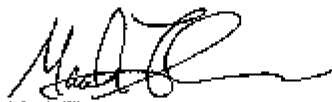
LETTER OF CONCURRENCE

As the Planning Council and Grantee Co-Chairs, we hereby submit the 2009-20011 Comprehensive Plan for the Denver Transitional Grant Area (DTGA). Guided by our DTGA needs assessment, evaluation of the previous comprehensive plan, and an early draft of the Statewide Coordinated Statement of Need for Colorado, the DTGA Part A 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.

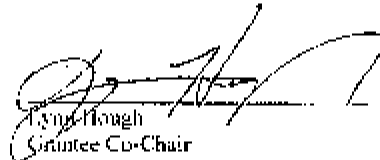
The goals and strategies outlined in the plan will help define a vision for how the Part A program can work to serve the HIV community in the DTGA, respond to the changing needs of the epidemic, and address the unmet health care needs of those not currently in the system.

The comprehensive plan was formally reviewed and approved by Planning Council members on December 8, 2008. 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.



Mark Thrun
Planning Council Co-Chair



Lynn Hough
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The 2009 – 2011 Comprehensive Plan was developed through the collaborative efforts of many individuals who are committed to quality HIV service provision in the Denver metropolitan area.

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Introduction

This Comprehensive Plan is designed to meet the HRSA requirement that all Part A grantees develop an updated plan for the organization and delivery of health and support services in their jurisdictions. The guidelines for the document are specifically identified as follows. Each plan must reflect a system that:

1. delivers quality core medical services;
2. eliminates disparities in access to services;
3. conducts strategic outreach to PLWH/As not in care; and
4. assesses results based on clinical quality measures.

Comprehensive plans are expected to identify time-delimited goals and objectives, and to include approaches for coordinating with local HIV prevention services as well as substance abuse programs. This plan meets HRSA's specified requirements by providing strategies to respond to key issues raised in local needs assessment findings.

Strategic Planning Process

The 2009-2011 Comprehensive Plan was developed through a detailed planning process that involved input from the Denver HIV Resources Planning Council, the Mayor's Office of HIV Resources (MOHR), and the Colorado Department of Public Health and Environment (CDPHE). In the Denver TGA, MOHR is the Part A grantee, and CDPHE is the Part B grantee for the state of Colorado. The planning process was facilitated by an independent team of consultants who conducted planning meetings and wrote the document in collaboration with Planning Council leadership.

Input for the 2009 Plan was obtained through a series of retreats for members of the Planning Council. First, a half-day kick off retreat was conducted with the Planning Council Executive Committee. This first retreat set the stage for additional meetings to follow and helped identify preliminary three-year goals. Next, a series of 2-hour mini retreats were conducted with members of each Planning Council committee. Five retreats were held over a several week period to gather input from the subcommittees of the Planning Council: the Metro Denver AIDS Services Coalition (MDASC), the Membership Committee, the People of Color Leadership Committee, Rebuilt +, and the Evaluation and Assessment Committee. Finally, a second half-day retreat was held with the Executive Committee, to follow up on the mini-retreat findings. In this follow up retreat, the Planning Council confirmed its mission, vision, values and defined objectives and goals for the coming three-year period.

As the Comprehensive Plan was developed in writing, successive drafts were reviewed by Executive Committee leaders to ensure alignment with the Planning Council's vision for the document. After the Planning Council retreats were completed, input from consumers and community members was obtained through a Community Forum designed to gather feedback from multiple stakeholders. Individual sections of the document were then compiled into a near-final version of the Plan, which was presented to the full Planning Council for review. A final revision was completed to incorporate Planning Council member feedback, and the Plan was formally adopted by the Planning Council on December 8, 2008. This adoption meeting was attended by

Mayor John W. Hickenlooper of the City & County of Denver, the Chief Elected Official of the Denver TGA.

Plan Components

The 2009-2011 Comprehensive Plan identifies an overarching strategic direction for the Denver TGA in four parts. Section I describes the current status of the TGA, including its HIV/AIDS epidemiological profile, needs assessment findings, established continuum of care, and specific barriers to care. Section II outlines the mission, vision, and values of the TGA, to explain the intended direction for service delivery. Section III delineates the goals and objectives agreed upon through the mini-retreats and input gathering sessions. Finally, Section IV provides a tracking mechanism that will be used by the Planning Council to monitor its implementation of defined action steps.

Executive Summary

Profile of the TGA

The 2009 Comprehensive Plan starts with Section I, entitled "Where Are We Now?" This section identifies the current status of the TGA. The Denver TGA has received Part A funding for 16 years, since 1993. This funding goes to support HIV service provision in 6 Denver metropolitan area counties: Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson. The TGA covers 3,760 square miles and has a total population of 2,307,441. The TGA represents 49.5% of the population of the State of Colorado (4,804,353). The general population is comprised of: Caucasians, 79%; Latinos, 19%, African-Americans, 5.4%; Asians, 3%; and Native Americans, 1%.

The majority of persons living with HIV/AIDS are Caucasians (67%), followed by Latinos (17%), African-Americans (14%), then Asian/Pacific Islanders (1%), Native Americans (1%), and multiracial individuals (less than 1%). Among the 425 persons who were newly diagnosed with HIV/AIDS in 2007, nearly half (45%) were persons of color, with African Americans and Latinos representing a disproportionate number of the newly diagnosed. African Americans comprise 5.4% of the general TGA population, but were 19% of those newly diagnosed in 2007. Latinos comprise 19% of the general TGA population, but were 23% of those newly diagnosed. Women are also disproportionately represented among the newly diagnosed. In 2007, 15% of those newly diagnosed with HIV/AIDS were women, as compared to 9% of those living with HIV/AIDS cumulatively.

Although HIV/AIDS primarily affects the gay male population in Denver, according to CDPHE data, heterosexual transmission represents 13% of the newly diagnosed (as opposed to only 8% of living HIV/AIDS cases). In addition, IDUs represent 11% of the newly diagnosed, and 16.6% of the population living with HIV/AIDS in the Denver TGA.

Current Continuum of Care

The TGA currently maintains an exemplary continuum of care that was identified by HRSA in their biannual report to Congress as a model for implementation of the new HIV/AIDS Treatment Modernization Act. For FY 2009, the Planning Council will fund 13 service categories with Part A funding. More than **89%** of all spending will be dedicated to the provision of the essential core services identified by HRSA: Outpatient/Ambulatory Health Services, AIDS Pharmaceutical Assistance (Local), Oral Health Care, Medical Case Management, Mental Health Services, Substance Abuse Services - Outpatient, Home Health Care, and Home and Community-Based Health Services.

Primary medical care will be delivered through five service providers: Denver Health Medical Center, Children's Hospital, University Hospital, Clinica Tepeyac, and the newest funded provider, Metro Community Provider Network (MCPN). Through their pharmacies, these providers will assist clients with adherence to drug regimens and coordinate the dispensing of HIV medications provided through patient medication assistance programs and the state ADAP. Both Denver Health Medical Center and University Hospital have Ryan White-funded dental clinics on site, and Clinica Tepayac is coordinating dental care with University Hospital. MCPN

is expected to co-locate dental services onsite as well, through the Community-based Dental Partnership Program. Along with these primary care providers, 12 additional agencies will provide support services, ranging from food bank to non-medical case management.

Within the TGA continuum of care, HIV/AIDS care access points are geographically dispersed and accessible. The majority of service providers are located in Denver County. These service providers are located within the communities where PLWH/A populations are most highly concentrated, particularly in central Denver (for Caucasian populations); west Denver (for Latino populations); and North- and East-central Denver (for African American populations).

Perceived Areas for Improvement

The Denver TGA currently provides services to minority PWLH/As at levels that exceed those groups' representation within the overall PLWH/A population. However, even when reviewing this accomplishment and noting other service delivery successes, Planning Council members identified several key areas for improvement to the system of care. Members acknowledged that since the development of the 2006 Comprehensive Plan, the TGA has experienced an "improved culture" under new Planning Council leadership. There is now more flexibility in running the Planning Council, and participants have a greater voice in determining the direction of HIV care as well.

In retreat discussions, Planning Council members repeatedly emphasized a desire for concrete data to drive decision making. They also noted that although the current membership of the Planning Council has strong energy and commitment, the existing structure of the organization struggles to capture that energy. The current structure lacks the necessary processes to capitalize on the enthusiasm of its members. There was expressed a strong desire for more collaboration with the state of Colorado and other non-Part A funded HIV resources, to maximize efficiencies and reduce duplication of efforts. Finally, emphasis was placed on the need for the system of care to evolve to meet changes in the status of HIV as a disease. Once thought to be a terminal illness, HIV has progressed today to a chronic illness model, as technology has helped to extend lifespans of PWLH/As through medications and more effective treatment protocols.

Plan Goals and Objectives

To address the improvement areas identified throughout the planning process, the 2009 Comprehensive Plan outlines four main goals for the coming three-year period. These goals center around refining the Planning Council operating structure to better achieve requirements of the HRSA mandates and HIV/AIDS Treatment Modernization legislation. First, the Planning Council will implement a Quality Improvement and project management structure to address critical issues within the TGA. Such issues include initiatives for the TGA's four priority focus areas of HIV service provision: Linkage to Care; Eliminating Health Disparities; Retention in Care; and Adherence/Medical Self-Management. To refine its structure and better address these priority focus areas, the Council adopted a second goal: establish workgroups to take on critical TGA initiatives. These workgroups will replace the current Planning Council committee structure and will be created in stages to encourage Council member buy-in and ensure a smooth operational transition.

Third, the Planning Council will take steps to improve its own strategic functioning by establishing a Development Committee and recruiting members to support the development of future leadership. Fourth, the Planning Council will ensure that strong communication exists between MOHR, the Planning Council, and TGA service providers. Such communication will enable all TGA providers to connect system participants with the most effective care from Part A and non-Part A sources.

SECTION 1: WHERE ARE WE NOW? ASSESSING THE CURRENT CONTINUUM OF CARE

Description of the Part A Program

In their biannual report to Congress, HRSA identified the Denver TGA as a model for implementation of the new HIV/AIDS Treatment Modernization Act. The Denver TGA has received Part A funding for 16 years, since 1993. For FY 2009, the Denver TGA HIV Resources Planning Council (Planning Council) chose to fund 13 service categories with Part A funding. More than **89%** of all spending will be dedicated to the provision of the essential core services identified by HRSA: Outpatient/Ambulatory Health Services, AIDS Pharmaceutical Assistance (Local), Oral Health Care, Medical Case Management, Mental Health Services, Substance Abuse Services - Outpatient, Home Health Care, and Home and Community-Based Health Services.

Primary medical care will be delivered through five service providers: Denver Health Medical Center, Children’s Hospital, University Hospital, Clinica Tepeyac, and a new provider, Metro Community Provider Network (MCPN). Through their pharmacies, these providers will assist participants with adherence to drug regimens and coordinate the dispensing of HIV medications provided through patient medication assistance programs and the state ADAP. In addition to these primary care providers, 12 additional agencies will provide support services, ranging from food bank to non-medical case management.

HIV/AIDS care access points are geographically dispersed and accessible. The majority of service providers are located within the communities where PLWH/A populations are most highly concentrated, particularly in central Denver (for Caucasian populations); west Denver (for Latino populations); and North- and East-central Denver (for African American populations).

Epidemiological Profile of the Denver TGA

Overview of the Current Epidemic

The data included in the following narrative are not based on CDC estimates but rather on **actual numbers** gathered through Colorado names reporting statistics, long determined by the CDC to be the “gold standard” of HIV/AIDS reporting. Names reporting of HIV infection and AIDS has been required in the state of Colorado by regulation since 1985 and by statute since 1987. The names reporting law has enabled the Denver TGA to have the benefit of assessing the epidemic through an analysis of actual numbers for over 21 years. The law mandates that both laboratories and physicians report any cases of HIV and AIDS within seven days of diagnosis. Cases must be reported to the HIV Surveillance Program of the Colorado Department of Public Health & Environment (CDPHE). As each case is reported to CDPHE, it is entered into a database known as the “HIV and AIDS Reporting System” (HARS). CDPHE uses the HARS database to provide the Denver TGA with regular updates regarding profiles of those individuals affected by the epidemic.

The TGA uses local CDPHE data, generated as a result of names reporting, because this data provides the most accurate assessment of HIV/AIDS epidemiology within the Denver TGA. CDPHE initiated its active system of surveillance for HIV and AIDS expressly for the purpose of accurately characterizing the scope of the epidemic in Colorado. This surveillance system has

been in place since 1987, so it has had the benefit of 21 years of development. In 2001, the surveillance system was assessed through an evaluation study, which documented that the completeness of AIDS and HIV reporting in Colorado was approximately 97% for recently diagnosed cases. The CDPHE system is highly comprehensive in its monitoring of HIV-related laboratory tests, maintaining records on all tests that are indicative of or highly correlated with HIV, including HIV-positive antibody tests, HIV viral loads, positive cultures for HIV, and CD4 counts of less than 500mm. All of the AIDS cases documented by the system meet the 1993 CDC surveillance case definition for AIDS, which includes HIV positive patients with CD4 counts of less than 200mm or those diagnosed with one of 21 opportunistic infections considered to be definitive of AIDS.

HIV/AIDS cases by demographic characteristics and exposure category in the EMA/TGA:

Total HIV/AIDS Prevalence. As of December 31, 2007, there are 4,765 persons living with HIV and 3,269 persons living with AIDS, for a total of 8,034 PLWH/As in the Denver TGA. Of this total amount, 7,295 individuals are male (91%) and 739 are female (9%). The persons living with HIV/AIDS fall into the following racial/ethnic groups, in descending order of size: Caucasian, not Latino, 5,407 (67%); Latino, 1,334 (17%); African-American, not Latino, 1,157 (14%); Asian/Pacific Islander, 64 (1%); and Native American, 56 (1%). An additional 16 persons (less than 1%) are identified as multiracial.

For all PLWH/As, the most common exposure category is MSM, with 5,396 cases (67%). MSM/IDUs account for 730 cases (9%), followed by heterosexuals with 626 cases (8%) and IDUs with 602 cases (8%). There are 618 PLWH/As (8%) with no identified risk, and 63 PLWH/As (1%) are classified as Other exposure. In terms of age ranges, the largest age group is 20-49 year olds, with 5,343 cases (67%). Individuals over age 49 make up the next largest population, with 2,659 cases (33%). The youngest age groups comprise less than 1% of the total PLWH/A population. These are: 14-19 year olds, with 16 cases, and 0-13 year olds, with 16 cases.

People living with HIV. The demographic breakdown of people living with HIV (non-AIDS) in the TGA largely resembles that of the total PLWH/A population. As of December 31, 2007, there are 4,765 persons living with HIV (non-AIDS) in the Denver TGA. Of these, 4,350 are male (91%) and 415 are female (9%). The ethnic breakdown of this group is as follows, in descending order of size: Caucasian, not Latino, 3,346 (70%); Latino, 701 (15%); African-American, not Latino, 649 (14%); Asian/Pacific Islander, 34 (less than 1%); and Native American, 30 (less than 1%). An additional 5 persons (less than 1%) are identified as multiracial.

For individuals with HIV (non-AIDS), the most common exposure category is MSM, with 3,230 cases (68%). MSM/IDUs account for 442 cases (9%), followed by IDUs with 328 cases (7%) and heterosexuals with 318 cases (7%). There are 419 cases (9%) with no identified risk, and 28 cases (less than%) are classified as Other exposure. In terms of age ranges, as with the overall PLWH/A population, the largest age group is 20-49 year olds, with 3,183 cases (67%). Individuals over age 49 make up the next largest population, with 1,563 cases (33%). The youngest age groups comprise less than 1% of the total HIV (non-AIDS) population. These are: 14-19 year olds, with 10 cases, and 0-13 year olds, with 10 cases.

People living with AIDS. As with the HIV (non-AIDS) population, the demographic breakdown of people living with AIDS in the TGA also largely resembles that of the total PLWH/A population. As of December 31, 2007, there were 3,269 persons living AIDS in the Denver TGA. Of this total amount, 2,945 individuals are male (90%) and 324 are female (10%).

The persons living with AIDS fall into the following racial/ethnic groups, in descending order of size: Caucasian, not Latino, 2,056 (63%); Latino, 631 (19%); African-American, not Latino, 513 (16%); Native American, 29 (less than 1%); and Asian/Pacific Islander, 26 (less than 1%). An additional 13 persons (less than 1%) are identified as multiracial.

For individuals living with AIDS, the most common exposure category is MSM, with 2,167 cases (66%). In this category, heterosexuals account for the next largest group at 311 cases (10%), followed by MSM/IDUs with 288 cases (9%) and IDUs with 271 cases (8%). There are 196 AIDS cases (6%) with no identified risk, and 36 cases (1%) are classified as Other exposure. In terms of age ranges, again the largest age group is 20-49 year olds, with 2,167 cases (66%). Individuals over age 49 also make up the next largest population, with 1,095 cases (34%). The youngest age groups again comprise a small percentage of the entire population living with AIDS, in this case less than 1%. These are: 14-19 year olds, with 3 cases, and 0-13 year olds, with 3 cases.

New AIDS cases reported within the past two years (2006, 2007). Over the past two years, from January 1, 2006 through Dec. 31, 2007, 427 new AIDS cases were reported in the Denver TGA. These new AIDS cases reflect demographic and exposure category profiles that differ from those of persons living with HIV and AIDS. In terms of gender differences, newly diagnosed AIDS cases among women represent 66 cases (15%), with males representing 361 cases (85%). Of total PLWH/As, by comparison, women represent only 9% of cases. Similarly, in terms of ethnic breakdown, Caucasians are represented at much lower percentages among those newly diagnosed with AIDS, comprising 218 cases (51%), compared to 67% of total PLWH/As. Minority populations, by contrast, represent a much higher percentage of the newly AIDS diagnosed. In particular, Latinos represent 115 cases (27%), compared to 17% of all PLWH/As, and African Americans represent 83 cases (19%), compared to 14% of all PLWH/As. Newly diagnosed Asian Pacific Islanders represent 8 cases (2%); American Indians represent 2 cases (1%); and 1 case (less than 1%) was categorized as multi-racial.

Similarly, exposure categories and age groups also reflect diverging profiles among those newly diagnosed with AIDS. In terms of exposure categories, while the majority of newly diagnosed cases are still among MSM (247 cases, or 58%), this percentage is smaller than the 67% of MSMs reflected in the total PLWH/A population. Infections in the heterosexual risk category are on the rise, with 64 newly diagnosed AIDS cases representing 15% of the population, as opposed to 8% among all PLWH/As. IDUs follow with 36 cases, or 8% of the newly diagnosed, compared to 8% of the general PLWH/A population, and MSM/IDUs account for 24 (6%) of the newly diagnosed cases, compared with 9% of the total PLWH/A population. Finally, 56 new cases (13%) were classified as no identified risk and/or Other exposure.

In terms of age ranges, the largest category among those newly diagnosed with AIDS is the 40-49 year old age group with 152 cases, representing 36% of diagnoses. Individuals aged 30-39 make up the next largest newly diagnosed group, with 140 cases (33%). The third largest newly diagnosed age group is individuals aged 49 and older, with 65 cases (15%). The youngest age groups represent more than 17 % of the newly diagnosed population: 25-29 year olds represent 46 cases (11%); 20-24 year olds represent 21 cases (5%); and 13-19 year olds represent 4 cases (1%). There were no newly diagnosed AIDS cases in the 0-12 year old age category for this time period.

Judging from Denver's newly diagnosed cases, AIDS is affecting women, people of color, high-risk heterosexuals, IDUs, and youth at rates higher than their representation in the overall PWLH/A population. MSM remain the largest HIV/AIDS population in the TGA overall, par-

ticularly those ages 40 and over, but AIDS diagnoses are affecting special populations to a significant degree.

Disproportionate impact of HIV/AIDS on certain populations in comparison to the impact on the general population: In the Denver TGA, males as a gender have disproportionate AIDS incidence and HIV/AIDS prevalence. Disproportionate AIDS incidence is also seen in three ethnic groups: African Americans, Latinos, and Native Americans. African Americans additionally have disproportionate HIV/AIDS prevalence.

Health System Disparities[1]

	TGA Population	% Population	AIDS Incidence	% AIDS Incidence	HIV/ AIDS Prevalence	% HIV/ AIDS Prevalence
Male	1,097,904	49.8%	361	85%	7,295	91%
Female	1,107,941	50.2%	66	15%	739	9%
Anglo	1,756,575	79.6%	218	51%	5407	68%
African American	120,017	5.4%	83	19%	1157	14%
Latino	409,106	18.5%	115	27%	1334	16%
Asian/Pacific Islander	70,950	3.2%	8	2%	64	1%
Native American	21,224	1.0%	2	1%	56	1%
Other	237,078	10.7%	1	0%	16	<1%

As the table shows, males are being diagnosed with AIDS at 1.7 times their representation in the Denver TGA, and they are living with HIV/AIDS at 1.8 times their representation. African Americans have 3.5 times more newly diagnosed cases of AIDS than their representation in the general population, and Latinos have 1.5 times more newly diagnosed cases. African Americans are also living with HIV/AIDS 2.6 times more than their proportion in the 6-county Denver TGA.

The epidemic also has a strongly disproportionate impact on homeless populations within the Denver TGA. According to a study conducted by the Metro Denver Homeless Initiative, in January 2007, there were an estimated 9,130 homeless persons in the 6-county TGA. This suggests that homeless persons represent 0.3 percent of the TGA population as a whole. According to the study, however, HIV and AIDS were reported among the homeless population at a rate of 2.5 percent (228 persons total). This number is consistent with the 401 persons served by Part A programs who reported being homeless at some point during 2007. Homeless persons are thus living with AIDS at 7.5 times their representation in the overall TGA population.

HIV/AIDS disproportionately impacts the formerly incarcerated as well. According to Kaiser State Health Facts, the HIV/AIDS rate among prisoners in the Colorado correctional system is 1%. In comparison, HIV/AIDS affects .3% of the TGA population as a whole. Thus, formerly incarcerated individuals are living with HIV/AIDS at a rate more than 3 times that of the general TGA population. Further, while formerly incarcerated individuals released in 2006 represented approximately .3% of the general TGA population (7,494), released inmates living with

[1] 2003 Census data compared TGA HIV/AIDS Epidemiology Data. AIDS Incidence data covers the two year period January 1, 2006 – December 31, 2007. HIV/AIDS Prevalence data reflects figures as of December 31, 2007.

HIV/AIDS in that year represented 1.0% of the PLWH/A population (75)[2]. Again, the representation rate of recently released inmates among PLWH/As in 2006 was 3.3 times that among the TGA population as a whole.

Populations of PLWH in the TGA that are underrepresented in the Ryan White Program-funded system of HIV/AIDS primary medical care: The AIDS epidemic has had a disproportionate impact on people of color—particularly African-Americans, Latinos, and Native Americans—however, these populations currently receive a level of service provision that exceeds their proportional representation within the TGA's epidemiological profile. This level of service provision is documented by comparing data from our local epidemiological studies against data derived from the RWCAREWare system, which tracks participant utilization of Part A-funded services. For all funded services, persons of color receive treatment at percentages equal to or greater than their representation in the HIV population as a whole. The comprehensive level of service provision applies not just to participants of color receiving all Part A-funded services, but to participants receiving Part A-funded primary care as well, as the table below documents.

Comparison of Persons Receiving Part A-Funded Services to HIV/AIDS Population

	Caucasian	Latino	African-American	Asian/PI	Native American
Percentage of HIV/AIDS Population*	67.3	16.6	14.4	0.8	0.7
Percentage of All Part A Participants*	52.5	25.1	18.3	0.7	1.4
Percentage of Primary Care Participants*	50.4	24.3	17.0	0.9	0.7

*Percentages total less than 100% because of unspecified and/or multi-race/ethnicity.

Emerging Populations

Utilizing new diagnosis data, RWCAREWare service utilization trends, and the 2005 and 2008 Needs Assessments, six emerging populations have been identified in the Denver TGA. These populations are: **1) MSM aged 40+ years; 2) Anglo MSM; 3) MSM of Color (MSMC); 4) Women of Childbearing Age, especially Women of Color; 5) Injection Drug Users (IDUs); and 6) Youth.**

MSM 40+ years: Denver had the highest percentage of People Living with HIV over 45 years of age in the 2003 epidemiological data produced by CDC (41.9%, the top ranking). Although this is the largest population in terms of special needs, we do not have a great deal of historical data on the complexity and co-morbidities associated with HIV and aging. Emerging information suggests increased cancer and cardiovascular conditions are occurring among persons with long-term HIV infection and long-term use of antiretrovirals.

Based on trends in the overall population, we can anticipate increased need for medical services based solely on the aging factor. However, certain questions will need to be investigated. Will the addition of HIV exacerbate common aging issues? What of mental health? This is a population that once braced itself for the inevitability of a premature death – will being a long-term survivor present itself with mental health issues? What coping skills will need to be addressed when individuals no longer see HIV as their primary concern but instead are focused on

[2] Colorado Department of Corrections Monthly Report, 2006 Adult Inmate Releases, October 2007. These figures are based on an estimate of 80% of the 9,367 formerly incarcerated individuals residing in the Denver TGA.

the general concerns of aging? Given the relative newness of aging as a co-morbidity, we do not have reliable data on the costs and complexities involved. However, this is certainly a population that will demand tracking in the future.

White MSM: After MSM 40+, a second special needs group is White MSM. This is the largest group overall and within the MSM exposure category in the TGA. In the latest needs assessment, White MSM in care identified their service needs in the following order: Primary Medical Care, Dental Care, Emergency Housing Assistance, Prescription Drugs, and Mental Health Services. Barriers to care entry included the side effects of medications, a tendency to ignore or not understand their laboratory values, and difficulties in obtaining housing.

Out-of-Care White MSM rated services highest that would expedite care entry, including: Dental, Out Patient Medical, Case Management, then Peer Counseling and Counseling on the Side Effects of HIV Medications. Barriers to care cited for this group included: 1) the perception that they don't "feel sick"; 2) transportation issues; and 3) high costs associated with care. Of the "Out of Care" White MSM, 63% were erratically in care, with 80% of these not accessing care within the last 7 to 12 months. 25% (2 respondents) had never been in care and 13% were newly diagnosed.

MSM of Color: This group comprises two main sub-groups, Latino MSM and African-American MSM. Latino MSM prioritized Dental Care, Primary Medical Care, Food Bank, Case Management and Prescription Drugs as key needed services. Specific areas cited as gaps by this population were the critical areas of HIV Medications and Health Insurance. Barriers faced by in care Latino MSM were cited as: 1) Case Management; 2) Client Advocacy; 3) Emergency Financial Assistance; 4) Emergency Housing Assistance; and 5) Food Bank. For "Out of Care" Latino MSM, barriers to care entry included: 1) Costs; 2) Transportation; 3) Lack of knowledge about where to access medical care; 4) Perception that they don't need medical care; and 5) Depression.

With respect to African-American MSM, a cultural stigma regarding HIV disease was reported by all "In Care" and "Out of Care" survey respondents. Their rationale for avoiding care stemmed from concerns about the safety of HIV medications, with this fear first raised at the beginning of the epidemic in reaction to AZT. The top 5 service needs cited for this population were identical to those of Latino MSM: Dental Care, Primary Medical Care, Food Bank, Case Management and Prescription Drugs. Barriers to care among African-American MSM were also similar to those cited by Latino MSM: 1) Costs; 2) Perception that they don't need medical care; 3) Lack of knowledge about where to access medical care; and 4) profound distrust of the medical system specific to HIV/AIDS for African-Americans.

Women of Childbearing Age, especially Women of Color: According to the Needs Assessment findings, this population reported predominantly heterosexual transmission, with only 10% citing drug use. Among the "In Care" Women of Childbearing Age, 90% were HIV+ and 10% had AIDS. All the "Out of Care" Women of Childbearing Age were HIV+. Special needs for this group were identified as: 1) Prescription drugs; 2) Food Bank; 3) Primary Medical Care; 4) Dental Care; and 5) Case Management. In terms of barriers to care, the "worry that others will find out I am HIV+" was the primary factor affecting care entry.

Injection Drug Users (IDU): The special needs of the IDU population were determined through the survey process for "In Care" and "Out of Care" needs assessment participants. The top 5 service needs were listed as: 1) Primary Medical Care; 2) Prescription Drugs; 3) Case Management; 4) Emergency Financial Assistance; and 5) Substance Abuse Services. Barriers to care included the following: 1) Didn't know where to access care; 2) Transportation issues; 3)

Costs; 4) Perception that they didn't need care: 5) Mistrust of doctors; 6) Problems with the way they were treated; and 7) Depression. Among the Out-of-Care respondents, 53% were erratically in care, of which 75% had not accessed care in 7-12 months, and 33% had **never** been in care.

Youth: Based on 2008 CDPHE epidemiology data, Youth (ages 13-24) represent approximately 9% of PLWH/As in the Denver TGA. Of PLWH/A Youth, 98% reside in the City and County of Denver; 88% of these are male and 12% are female. Fifty-six percent are Latino, 22% are African-American, and 22% are White. During the needs assessment, the special needs of this group were identified as: 1) Food Bank; 2) Case Management; 3) Housing Assistance; 4) Primary Medical Care; and 5) Health Insurance. Subsistence needs were dominant among Youth. Of the "Out of Care" Youth, 67% were erratically in care. Of these Youth, 67% had not accessed care for 7-12 months, and 33% had not accessed care for 4-6 months.

Impact of Co-Morbidities

The average cost of treatment per HIV/AIDS participant in the TGA is estimated at $23,073 per year. This estimate is based on an average of $2,388 in inpatient costs per participant per year; $4,387 in outpatient costs; $14,068 in costs for antiretroviral therapy (average wholesale price); and an additional $2,230 in non-antiretroviral outpatient pharmacy costs. This estimate was developed through a retrospective review of the costs of care for over 300 HIV/AIDS participants who started initial antiretroviral therapy at Denver Health, the largest primary care provider in the TGA. The participants in the review were followed for over three years on average. All costs are in 2005 dollars.

Based on this estimated cost figure, the 3,692 participants served in the Denver TGA Part A program require more than $85,000,000 in annual care costs. These costs are further increased by co-morbidities such as those explained below.

Sexually Transmitted Diseases (STD) Infection Rates: The most recent statistics from CDPHE (2005) indicate there were 15,234 cases of chlamydia in Colorado, resulting in a case rate of 334 per 100,000. The case rate in Denver County was 750 per 100,000. According to CDC Surveillance data for 2005, the case rate in the Denver Metropolitan Statistical area was 366 per 100,000.[3] CDPHE data show that the majority of the cases were reported in women, with a case rate of 485.2 compared to 182.9 among males. The 20-24 and 15-19 age groups continue to have the highest-age specific chlamydia rates, with case rates of 2,500 per 100,000 among females in both age groups.

Colorado also reported 3,276 cases of gonorrhea with a case rate of 71.8 cases per 100,000. The case rate in Denver County is three times higher, or approximately 235 cases per 100,000. In the state as a whole, the highest age-specific gonorrhea cases are found in the 20-24 and 15-19 age groups. Within these groups, females have higher case rates than males, but female and male case rates are roughly equal within the overall population.

Finally, there are 46 cases of syphilis in Colorado translating to 1.0 cases per 100,000 population as reported by CDPHE. Eighty percent or 37 of all syphilis cases are in the Denver TGA, with a case rate of 1.6 per 100,000. By contrast, there are a reported 50 cases of PLWH/As co-infected with syphilis, for a case rate equivalent to 654.8 per 100,000. The discrepancy in these case numbers is attributed to differences in reporting mechanisms and the jurisdiction of original diagnosis.

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[3] CDC, Sexually Transmitted Diseases Surveillance Report, 2005.

Homelessness: As discussed in the Epidemiological Profile above, homelessness has a highly disproportionate impact on PLWH/As in the Denver TGA. According to the Metro Denver Homeless Initiative (MDHI), the homelessness case rate as of January 2007 was 395.7 per 100,000, based on an estimate of 9,130 cases. Comparatively, homelessness among the TGA PWLH/A population reflects a case rate of 2,986 per 100,000, based on 228 reported homeless PLWH/As documented by MDHI for the same time period. PLWH/As are thus 7.5 times more likely to be impacted by homelessness than are residents of the TGA overall. They are 9.3 times more likely to experience homelessness than are residents of the state of Colorado as a whole, based on a statewide case rate of 320.4 per 100,000.[4]

Homelessness complicates the delivery of care to HIV/AIDS infected individuals because without a stable living situation, individuals are less inclined to be proactive about their health needs with regard to both prevention and treatment. In terms of prevention, homeless individuals are at a much greater risk for infection from HIV: according to the MDHI 2007 study, the homeless population has a reported rate of HIV prevalence at least 8.3 times higher than that of the general TGA population (2.5% versus .3%). In addition, treatment programs tend to be very difficult to maintain for homeless populations. Because of their transient living situations, they often access medical services only on an emergency basis rather than through regular clinic visits. As with other co-morbidities, emergency care for homeless individuals increases the cost and complexity of service delivery and exacerbates problems with medication adherence.

Lack of Health Insurance: Along with homelessness, another complicating factor for HIV service provision is lack of health insurance. According to the Colorado Health Institute, approximately 23% of individuals were without health insurance in Denver County alone. This rate is 50 percent higher than the U.S. national estimate of 15.3% uninsured, provided by the U.S. Census Bureau.[5]

Estimates of the HIV-infected population without insurance vary widely, from a low range of 50.5% to a high range of 76.2%. PLWH/As are thus 2 to 3 times more likely to be uninsured than are members of the general population. Even using a far more conservative estimate of 30% uninsured, this would mean that 2,410 of the 8,034 PLWH/A in the Denver TGA are without health insurance. The Colorado Medicaid Program does provide medical coverage for approximately 10%, or 803, of Denver PLWH/A. Again using conservative estimates, approximately 1,607 persons (or 20% of the PLWH/A population) are without any form of health insurance, including Medicaid.

Our RWCAREWare service utilization data shows that for 2007, 1,729 Part A participants maintained no health insurance coverage, reflecting an uninsured rate of 46.8%. This rate is an increase of 28.9% over the 2006 uninsured rate for the Part A population (36.3%). At a cost of $23,073 per person for annual HIV/AIDS treatment, the total cost to treat these 1,729 uninsured participants alone exceeds $39 million.

Poverty: Individuals who live in poverty have difficulty accessing care and have insufficient income to address their health care needs. In particular, having a low income compromises the ability of PLWH/As to obtain adequate primary care and treatment. Their treatment can be inhibited by obstacles such as not having funds for bus fare and concerns about how to meet their immediate survival needs. As a result of these obstacles, many poorer PLWH/As resort to expen-

[4] Colorado Coalition for the Homeless, 2007 Point-in-Time Study.
[5] U.S. Census Bureau, Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements.

sive emergency room services at more advanced stages of their illness, increasing the cost and complexity of the care that they may require.

Poverty is beginning to emerge as a significant problem in the Denver TGA, both for the general population and for the population living with HIV/AIDS. According to the USDA Economic Research Service, approximately 10.2% of Colorado residents were living in poverty as of 2004. Individuals living below poverty within the general population are divided geographically by county within the Denver TGA as follows:

Denver TGA Populations Living in Poverty

County	Population	Individuals Living Below Poverty Level	%
Adams	414,338	44,749	10.8%
Arapahoe	537,197	44,050	8.2%
Broomfield	45,116	2,346	5.2%
Denver	566,974	86,180	15.2%
Douglas	263,621	9,754	3.7%
Jefferson	526,994	37,944	7.2%
Denver TGA	**2,354,240**	**225,023**	**9.6%**

SOURCE: USDA Economic Research Service, 2004 County-Level Poverty Rates for Colorado

This average figure of 9.6% for the general population covers individuals living at or below the federal poverty level. It would likely be significantly elevated if statistics were provided for those living at or below 300% of the federal poverty level.

The effect of poverty on the HIV/AIDS population is dramatic when compared to these estimates of poverty incidence in the general TGA population. To assess the percent and number of HIV/AIDS-infected persons living at or below 300% of the 2008 federal poverty level ($10,400), we evaluated income data from RWCAREWare on participants served through Part A providers in 2007. Of these 3,692 participants served by the Ryan White system in 2007, we estimate that 100% were living at or below the 300% threshold ($31,200). The average income among Part A participants served is estimated at $8,000 per year, and 120 participants reported no household income data. This means that on average, at least 3,572 (97%) of the Ryan White participants served were living at 80% of the federal poverty level.

Current income data was not available for the entire HIV/AIDS population within the Denver TGA, but the data from Part A participants indicates that **at least** 3,572 (44.5%) of the 8,034 PLWH/As in Denver are living at or below 300% of the federal poverty level, and on the average at 80% of the federal poverty level. That number alone amounts to 4.6 times the representation of poverty-stricken individuals within the general Denver TGA population.

Other Co-Morbidities and Complicating Factors:

Tuberculosis. In 2006, the TGA reported 85 cases of tuberculosis with an overall case rate of 3.7 per 100,000 of the population. By comparison, there are currently a total of 48 persons living with AIDS and TB in the Denver TGA out of 8,034 PLWH/As. This is equivalent to an extrapolated co-infected case rate of 597.5 per 100,000 persons, which is 161 times the rate of TB in the general population.

In addition to its disproportionate prevalence among PLWH/As, tuberculosis has a particularly disproportionate impact on minority populations. People of color comprise 75% of the PLWH/As who are co-infected with TB. This disproportionate impact on minority PLWH/As is reflective of the impact of TB on the state as a whole. Although Colorado remains a low inci-

dence state, since its case rate is lower than 3.5 per 100,000 of the population, the case rate for minority populations is 9.0 per 100,000. This rate is 23 times higher than that of the majority population in the state.

Hepatitis-C. HCV/HIV co-infection poses special clinical challenges for the treatment of HIV. First, it tends to be more difficult to ensure that patients adhere to drug therapies when they are being treated for both illnesses. Second, Hepatitis-C co-infection often results in overlapping drug toxicities, such as anemia caused by both ribavirin and AZT. Hepatitis-C co-infection leads to accelerated rates of liver failure as well as the phenomenon of immune reconstitution hepatitis among co-infected patients who start on antiretroviral therapy. Finally, Hepatitis-C co-infection produces an increased incidence of antiretroviral-related hepatotoxicity.

According to the most recent CDPHE statistics (2005), there are a total of 2,462 cases of Hepatitis C virus (HCV) among the general population of the TGA. This equates to 0.1% of the general population, or a case rate of 106.7 per 100,000. By comparison, there are a total of 595 PLWH/As co-infected with HCV in the Denver TGA, comprising 7.4% of the HIV/AIDS population. This is equivalent to a case rate of 7,406 per 100,000 persons, which is 69 times the rate of HCV infection in the general population.

Intravenous Drug Use (IDU). Intravenous drug use increases both the cost and complexity of HIV/AIDS service provision in the TGA. IDU disproportionately affects the HIV/AIDS population to a significant degree. In 2007, there were a total of 1,332 IDUs and MSM/IDUs among the PWLH/A population, accounting for 16.6% of PWLH/As, or a case rate of 16,580. This rate is 35 times that of IDUs in the overall TGA population and 53 times the case rate in the state as a whole. There are currently an estimated 10,900 IDUs in the TGA, for a case rate of 472.4 per 100,000, according to data supplied by the Colorado Department of Human Services' Alcohol and Drug Abuse Division (ADAD). The state of Colorado is estimated to have 15,000 to 18,000 current IDUs, for a case rate of 312.21 per 100,000.

Intravenous drug use impacts the cost of care for Denver PLWH/As, particularly due to the high percentage of PLWH/As who have a substance abuse history. Of the 3,692 participants seen in the Part A system in 2007, 960 of these had a substance abuse history (26%) and 698 had both substance abuse and mental health histories (18.9%). These two populations comprise a total of 1,658 individual with substance abuse histories, or **45%** of the entire Ryan White PLWH/A population. These populations will require an estimated additional cost of $1,424 per year per participant for treatment in FY 2009.

Costs are also increased for IDUs who do not receive treatment, which in Denver may amount to a significant percentage of Ryan White participants. In 2007, a total of 404 individual received Part A-funded substance abuse treatment, representing 24.4% of those with substance abuse histories. The remaining 75.6% of individuals with substance abuse histories received no treatment. This number of untreated individuals (1,254) represents 34% of the entire Part A participant population, and adds its own costs to the burden of care because of drug abuse-related health complications. Even assuming that some of the 1,254 had successfully resolved substance abuse problems and required no present treatment, the costs posed by lack of treatment could still be substantial.

Along with increasing costs, intravenous drug use impacts the complexity of care delivery for affected PLWH/As. IDU are at a greater risk of health complications brought about by needle sharing, unprotected sex, prostitution, violence, and sexual assault. They are often affected by mental illness, poverty, homelessness, and incarceration as well. Because they lack trust in agency providers, they find it difficult to access medical care. They may fail to show up

for treatment and experience relapses, both of which make it difficult for them to adhere to treatment regimes. Women IDU may be reluctant to disclose their abuse history for fear of losing their children, which exacerbates treatment access problems.

Other Substance Use. The most recent data from the Substance Abuse and Mental Health Administration (SAMHSA) ranks Colorado 12th compared to other states for past drug dependence of individuals participating in the National Household Survey on Drug Abuse. The following rates for other substance abuse in the TGA are reported by Colorado's ADAD:

Denver TGA Other Substance Abuse Rates

Substance	Prevalence	% of Total TGA Population
Alcohol	143,835	6.8%
Marijuana	95,890	4.5%
Cocaine	21,096	1%
Stimulants	3,836	0.18%
Total	**264,657**	**12.5%**

ADAD statistics also reveal the complicating impact of methamphetamine (meth) use on care for MSM PLWH/As in the TGA. Methamphetamine use disproportionately impacts MSM PLWH/As at a rate nearly double that of the general MSM population. According to a study published in 2006, a survey of 981 MSMs revealed an 11% rate of meth use among MSM, compared to a 20.9% rate of use among MSM PLWH/As. Methamphetamine use puts MSM at a higher risk of complications due to multiple partners and unprotected sex, which increases the risk of STD co-infection. Of the overall MSM population surveyed, meth users had 1.75 times more sexual partners during the year than did non-meth users, and they were 1.6 times more likely to have unprotected sex. Meth use is further correlated with higher incidence of HIV infection. Although both groups were equally likely to test for HIV (93%), meth users reported 2.13 times more HIV positive results (31.7%) than did non-meth users (14.9%).

Chronic Mental Illness. Another problem that presents a challenge to the Denver TGA's service delivery system is mental illness in HIV/AIDS patients. It can be a contributing factor in new infections among uninfected persons, and, if left untreated, can also lead participants who are already infected to become re-infected. Chronic or periodic mental illness erects a formidable barrier to primary care and anti-retroviral drug therapies. Participants suffering from mental illness have difficulty maintaining the daily regimens and appointment schedules necessary for adequate care. They also can be extremely difficult for providers to work with, particularly if they have personality disorders that cause them to interact in a hostile manner or to be secretive and suspicious of recommended treatment.

In the Denver TGA, a total of 1,303 persons (35.3%) accessing Part A-funded services were reported to have an established history of mental illness or other mental health disorders in 2007. An additional 698 persons (18.9%) were reported as having both a substance abuse and a mental illness history during the same period. This combined total of 2,001 persons represents 54.2% of the 3,692 participants who accessed Part A-funded services. Of the 2,001 participants who were reported as having a mental illness history in 2007, only 708 or 35.4% were reported as accessing treatment for their disorders. This means that 64.6% of the participants with mental illness histories did not receive treatment in 2007.

Mental illness increases the cost of care for treating participants with HIV/AIDS. Those who do access treatment for mental health disorders definitely require more resources from the

system than those without mental heath issues; in FY 2009, the service cost for annual treatment will add an additional $521 per participant served. In addition to treatment costs, a further financial burden is imposed by mentally ill participants who do not receive treatment. Mental illness may interfere with participants' abilities to maintain stable living situations, participate in working relationships with treatment providers, and follow regular medication schedules. As a result, non-treated mentally ill participants are more likely to be affected by homelessness and to require costly emergency care.

Impact on Service Delivery System of Formerly Incarcerated:

Finally, along with the other co-morbidities and complicating factors discussed above, individuals released from prison with HIV/AIDS present a specific challenge to the service delivery system because of their high level of support needs. Research shows that the formerly incarcerated are likely to face homelessness, substance abuse problems, and mental health concerns. They may engage in commercial sex work or struggle to deal with low incomes and lack of basic necessities, such as food and clothing.[6] Because of their high level of basic needs when reintegrating into the community, the formerly incarcerated are more likely to utilize more Part A system resources per person, including service provider time and care costs.

Over the period 2004-2006, based on reports from the Colorado Department of Corrections and the Bureau of Justice Statistics, a total of 260 PLWH/As were released from the custody of the penal system in Colorado. Approximately 80%, or 208, of these individuals are estimated to reside in the Denver TGA. At a per-participant rate of $23,073 annually for basic medical treatment, the care costs for these former inmates alone is $4.8 million. In terms of Ryan White system resources, these participants are likely to require the following additional services: mental health (estimated at $605 per person); substance abuse ($2,498); emergency financial ($763); housing ($1,074); and food bank services ($161), for a total of $5,101 in additional services per person. These services represent an added cost to the system of $1,061,008 per year, for a total estimated cost of more than $5.8 million.

For comparison purposes, Colorado ranks 21st in the nation in terms of its HIV rate among inmates. The statewide case rate is 1,000 per 100,000 of the inmate population, slightly below the United States average of 1,900 per 100,000. From 2004 through 2006, there were 26,026 inmates released from the penal system in Colorado, for a case rate of 541 formerly incarcerated per 100,000 of the overall state population. At an estimated 80% in the Denver TGA, this amounts to 20,821 in the TGA, for a case rate of 902 per 100,000 of the TGA population. The 208 formerly incarcerated inmates with HIV/AIDS represent 2.6% of the PLWH/A population in the TGA, for a case rate of 2,589 per 100,000. Considering individuals released over a three-year period, the formerly incarcerated are thus represented among Denver TGA PWLH/As at a case rate more than 4.8 times greater than their representation among the general state population and 2.9 times greater than their representation among the TGA population.

Description of the Current Local and State Response to the Epidemic

The Denver TGA coordinates its resources with other Federal, State, and local resources which are available to People living with HIV/AIDS in the metro area. Information about the current local and State responses to the epidemic is reviewed regularly within the Denver TGA,

[6] R.D. Glymph, et. al., "Connecting Formerly Incarcerated with HIV/AIDS Services," *Int Conf AIDS.* 2004 Jul 11-16, p. 15.

particularly during the priority setting and resource allocation processes. The Mayor's Office of HIV Resources prepares a report on *Other Funding Sources* which describes the purpose of the various funds, the amounts available, and how they complement Part A funds.

Additionally, service provision data is also coordinated across Ryan White Parts A, B, C, and D, and shared through a central data collection mechanism, which MOHR now operates for each of the Parts of the Ryan White program in the state of Colorado. This data is maintained in the RWCAREWare database. In addition to maintaining client-level data for Part A programs, the central database also maintains data for all of Part B service provision through CDPHE programs and for all Part D service provision through Children's Hospital, our regional WICY provider. At present, the central database contains only a portion of Part C client-level data, which is provided by the Early Intervention Services program of the Denver Health Clinic. However, MOHR is in the process of expanding to include all of Part C data. Discussions are also underway to develop a compatible data tracking system for the Part F Community-based Dental Partnership Program.

Report on the Availability of Other Public Funding

Coordination with Other Federal and Local Resources:

Colorado Medicaid Program. The Department of Health Care Policy and Finance is the state agency that manages the Colorado Medicaid program. In FY 2007, the Colorado Department of Health Care Policy and Finance expended approximately $6,000,000 to cover HIV/AIDS related services. These services included: primary care, prescription medication, dental extractions, hospice care, and limited support services. With these services, Medicaid funding assists a large number of PLWH/A through Medicaid Health Maintenance Organizations (HMOs) in the Denver TGA. Consumer surveys for the past two years have shown increased satisfaction with the quality of services for disabled adults enrolled in the Medicaid HMOs.

Medicaid in the state of Colorado is characterized by notably conservative eligibility guidelines, and ranks 47th out of 50 states in its per capita spending. Although there is an HIV waiver in place for individuals who need Long Term Care, the majority of PLWH/As do not utilize Medicaid to access needed medical services because they must first receive a disability determination through Social Security before they can qualify for Medicaid. Due to the Social Security disability eligibility limitations within the state, very few individuals with HIV are able to qualify for Medicaid. This circumstance is unique for Colorado in comparison to many states, and it explains why a large percentage of medical care costs are covered through Ryan White funds rather than through Medicaid.

Medicare. In FY 2007, approximately $700,000 in Medicare funds were expended in the Denver TGA to cover HIV/AIDS related services. In the TGA, Ryan White Part A funding helps to fill the gap in coverage people experience while applying for Medicaid and Medicare. Once a participant receives Supplemental Security Income (SSI) benefits, he or she automatically receives Medicaid. However, if a participant receives SSDI benefits, he or she may exceed the Medicaid income limit, therefore losing Medicaid benefits. Subsequently, the participant must wait 24 months from disability determination to qualify for Medicare, and in the meantime does not have medical coverage through Medicaid or Medicare.

In this interim period, Ryan White Part A funding is available and used primarily to provide funding for Outpatient/ambulatory medical care, AIDS Pharmaceutical Assistance (local),

Oral Health Care, Medical Case Management, Mental Health, Substance Abuse Services Outpatient, Home and Community Based Health Services. Once a participant is eligible for Medicare, they still may not have complete medical coverage or any prescription benefits because Medicare Part A covers only inpatient care. Medicare Part B only covers physician visits and laboratory work, and Medicare Part D covers prescription benefits. Both Medicare B and D are voluntary programs with additional costs. Because both Medicare Part B and Part D require people to incur additional expenses each month, many participants cannot afford to expend the dollars, and Ryan White funds are used in part to fill the gap for PLWH/As. Medical Case Managers work with PLWH/As to assist them to apply for Qualified Medicare Beneficiary (QMB) or Special Low-income Medicare Beneficiary (SLMB), which are benefits provided to Medicare qualified individuals who do not qualify for Medicaid benefits, but do qualify for some Medicaid assistance to pay for some or all of their Medicare premiums. The state ADAP program, which is managed by the state of Colorado through CDPHE, offers a program called Bridging the Gap to assist participants on Medicare D to pay for their premiums, co-pays, co-insurance and to cover expenses during the Medicare D "coverage gap." This program is supported with funds from the State of Colorado Tobacco settlement fund.

State Child Health Insurance Program. Child Health Plan Plus (CHP+), also known as the Children's Basic Health Plan, subsidizes health insurance coverage for low-income children. Eligible children are under age 19, live in a family earning less than 185% of the federal poverty level (FPL), and are not eligible for Medicaid. Families earning more than 100% of the FPL pay a state-subsidized monthly premium for covered benefits. Once a child is declared eligible for the program, he or she remains covered by the program for 12 months unless the family changes coverage or fails to make required premium payments. CHP+ provides health coverage for more than 22,000 children in Colorado. CHP+ benefits include inpatient and outpatient hospital, physician, ancillary, therapies, prescription drugs, and mental health services. The CHP+ benefits package excludes dental services. Depending on the geographic area in which an enrollee resides, services are provided either by an HMO or by a fee-for-service network. Primary care programs for Parts A, C, and D assist in eligibility screening for CHP+.

Veterans Affairs Programs. One of the Veterans Affairs' (VA) regional facilities is in the Denver TGA. The full-service VA hospital houses an HIV-specific clinic that serves 218 participants, all of whom are former military personnel. Approximately 80% of the VA's total participants reside in the Denver TGA. Staffing for the clinic includes a full-time nurse practitioner and three part-time physicians who provide primary medical care, laboratory work, and medications to their participants. Veterans who are HIV-positive, regardless of stage of disease, are eligible for these services. Working with this organization to help us identify unmet need is a high priority for the Denver TGA.

Housing Opportunities for Persons with AIDS (HOPWA). The City and County of Denver's Housing and Neighborhood Development Department administer HOPWA funds in the Denver TGA. The FY 2008 award for the Denver metropolitan area was $1,797,040. The funding was used to provide the following services: short term rental assistance, tenant based housing subsidies, subsidized HOPWA Units, residential housing with supportive services for the chronically homeless, day shelter and medication adherence services for homeless people living with HIV/AIDS, housing development, and limited supportive services. The short term rental assistance funds are used to prevent evictions and assist with deposits. HOPWA rental assistance and Part A Emergency Housing Assistance are closely linked and are administered through the same program. Additionally, HUD has awarded a 3 year HOPWA Special Projects of National Sig-

nificance (SPNS) grant in the amount of $730,000 dollars to the Colorado AIDS Project (CAP) for the MOSAIC Transitional Housing program. CAP also receives $400,000 dollars from HUD and McKinney act funds to support the Juan Diego Project and Dave's Place Supportive Housing programs targeting people living with HIV/AIDS who are homeless.

CDC Prevention Program. CDPHE is currently engaged in contractual agreements with twenty agencies to provide HIV risk-reduction counseling, testing, and referral services in the six-county region of the Denver TGA. For FY 2008, CDPHE received approximately $4,390,000 in CDC funding for services to assist in the prevention of primary and secondary HIV infection. The services are provided through sexually transmitted disease clinics, state-designated counseling and testing sites, family planning clinics, and substance abuse treatment centers. State Medicaid funds do not cover any testing done at these sites.

The Mayor of Denver (CEO) has appointed the coordinator for the Statewide Community Planning Group (CPG), Coloradoans Working Together, to the Planning Council. The coordinator of the Planning Council has also joined the prevention-planning group. Both grantees have a long history of collaboration in initiatives targeting African-Americans. Similarly, both grantees have successfully partnered with community-based organization to develop a conference targeting African-Americans. Additionally, MOHR is collaborating with the prevention grantee in providing capacity to identify additional funding sources for mental health and substance abuse prevention and treatment services that are inclusive of harm reduction strategies.

Services for Women and Children. The National Institutes of Health provides research monies for clinical research in the Denver area. The Children's Hospital (TCH), whose participants are pregnant women, their infants, and youth, receives approximately $900,000 of these research funds. TCH is also a Ryan White Part D provider serving women and children, as discussed under other Ryan White funding. In addition, the Empowerment Program's Women's AIDS Project receives funding for housing services for women who are HIV-positive. These funds are available through the Shelter Plus Care Program on a matching basis. Each dollar of direct housing cost is matched by an equal amount of services, typically in the form of case management. This program also receives emergency shelter grant funding for the short-term housing of women who currently are residing on the streets.

Other State and Local Service Programs:

In addition to the coordination described above, the Denver TGA also coordinates its efforts with other state insurance programs and a community food and nutrition program.

Other State Insurance Programs. The Qualified Medicare Beneficiary (QMB) and Speciaified Low-income Medicare Beneficiary (SLMB) programs provide benefits to Medicare qualified individuals who do not qualify for Medicaid benefits, but do qualify for some Medicaid assistance to pay for some or all of their Medicare premiums. The cost of the premium is much lower than the actual claims the state would have to pay under Medicaid for health services rendered. Additionally, Cover Colorado – a high-risk insurance program – enrolls PLWH/As, which allows them an opportunity to secure insurance coverage.

Community Food and Nutrition. The Denver Department of Human Services provides limited support for food and nutritional supplements through grants made to two AIDS service organizations. One of these programs provides home delivered meals to PLWH/As and the other recipient program serves HIV-positive women.

Local and Federal Funds for Substance Abuse/Mental Health Treatment Services:

Substance Abuse Treatment Services. The Planning Council receives information about substance abuse prevention and treatment through the Other Funding Sources report as well as

through service provider and consumer participation in both processes. Colorado Medicaid does not cover substance abuse treatment except for pregnant women. Care for pregnant women with substance abuse disorders is provided through Medicaid's Special Connections Program offered at multiple sites throughout the Denver TGA. This treatment is available during pregnancy and for 60 days postpartum. The Special Connections Program is affiliated with the Part A-funded Addiction Research and Treatment Services (ARTS) program, run through the University of Colorado Denver School of Medicine, which offers van transportation for treatment groups three times weekly. Medicaid also covers limited residential treatment for substance abusers that qualify for two, three-day detoxification and assessment. Additionally, the State of Colorado receives a block grant from the Substance Abuse Mental Health Services Administration. This block grant is administered through the Signal Program, and it provides funds for HIV early intervention primary care services for substance-abusing participants who are receiving mental health and substance abuse treatment. Within the Denver TGA there are two recipients of this funding who also receive Part A funds.

Mental Health Treatment Services. Federal funding for HIV-related mental health treatment services in the Denver TGA is provided to one treatment program, the Mental Health Center of Denver (MHCD). MHCD is the largest mental health treatment provider in the state of Colorado. MHCD operates a collaborative, community-based program that has provided integrated mental health services to more than 360 people infected and affected by HIV/AIDS since 1994. The program provides intensive mental health counseling for persons who are HIV positive, particularly under-served populations including women, children/adolescents, persons of color, monolingual Spanish speakers, men who have sex with men (MSM), recently-released incarcerated persons, homeless persons, persons who are in recovery from injection drug use, and caregivers/significant others who are experiencing emotional distress related to support and care for an infected loved one. The MHCD program is also supported by a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), in the amount of approximately $250,000 per year for four years and $100,000 per year for training.

Other Ryan White Funding:
Information from Part B, C, D, F, and MAI Programs.

ADAP. The ADAP program for the State of Colorado is administered by CDPHE. In FY 2007, CDPHE provided access to 68 medications, including 26 antiretrovirals. CDPHE expended nearly $13.9 million in ADAP funds serving approximately 894 participants across the state. Approximately 80% of all participants served reside in the Denver TGA. An average of 18 prescriptions per participant are provided annually by the program, for a total of 27,000 prescriptions. The ADAP program is funded by the Part B awards from both the state of Colorado and the Denver TGA. The TGA received approximately $500,000 for its FY 2008 Part B award, which it allotted to CDPHE for use in covering ADAP. Part B funds in support of this program totaled $9,527,197 during FY 2008.

Bridging the Gap. The Bridging the Gap, Colorado is a pharmaceutical assistance program that pays for premiums, copayments, and other costs for people who have a Medicare Part D prescription drug plan and sustains participant access to prescribed medications while they are in the Part D "coverage gap." This program is managed by CDPHE utilizing Colorado State Tobacco settlement dollars.

Health Insurance continuation programs. CDPHE offers several subsidy programs to assist eligible participants, who have eligible health insurance plans, to remain on their health in-

surance plans or continue COBRA coverage, by paying for part or all of their insurance premiums, co-pays, or co-insurance.

Mental Health services at Kaiser. CDPHE funds some additional Mental Health services through Kaiser which benefits both the Denver TGA and positive people living in other areas of the state.

FirstCare Program. CDPHE funds the FirstCare program as a linkage to care service for newly diagnosed persons or those whose care has lapsed. This program allows participants to avoid nearly all out-of-pocket costs for the first three-to-six months of care in regard to outpatient care and other Ryan White fundable services. This is one effort designed to reduce initial barriers to care for newly diagnosed people. The program is of particular importance to reduce barriers to care for PWLH/As recently released from incarceration, because it allows immediate access to services while complicated jurisdictional issues are sorted through.

Part C. In the Denver TGA, Ryan White Part C funds are granted to the Denver Health Medical Center. These funds are used for early intervention primary care and for support services to facilitate participant outreach and the provision of care. In FY 2008, the total Part C award was $792,601.

Part D. The Children's Hospital Immunodeficiency Program (CHIP) has been the sole provider of specialized care for children with HIV infection in the Rocky Mountain region since its inception in 1991. CHIP provides comprehensive, coordinated care for children, youth, and pregnant women who are infected with, affected by, or at-risk for HIV. The program is affiliated with the NIH as a research site for the Pediatric AIDS Clinical Trials Group, which assures access to the newest investigational drugs and to the most recent developments in the treatment of HIV disease. The multidisciplinary CHIP team is dedicated to providing state-of-the-art care that meets the medical, social, psychological, developmental, and nutritional needs of our HIV-infected clients. In 2007, CHIP served 382 clients—205 HIV positive, 30 indeterminate, 144 affected, and 3 unknown.

With Part A funds, Part D funds, and some support from The Children's Hospital, CHIP is able to provide its clients the following services: outpatient/ambulatory medical care, AIDS Pharmaceutical Assistance (local), medical case management, mental health services, psychosocial support, nutritional counseling, child care, interpreter services, prevention with positives, medical transportation, and access to research.

Colorado AIDS Education and Training Center (CAETC). The CAETC, which is part of the national Ryan White AETC network, receives $209,974 in direct funding annually to provide a wide range of training and education programs on varied HIV-related content areas statewide. The target audience for CAETC programs and resources is physicians, nurses, physician assistants, dentists, dental hygienists, and pharmacists. Based in the TGA, the CAETC staff is active in the continuum of care collaborative efforts, including service in committee work of the Planning Council, particularly participation in the Evaluation and Assessment Committee and the priority setting process. Several individuals who are AETC clinical educators/faculty are also Denver TGA Part A core service providers. This collaboration includes primary care, oral health care, substance abuse, and case management providers, as well as providers in other CBOs. All new Ryan White providers are encouraged to participate in the CAETC clinical training program as well as other program offerings throughout the year. The CAETC is a core member of the Community-based Dental Partnership Program management team.

Dental Programs. Colorado participates in one of the two dental initiatives funded through Part F of the HIV/AIDS Treatment Modernization Act. Since 2002, The University of

Colorado School of Dental Medicine (SDM) has been one of 13 recipients nationwide of Community-based Dental Partnership Program funds. The purpose of this award is to increase oral care capacity for persons living with HIV by building partnerships between teaching and provider programs. Total annual funding is level at $310,210, of which over 80% remains in the TGA, either at the SDM or the Metro partner, the Howard Dental Center.

The Community-based Dental Partnership Program is primarily a training initiative that includes curricula and student and resident placements in HIV dental care settings as well as training of practicing dentists in the field at five partner sites statewide. Funds for direct patient care costs are limited to 10% of the budget, but supplies, equipment, and other expenditures to enhance the dental care capacity are included. Thus far, two residents who completed the program are now practicing in HIV dental care sites. Through collaborations among the partners, service gaps are identified and an effort is now underway to secure additional funding for services to address gaps. Gaps to be addressed include the need for emergency dental services, liaison efforts between dental and medical care, and implementation of services not currently available to patients in program sites.

A few years ago, the SDM, which is the eligible reimbursement program applicant, withdrew from the Part F dental reimbursement program because the reimbursement rate was inadequate to cover the expense of managing the program, much less the cost of services provided to patients. The new General Residency Director plans to look into Part F again for feasibility of renewing participation, but effort may better be placed on seeking other sources of funds to support oral care program for persons with HIV/AIDS. Meanwhile, the dental school has continued to provide dental services to persons with HIV over the years, often on a pro-bono basis, and accepts referrals from the Part A providers for patients that need procedures the Part A clinics cannot provide. In the 2008 Comprehensive Needs Assessment, dental care was identified as the #3 need for PLWH/As in care in the Denver TGA, and the #5 most difficult service to obtain.

Minority AIDS Initiative (MAI). In FY 2008, a total of $284,932 was awarded to the TGA for MAI initiatives. These funds were allocated to cover Mental Health Services (32%), Substance Abuse Treatment Services (35%), and Non-medical Case Management (33%). The purpose of the TGA's MAI program is to help integrate minority PLWH/As into the larger Part A-funded system of care. The program focuses on outreach to new participants and the provision of short-term mental health and substance abuse treatment services as necessary to enable participants to begin primary care and transition into the Part A system.

Assessment of Need

Unmet Need Estimate

The Denver TGA (Part A) and CDPHE (Part B) have employed two different methods to estimate unmet need. Although these two methods have produced very different results, CDPHE and the Denver TGA are in agreement that utilizing two methods provides a fuller picture of the level of unmet need in both service areas. Both methods utilize the same data to determine the size of the HIV/AIDS population (CDPHE's HIV/AIDS Reporting System—HARS), but they differ in how they estimate the number or people in care. Utilizing these two methods together gives a more accurate understanding of unmet need in both the TGA and the entire state. The fol-

lowing discussion will outline the TGA's method for estimating unmet need, CDPHE's method for making this estimate, and the possible implications of each method on the other.

Summary

There are between 4,927 and 6,085 (48-57%) people living with HIV/AIDS in Colorado who may not be in primary care and have unmet need. There are between 2,625 and 4,535 (33-56%) people living with HIV/AIDS in the Denver TGA who may not be in primary care and have unmet need.

HIV/AIDS Population Summary						
	Colorado			TGA		
Methodology	Total population	AIDS	HIV-not AIDS	TGA Total population	AIDS (TGA)	HIV-not AIDS (TGA)
CDPHE (7/1/07-6/30/09)	10,619	4,507	6,112	not gathered		
TGA (1/1/07-12/31/07)	10,336	4,328	6,008	8,034	3,269	4,765

In Care Summary						
	Colorado			TGA		
Methodology	Total In Care	AIDS	HIV-not AIDS	TGA Total In Care	AIDS (TGA)	HIV-not AIDS (TGA)
CDPHE	4,534	2,759	1,775	3,499	2097	1402
TGA	5,409	2,201	3,208	5,409	2,201	3,208

Unmet Need Estimate						
	Colorado			TGA		
Methodology	Total Unmet Need	AIDS	HIV-not AIDS	TGA Total Unmet need	AIDS (TGA)	HIV-not AIDS (TGA)
CDPHE	6,085	1,748	4,337	4,535	1,172	3,363
TGA	4,927	2,127	2,800	2,625	1,068	1,557

Note: Grayed number cells reflect estimates utilizing the methodology of the other jurisdiction. See details below.

Estimation Methods:

Methods – population: Both CDPHE and the Denver TGA utilize data collected through the Colorado names reporting process to estimate the number of HIV positive persons living in the state, and specifically in the TGA. Colorado law mandates physicians and labs to report the names of all individuals who are diagnosed with HIV. The names of all persons reported as HIV positive are kept in a confidential central database housed at the CDPHE. Because of this names reporting requirement, CDPHE maintains an accurate account of all individuals who are diagnosed with HIV within both the State of Colorado and specifically within the TGA. CDPHE and the Denver TGA utilized two different time frames to estimate their unmet need, 7/1/07-6/30/08 and 1/1/07-12/31/07 respectively. CDPHE estimates that 10,619 people in Colorado were living with HIV or AIDS alive as of 6/30/08. Of this total, 4,507 were believed to be living with AIDS and 6,112 were believed to be living with HIV. As of 12/31/07, there were 4,328 PLWAs in Colorado, 3,269 of whom were living in the TGA. There were 6,008 individuals who are PLWH/non-AIDS/aware in Colorado, 4,765 of whom were living in the TGA. There were a total of 10,336 individuals living with HIV/AIDS in Colorado, and 8,034 were in the TGA.

Denver TGA (Part A) in care estimation method: RWCAREWare data for 2007 show a total of 2,509 unique individuals receiving primary care at one of the five Part A-funded outpatient/ambulatory care providers in the Denver TGA. In terms of non-Part A primary care, the Veterans Administration treats 228 patients, as documented in the Department of Veterans Affairs *VA HIV Report* for 2005. Another 616 patients are covered by Medicaid, based on a report generated in July 2006 by the Colorado Medicaid Data Team. An additional 2,056 patients are estimated to be treated privately. This number includes those treated at Rose Medical Center and Kaiser Medical and those seeing private practice physicians with expenses covered by private insurance providers. The private care estimate was obtained through personal interviews conducted by the Planning Council administrator with private service providers.

As indicated by the above numbers, a total of 5,409 unduplicated persons are estimated to be receiving primary care in the Denver TGA. Based on percentages within the Denver TGA epidemiological profile, an estimated 40.7% of those in care are PLWH/A's (2,201) with the remaining 59.3% of individuals being PLWH/non-AIDS/aware (3,208).

Estimates of unmet need: The estimate of unmet need is arrived at by subtracting those individuals who are identified (explained above) as receiving primary medical care from the total number of individuals within the Denver TGA as reported by CDPHE as being HIV positive.

Reasons for method: The methods used to generate the unmet need estimate were chosen because they provide the most accurate numbers available to the TGA at present. Colorado is a names-based reporting state, so the total PWLH/A population numbers reflect actual diagnosed individuals. The grantee office tracks Part A primary care services in RWCAREWare through a unique identifier for each patient, so the Part A in-care numbers also reflect actual treated individuals. The VA and Medicaid reports provided data based on individuals within the VA and Medicaid systems, so again the data is verifiable on an individual level.

Revisions or Updates: There were no revisions made to the estimate methods used from prior years. The estimation numbers were updated, however, to reflect FY 2007 data. Based on these updated numbers, the unmet need estimate has risen from last year's value of 2,184 to the current estimate of 2,625, an increase of 20.2%

Limitations: One limitation of the estimation methods is the use of percentages to estimate the HIV status of in-care patients. The grantee office maintains RWCAREWare data on the HIV status of individuals treated within the Part A system of care, but an exact breakdown by HIV status is not available from non-Part A sources. To provide an accurate estimate, percentages were based on the HIV/AIDS population as a whole, as determined by CDPHE. Another limitation is the lack of individually verifiable data on participants treated through private primary care providers. A third limitation concerns the possibility of duplicated numbers among the in-care estimates. Fortunately, this limitation is mitigated by the fact that Ryan White is the payer of last resort in the TGA. Hospitals only use Ryan White funds if Medicaid does not cover a patient's treatment. This fact helps to minimize the likelihood of duplicated numbers in primary care reporting. Finally, the largest limitation to the estimation process is the lack of an integrated TGA-wide database for tracking primary care among all HIV service providers. This limitation exists, however, because of the need to protect individual privacy.

CDPHE (Part B) in care estimation method: To estimate the number of people statewide living with HIV or AIDS who are accessing care, the Surveillance Program at CDPHE regularly analyzes CD4 and viral load test data reported by laboratories. CDPHE estimates that 10,619 people in Colorado were living with HIV or AIDS as of 6/30/08. Of this total, 4,507 were believed to be living with AIDS and 6,112 were believed to be living with HIV. If all of these individuals received a level of care consistent with Public Health Service Guidelines, CDPHE would receive at least one laboratory test result (CD4 or viral load) annually for each of these individuals. Of course, this would assume a perfectly functioning laboratory reporting system, which is known not to be the case, as described below under "limitations on the data."

Estimates of unmet need: During the period July 1, 2007 through June 30, 2008, a total of 17,249 valid CD4 or viral load tests were reported to CDPHE, as required under state regulations. The Surveillance Program matched these tests against the HIV/AIDS Reporting System (HARS) to estimate the extent to which PLWH/A were accessing care during that year. The results of this analysis were as follows.

Of the estimated 4,507 people living with AIDS, only 2,759 individuals had a CD4 or viral load test reported to CDPHE between July 1, 2007 and June 30, 2008. This represents only 61% of the total AIDS cases, meaning that potentially 1,748 people with AIDS could be out of care. For pediatric cases, out of the 16 pediatric AIDS cases, 9 (or 56%) had a reported CD4 or viral load test during the year ending June 30, 2008. In terms of HIV (not AIDS), of the estimated 6,112 people living with HIV, only 1,775 had a CD4 or viral load test reported to CDPHE between July 1, 2007 and June 30, 2008. This represents only 29% of the total HIV (not AIDS) cases, meaning that potentially 4,337 people with HIV (not AIDS) could be out of care. The situation is somewhat better for pediatric cases; of the 33 pediatric HIV (not AIDS) cases, 21 (or 64%) had a reported CD4 or viral load test during the year ending June 30, 2008. Newly diagnosed individuals appear to be accessing care more consistently. Of the 312 people diagnosed with HIV between July 1, 2007 and June 30, 2008, CDPHE estimates that 71% of them (222 individuals) had at least one CD4 or viral load test.

Limitations: There are serious limitations to the CD4 and viral load data that must be considered in estimating PLWH/A who are out of care, using this methodology. These limitations would tend to make it appear that fewer people with HIV or AIDS are in care than is in fact the case. The current Colorado regulation regarding the reporting of tests indicative of HIV or AIDS does not require laboratories to report all CD4 and viral load tests. Only CD4 counts be-

low 500/mm3 or CD4 percentages less than 29 are **required** to be reported. Therefore, a sizeable group of people with HIV or AIDS (and particularly people with HIV) may not be reported, even though they are in care and receiving regular CD4 tests. In addition, the Veterans Administration Medical Center (VAMC) does not report CD4 or viral load test results to CDPHE. As an indicator of care received, the VAMC reported 255 individual HIV/AIDS patient visits in 2005. Finally, CD4 and viral load tests among patients enrolled in clinical trials are not reported to CDPHE.

CDPHE (Part B) method applied to the TGA population: CDPHE analyzed their data based on the entire state of Colorado, and did not specifically break out the TGA data set. Utilizing their findings of 2,759 PLWA and 1,775 PLWH in care and applying the percentage of the total Colorado population that lives in the TGA (76% PLWA, 79% PLWH) provides an estimate of what CDPHE's in care findings mean specifically for the TGA. Out of 3,269 PLWA, there are possibly only 2,097 in care, and 1,172 out of care. Out of 4,765 people living with HIV (not AIDS), there are possibly only 1,402 in care, and 3,363 out of care. Utilizing this data in combination with the Denver TGA's methodology, we can see that out of 8,034 PLWH/A in the TGA, between 2,625 and 4,535 people are out of care (33%-56%).

TGA (Part A) method implications for CDPHE unmet need estimate: The TGA methodology for estimating PLWH/A in care is difficult to duplicate in the rural areas of Colorado. Although Part B collaborates with Part A to maintain statewide service provisioning data in RWCAREWare (managed by MOHR), most rural PLWH/As receive medical care through Part C clinics or private providers, and their data is not integrated into the TGA/State CAREWare dataset. Nevertheless, the TGA methodology does provide some information to broaden the state's understanding of unmet need. Simply utilizing the TGA's data on the number of people in care (5,409) and subtracting this from the total PLWH/As in Colorado (10,619), unmet need would be 4,927 people in Colorado. Without taking into consideration the rural areas (which could lower this figure further), the possible range of unmet need is between 4,927 and 6,085 (48-57%) people living with HIV/AIDS in Colorado.

Cross-program collaboration: The combination of having names reporting, the CDPHE surveillance program, and the RWCAREWare database provides the Denver TGA and CDPHE with a solid foundation for determining unmet need. This foundation is further strengthened by the close relationship between the Part A and Part B offices. CDPHE, the provider of the epidemiological and surveillance data, is also the Colorado Part B administrator. The Mayor's Office of HIV Resources (Part A Grantee) is the administrator of both State and TGA RWCAREWare data.

Collaboration also exists among other program grantees in the TGA. In addition to several ongoing meetings, a one-day retreat was held in 2007 for all Program offices in Colorado to revise, update, and implement a cross-program process for reporting unmet need. The meeting involved the CDC-funded Prevention office and all Colorado Ryan White funds recipients, including Parts A, B, C, D, and F including the AIDS Education Training Center (AETC).

The discussion above outlined the TGA's method for estimating unmet need, CDPHE's method for making this estimate, and the possible implications of each method on the other. There are limitations to the implications that can be drawn, without re-examining the source data.

Future planning will include a collaborative effort to consider the limitations and possibilities of both methodologies and to determine how to improve the unmet need estimate.

Gaps in Care

Gaps in service provision within the TGA were identified through a Comprehensive Needs Assessment conducted in 2008. The 2008 Comprehensive Needs Assessment focused on two main goals: obtaining participant feedback on the prioritization of HIV services and understanding why some PLWH/As do not receive medical care. Data was collected from participants within the following five high-risk groups:

1. White Men Who Have Sex with Men (White MSM);
2. Men of Color Who Have Sex with Men (MCSM);
3. Women of Color (WoC);
4. Injection Drug Users (IDUs); and
5. Men Who Have Sex with Men and who are also Injection Drug Users (MSM/IDUs).

These groups differ slightly from the groups identified in the Emerging Populations section above; in particular, Youth and MSM Aged 40+ were not included. These two groups require attention in upcoming needs assessments conducted by the TGA.

Information was gathered through focus groups and survey responses. Participants included 207 PLWH/As who were currently receiving medical care (In Care) and 121 PLWH/As who were considered out of medical care (OOC). Ultimately, one lesson learned from the needs assessment was that the distinction between "in care" and "out of care" was not always clear, because care status appears to be a fluid state in this population. Many of those individuals classified as In Care had been recently out of care, and many of the OOC respondents still had interaction with the medical community. Nonetheless, for the purposes of the assessment, respondents were classified as OOC if they met the following conditions:

1. Not receiving medical services for HIV; or
2. Last saw a doctor or nurse for HIV care more than a year ago; or
3. In the past 24 months, did not see a doctor or nurse for HIV care for at least 12 months in a row.

This last condition was added to ensure that the needs assessment captured participants who had recently entered care after a lapse in care. In addition to the PLWH/A responses, input was obtained from 39 service providers who represent Part A-funded agencies.

In the focus groups and survey responses, more than 40% of participants reported that Emergency Financial Assistance, Emergency Housing Assistance, and Transportation were either hard to access or took some effort. Regarding financial assistance, participants reported that some case managers and counselors did not provide them with accurate information about the amount of financial assistance they qualify for under Part A funding. This lack of information made it harder to access available financial resources. In describing housing barriers, participants noted long waitlists as well as limited housing for people with a criminal record or with sub-

stance abuse issues. Finally, concerning transportation, participants reported dissatisfaction with the current token system in the TGA. Many stated that too few tokens were provided to allow them to get to all of their service and medical appointments.

HIV Prevention Needs

The following HIV prevention needs have been identified for PLWH/As in the TGA. Sources include *Sex and Culture: A Mixed Methods Study of Denver MSM in the Third Decade of AIDS* (2004) by Anthony Natale; Coloradan's Working Together (CWT) *Needs Assessment Report Focusing on MSM* (2006); and Coloradan's Working Together (CWT) *Needs Assessment Report Focusing on High-Risk Heterosexuals* (2007). Information was also obtained through the National HIV Behavioral Surveillance Project (NHBS), and interviews conducted by CDPHE Disease Intervention Specialists.

Men Who Have Sex with Men (MSM):

In the research conducted on prevention needs, HIV Positive MSM (PMSM) report seeking additional educational and work opportunities appropriate for PMSM. These opportunities may include job training and retraining; establishing apprenticeship programs with the gay and lesbian business association; increasing condom distribution to PMSM living in housing designed to support those living with HIV or AIDS; and increasing awareness of multiple-strain HIV infections by partnering with health care providers to provide information during routine visits. Additionally, PMSM suggested establishing social support groups for their HIV negative partners.

In regards to HIV status disclosure, MSM including both those living with HIV and those reporting negative or unknown status described the most common reason for lack of disclosure as "fear of rejection by potential partners." The second most common explanation was the concern that once an individual disclosed his HIV status to a partner, he could not be confident that the partner would not tell others. Another commonly cited reason for lack of disclosure was the sense of shame brought about due to societal stigmas regarding HIV and discrimination against those who have it. Additional reasons for non-disclosure included: a fear of violence or other cruel treatment; vindictiveness or a desire to infect others; lack of care about infecting others; lack of knowledge regarding how to disclose; and lack of knowledge that the individual was HIV positive because of avoidance of testing.

When asked what gay and bisexual men who are living with HIV need to help them to disclose their status to partners, several suggestions were made. The most commonly offered idea was mutual support groups. Other suggestions included educating men regarding how to disclose, using role-plays and giving them a chance to practice. Public information campaigns also were commonly suggested in an effort to normalize disclosure in the community and make it more important and expected. Messages were recommended that would appeal to men living with HIV not to spread the disease to others, to respect others' rights and choices to stay negative, or to counter the notion that they have the right to decide for others.

Regarding what types of interventions would help gay and bisexual men who were living with HIV to disclose their status to partners, over three quarters of respondents suggested targeted public information campaigns while almost two-thirds suggested support groups that include both positive and negative men as well as interventions that involve the larger community of gay and bisexual men. Almost half of respondents suggested support groups with positive men

only, and one-third indicated one-on-one sessions with a professional counselor or sessions with a trained peer or mentor.

High-Risk Heterosexuals (HRH):

Amongst high-risk heterosexuals who are HIV positive, accessing services more appropriate for heterosexuals was highlighted by a number of research subjects as they noted that most services were more oriented around meeting the needs of gay men. The desire to be around other straight people who were positive was prevalent. An eagerness to help others and participate in prevention efforts was also commonly expressed.

Many of the participants thought it was a doctor's role to provide information about HIV to their patients and talk to patients about their risk behaviors and how to protect themselves. A few mentioned that providers should talk to their HIV positive clients about prevention and talk to the steady partners of positive patients. One participant also offered that doctors should talk to patients about substance use and histories of trauma and provide appropriate referrals. Several people also expressed that doctors and clinics should make condoms and literature on HIV available to their patients.

HIV Testing and Counseling:

In the majority of the interviews and focus groups included as part of the prevention needs research, participants talked about the importance and benefits of having counseling available to those testing for HIV. For those testing positive, it was important to obtain information from counselors about how to take care of themselves and their partners and how to access medical care and other services that they needed. It was also viewed as important for people to be given hope, to be reassured that they were not alone, and to be informed regarding help available to them for taking care of their health and meeting other needs.

Continuum of Care

The Denver TGA Continuum of Care is designed to assure that all eligible people living with HIV/AIDS have access to HIV medical care and learn to successfully manage their HIV disease. There are four main goals that assist us in succeeding in our mission: (1) Improved Linkage to Care; (2) Access to and Retention in Medical Care; (3) Adherence to and Medical Self-Management of Treatment; and (4) Eliminating Health Disparities. There are six Core services and six support services prioritized by the Planning Council. ***Non-Medical Case Management*** is the primary mechanism, coordinated with several prevention-funded programs, for providing linkage to care services in the TGA. Non-Medical Case Management provides outreach to newly diagnosed people, those lost to care, and difficult to reach populations, helping them to link to medical care and other HIV services. Non-Medical Case Management is also funded with MAI dollars to increase our ability to eliminate health disparities. This is a short term service designed to help people enter the larger continuum of care. ***Medical Case Management, Substance Abuse, and Mental Health*** services are the primary services provided to improve Access and Retention in Care by reducing barriers and eliminating disparities. These services address the complicated psychosocial, health literacy, and low medical self-management issues that can be barriers to a person's ability to access and stay in care. ***Home Health, Medical Transportation, Food Bank/Home Delivered Meals, Emergency Assistance, and Housing Assistance*** are ser-

vices that are accessed through Medical Case Management and Primary Care referrals. These services can be utilized to reduce urgent barriers caused by poverty and economic disparities. ***Outpatient/Ambulatory Care, Oral Health, and AIDS Pharmaceutical Assistance*** services are the heart of the Denver TGA continuum. These services work to provide quality care to all who are otherwise medically indigent, assisting them to adhere to their prescribed treatment and successfully manage their disease.

Ongoing Efforts to Improve Responsiveness of the Continuum of Care: In FY 2007, the Denver TGA created five new programs designed to ensure that the Denver TGA's evolving continuum of care remains responsive to changes in the epidemiological profile. In FY 2008, these programs continued their efforts to serve new target populations.

The first of the five new programs was designed to serve a newly emerging population that had previously been impeded from receiving care. This population is that of undocumented immigrants, primarily from Mexico. Within the TGA as a whole, these PLWH/As currently face specific barriers that inhibit their ability to receive services. The most significant barrier to care is the fact that some members of this population are not eligible for primary medical care through either of the TGA's two main primary care clinics. For a detailed description of this and other barriers faced by undocumented immigrant PLWH/As, please see the discussion below regarding Unique Service Delivery Challenges.

To address the specific needs of this largely monolingual Spanish-speaking population, the TGA has contracted with two new medical providers. In 2007 the TGA first contracted with a small full-service medical clinic, Clinica Tepeyac, located in Northwest Denver County. In 2008, the TGA added a contract with the Metro Community Provider Network (MCPN) in Aurora, East of Denver County. Clinica and MCPN help the continuum of care to meet the medical needs of those who cannot otherwise access primary care provision. Clinica and MCPN's missions are to provide a gateway to health for uninsured populations in metro Denver. They have bilingual clinic staff to provide medical services for indigent participants and they also train other agencies in culturally appropriate care.

Both programs are guided in part through consultations with medical providers from Denver Health or University Hosptial, two of the TGA's main primary care agencies and the largest providers of HIV care in the Western region. The collaborative working relationships between Clinica and Denver Health and MCPN and University Hospital enable the new clinics to benefit from 15 years of the care providers' experience, ensuring that an underserved population receives a high quality of HIV care. MCPN is a network of clinics. Eventually the TGA may have the opportunity to expand HIV services to other clinics in the network and continue to broaden access to HIV care.

In addition to funding two new clinics to provide primary care, the TGA also established four new substance abuse programs in FY 2007 to address unmet needs in specific emerging populations. The first program provides treatment and counseling for HIV positive MSM who use crystal meth. This program is offered through the Mile High Council on Substance Abuse and Mental Health, an agency that provides ongoing care and a supportive, safe environment for individuals addressing substance abuse issues. The program also places a high emphasis on the importance of engaging in primary medical treatment.

A second new substance abuse initiative is a supplement to an existing methadone program at Addiction Research and Treatment Services (ARTS), an existing funded provider. This program has enabled a methadone-based substance abuse clinic to add onsite primary care and mental health treatment to its offered services. The program's model is built upon the opportu-

nity to work with participants who show up at the clinic for their methadone dose. When the participants arrive, a medical professional at the clinic helps to facilitate primary care treatment intervention. The ARTS program is staffed by primary care personnel from University Hospital, the second main primary care site in the Denver TGA.

The remaining two newly funded programs provide substance abuse outpatient care for HIV positive individuals recently released from prison. The rationale for both programs is based on the finding that PLWH/As who are leaving the prison system almost always experience substance abuse problems of some kind. If those problems are not addressed as soon as the individuals are released from incarceration, the problems can escalate, making it much more difficult to engage the individuals in ongoing medical care.

One of the programs for former prison inmates is funded through It Takes a Village, an agency that targets African American participants. This program serves formerly incarcerated male PLWH/As. The counselor on staff is a bilingual Spanish speaker, so the program has the capacity to serve monolingual Latino participants as well. This population is reluctant to seek services within the larger Ryan White system due to cultural barriers that make them very system-wary.

The fourth substance abuse program serves women participants, many of whom are also former inmates. This program is an expansion of the Empowerment Program, a service provider that has historically served women populations in the TGA. The Empowerment Program targets their substance abuse treatment initiative to sex workers and women released from the prison system or those with criminal histories.

The System of Care and Part A Service Utilization: In FY 2008, the Planning Council provided funding to 12 service categories with Part A dollars. Part A funds are used only when no other funds exist to sustain the continuum and fill gaps in service. In FY 2008, MOHR contracted with 16 separate agencies to provide services in the 12 supported categories. Collectively, these service categories represent a comprehensive continuum of care that provides PLWH/As with the following services: Outpatient/Ambulatory Health Services; AIDS Pharmaceutical Assistance (Local); Oral Health Care; Medical Case Management; Mental Health Services; Substance Abuse Services - Outpatient; Food Bank/Home-Delivered Meals; Emergency Financial Assistance; Housing Services; Medical Transportation Services; Case Management (Non-Medical); and Home and Community-Based Health Services.

In addition to the above-mentioned Part A funded service categories, two additional service categories are funded for the TGA through the Ryan White Part B award from the State of Colorado. These are: AIDS Drug Assistance Program (ADAP) and Health Insurance Premium and Cost Sharing Assistance. PLWH/As within the Part A system of care benefit from these two services with the costs being covered by Part B dollars. Coordination of these Part B-funded categories enhances Part A service delivery by enabling participants to seamlessly access critically needed components of care. The integration of ADAP in particular promotes adherence to medication regimes that are vital for the maintenance of effective primary care and positive health outcomes.

Part F funds through the Community-based Dental Partnership Program also benefit Part A clients. The majority of this statewide grant, which is intended to increase oral health care capacity and enhance comprehensive medical care for HIV-infected individuals, supports oral care programs at the grantee site, the University of Colorado School of Dental Medicine, and one of five partner sites, the Howard Dental Clinic. Women and children in the TGA also benefit from

the services provided by the Part D grantee, The Children's Hospital and their Human Immunodeficiency Program (CHIP).

By analyzing data from RWCAREWare, the Denver TGA is able to quantify the number of unduplicated participants receiving any Part A-funded service. This data is also used to identify key points of access for the newly diagnosed. In FY 2008, we served a total of 3,692 unduplicated participants, and 619 (or 16.8%) of these participants were new. Service utilization by category within the Denver TGA is detailed in the table below.

Service Category	Total Number of Clients Served	% of Ryan White Part A Clients Served
Outpatient/Ambulatory Health Services	2,509	68.0%
AIDS Pharmaceutical Assistance (Local)	1,495	40.5%
Oral Health Care	832	22.5%
Medical Case Management	2,060	55.8%
Mental Health Services	829	22.5%
Substance Abuse Services - Outpatient	259	7.0%
Food Bank/Home-Delivered Meals	1,131	30.6%
Emergency Financial Assistance	329	8.9%
Housing Services	366	9.9%
Medical Transportation Services	1,092	29.6%
Case Management (non-Medical)	233	6.3%
Home & Community-Based Health Services	554	15.0%

Increasing Access to Service and Reducing Health Disparities: The Denver TGA has developed a continuum of care that is responsive to the needs of PLWH/As and flexible enough to address the needs of emerging communities, particularly those who know their HIV status and are not in care. As consumer needs and available resources shift, the continuum has been sustained because of a TGA-wide commitment to effective networking and collaborative planning among service providers, MOHR, the Planning Council, and consumer activists. To track our effectiveness in increasing access to services, the Denver TGA relies extensively on data available through RWCAREWare. This allows the Denver TGA to compare the number of participants using Ryan White-funded services to the number of PLWH/As in the epidemiological profile. These data comparisons show that participants from underserved communities are accessing services, often at a greater rate of utilization than gay white men who comprise the majority of participants in the Denver TGA. While efforts are continually increasing to reach out to those who have been diagnosed with HIV and are not in care, data from RWCAREWare demonstrate that the current continuum of care in the Denver TGA is responsive to the needs of racial and ethnic minorities.

Similarly, the continuum of care is also responsive to the needs of the Denver WICY population living with HIV/AIDS. In 2007 the Denver TGA served 720 female participants, comprising 19.5% of the total participants served. This level of service provision greatly exceeds the percentage of women represented in the overall HIV/AIDS population, which is 9.2%. In 2007, a total of 8.2% of participants served were infants, children, and youth, while this population accounts for less than 2% of the overall HIV/AIDS population in the Denver TGA.

Programs for Newly-Infected, Underserved, and Hard-to-Reach Populations: Part A programs facilitate access to primary care as well as strive to keep participants in care, while

continuing to remove barriers to access medical care and treatment. An emerging factor in access to care relates to the economic status of those who are newly infected. Persons of color, especially women of color, have historically been much more economically disadvantaged not only in the Denver TGA but nationally. The percentage of the Denver Health Medical Center (DHMC) sample population without insurance (76.2%) and living in poverty (67.2%) is significant. Emerging populations have an increasing dependence on Ryan White, Medicaid, and indigent care, which stresses all of the systems set up to provide needed services. Additionally, many service providers report that an increasing number of individuals are entering the continuum of care much later in the disease spectrum at an increased cost. In general, harder to reach populations increase the complexity and cost of service delivery, and MOHR and the Planning Council continue to make efforts to reach these populations.

The Denver TGA's Medical Case Management System: Medical case management is designed to assure that every PLWH/A has access to HIV medical care and the self management skills needed to succeed and engage in care. Medical Case Management is a coordinated service that assures participants receive services from no more than one provider, thus decreasing duplication of costs and system inefficiencies. MCM conducts comprehensive psychosocial assessments, creates individualized care plans, refers participants to needed services and follows up on the success of the referrals.

Although the transition stemming from the revised HRSA categories, "Case Management" to "Medical Case Management," continues to be evaluated and re-defined in the Denver TGA, several of the funded providers have actively worked to develop a model of care that is medically focused. All participants are assessed for acuity of need and caseloads are managed based on these assessments. Staff are trained in Motivational Interviewing skills as a tool to help participants make changes that improve their engagement in and adherence to care. Motivational Interviewing allows Medical Case Managers to help participants build towards positive life changes while addressing behavioral barriers to care, such as substance abuse and untreated mental illness. Participants are assessed for health literacy and adherence problems that could become barriers to their success in medical care. Medical Case Managers have regular case conferences with the Part A-funded medical care providers to discuss participants who have barriers to care, to create coordinated care plans, and to provide consistent messaging around adherence and treatment options for participants served by multiple providers. There are currently three agencies that receive Part A funding for medical case management in the Denver TGA. Two of the agencies are AIDS service organizations (ASO), limiting their work to those individuals who are HIV positive, and the other one is an HIV/AIDS program within a community-based organization (CBO). Each of the agencies uses the psychosocial model of service delivery, helping participants understand all factors that impact their health behavior in an effort to optimize outcomes. Part A funds a total of 12.55 FTE medical case managers throughout the Denver TGA.

Cultural Competency Requirements: As part of its medical case management system, the Denver TGA has placed a strong emphasis on cultural competency among funded providers. Cultural competency refers to the ability of organizations and systems to function and perform effectively in cross-cultural situations. These include serving a diverse body of participants characterized by differences in race, color, religion, national origin, gender, age, sexual orientation, gender variance, marital status, military status, and physical and mental abilities. MOHR and the Planning Council are mandated by Denver City Ordinance to eliminate discriminatory practices in the delivery of health and welfare services.

For the Denver TGA, however, addressing the issue of competency does not stop at avoiding discriminatory practices. In past years it has been a requirement of funding that a minimum of eight documented hours of cultural proficiency training be acquired by 90% of the staff and volunteers who have direct participant contact at medical case management agencies. This training includes the following principles of Cultural Competence: 1) Inclusiveness—decision-making that includes perspectives from diverse points of view, from within and outside the organization, where appropriate; 2) Valuing Cultural Differences—through actions, practices and implementation of policies all members of the organization reflect a high regard for cultural differences; 3) Employment Equity—implementing actions that prevent, identify and remove discriminatory barriers in the organization's recruitment, hiring, training, retention and promotion practices; and 4) Service Equity—demonstrated ability to provide accessible and relevant services to the targeted groups.

The most recent medical case management RFP included the following language on cultural competency: *"Applicants need to recognize that cultural competence is an important component for access and delivery of services. Applicants should commit to continuing self-assessment regarding cultural competence, with careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources and adaptations of service models in order to better meet the needs of culturally diverse communities. It should be the goal of each agency to provide 100% access to appropriate services resulting in 0% disparity in health outcomes for disparate populations."* Cultural competence is not a static acquired skill, but rather a continuous growth process. The MOHR administrative office continues to monitor this activity as part of site visits.

Resource Inventory and Profile of Ryan White Program Funded Providers

The agencies listed below are funded by Part A dollars or provide other Ryan White funded services within the TGA. The columns to the left indicate additional sources of funding for these organizations.

Agency	Part A/MAI Service Description	Part B	Part C	Part D	HOPWA
ARTS/UCHSC ARTS Special Services Clinic Jodi Suckney, Program Director 303.355.1014 FAX 303.355.0899 2121 E. 18th Avenue Denver, CO 80206 http://www.artstreatment.com	Provides substance abuse treatment services for PWLH/As.				
Brother Jeff's Cultural Center Brother Jeff Fard 303.293.8879 Fax: 303.293.8879 2836 Welton Street Denver, CO 80205		MAI, ADAP Outreach and Enrollment Program			

Agency	Part A/MAI Service Description	Part B	Part C	Part D	HOPWA
CDPHE Colorado Department of Public Health and Environment James B. Martin, Executive Director Ned Calonge, M.D., M.P.H., Chief Medical Officer 303.692.2200 4300 Cherry Creek Drive South Denver, CO 80246-1530 http://www.cdphe.state.co.us		Administers all Part B funding and AIDS Drug Assistance Program (ADAP) for the state of Colorado			
Children's Hospital HIV Program Carol Salbenblatt, R.N., Clinic Coordinator 303.764.8233 FAX 303.837.2707 1056 E. 19th Avenue, B-055 Denver, CO 80218 http://www.chipteam.org	Provides HIV medical care, local drug reimbursement, and mental health services for WICY PWLH/As in the Denver TGA.	FirstCare Presumptive Eligibility Project Perinatal Project		X	

Agency	Part A/MAI Service Description	Part B	Part C	Part D	HOPWA
Clinica Tepayac Patti Urias, Enrollment 5075 Lincoln Street Denver, CO 80216 303.458.5302 Fax: 303.433.7452 http://www.clinicatepeyac.org/	Provides HIV medical care for PWLH/As in the TGA. Serves undocumented immigrants who are not eligible to be treated at Denver Health, the Colorado Indigent Care Program (CICP) care provider for Denver County. The clinic's bilingual and bicultural staff primarily serves Latino participants.				
Colorado AIDS Project Ruth Pederson, Executive Director 303.837.0166 FAX 303.861.8287 2490 W. 26th Avenue, A-300 Denver, CO 80203 http://www.coloradoaidsproject.org	Provides medical case management services for HIV+ clients to ensure linkage to and retention in care. Additional core and support services include: mental health treatment, substance abuse treatment, emergency financial assistance, food bank/home delivered meals, housing assistance, medical transportation, and insurance continuation.	Insurance Continuation Programs			X

Agency	Part A/MAI Service Description	Part B	Part C	Part D	HOPWA
Denver Health Medical Center Pat Gourley, R.N., Clinic Coordinator 303.436.7240 FAX 303.436.4779 605 Bannock Street Denver, CO 80204 http://www.denverhealth.org/dph	Provides HIV medical care, oral health care, local drug reimbursement, mental health services, substance abuse treatment services, and medical transportation for PWLH/As in Denver County. Serves as the Colorado Indigent Care Program (CICP) care provider for Denver County.	Drug Resistance Testing FirstCare Linkage to Care Retention in Care Temporary Assistance Fund Correctional Project	X		
Empowerment Program Carol Lease, Executive Director 303.320.1989 FAX 303.320.3987 1600 York Street, Suite 201 Denver, CO 80206 http://www.empowermentprogram.org	Provides medical case management, substance abuse treatment services, and medical transportation for women PLWH/As in the TGA.				X
Howard Dental Center Denise Coleman, Clinic Coordinator 303.863.0772 FAX 303.832.7823 1420 Ogden Street Denver, CO 82018 http://www.howardental.org	Provides oral health care services for PWLH/As in Denver County.				

Agency	Part A/MAI Service Description	Part B	Part C	Part D	HOPWA
Kaiser Permanente Emily Bruce, RN BSN 303.861.3133 2045 Franklin Street Denver, CO 80205		Mental Health Services FirstCare Fund, for copays and specialty fees			
It Takes A Village Imani Latif, Program Director 303.367.4747 FAX 303.367.0227 1475 Lima Street, Suite 225 Aurora, CO 80017 http://www.ittakesavillagecolorado.org	Provides non-medical case management and substance abuse treatment services (outpatient) for minority PWLH/As in the Denver TGA. Primarily serves African-American participants.				
Jewish Family Services Yana Vishnitsky, LCSW President & CEO 303.597.5000, X 314 FAX 303.597.7700 Joyce and Kal Zeff Building 3201 South Tamarac Drive Denver, CO 80231 http://www.jewishfamilyservices.org	Provides home health services for PWLH/As in the Denver TGA.				

Agency	Part A/MAI Service Description	Part B	Part C	Part D	HOPWA
Project Angel Heart Sandy Nagler, Program Director 303.830.0202 X 13 FAX 303.830.1840 4190 Garfield Street, Suite 5 Denver, CO 80216 http://www.projectangelheart.org	Provides home-delivered meals for PWLH/As in the Denver TGA.				
Mental Health Center of Denver Carl Clark, M.D., Program Director 303.504.6649 FAX 303.757.5245 1555 Humboldt St., 3rd Floor Denver, CO 80233 http://mhcd.org carlclark@mhcd.com	Provides mental health treatment services for PLWH/As in the TGA.				
Metro Community Provider Network Barry Martin, M.D., Clinical Director 303.761.1977 3701 South Broadway Street Englewood, CO 80113 www.mcpn.com	Provides HIV medical care for PWLH/As in the TGA. Serves undocumented immigrants who are not eligible to be treated at Denver Health, the Colorado Indigent Care Program (CICP) care provider for Denver County. The clinic's bilingual and bicultural staff primarily serves Latino participants.				

Agency	Part A/MAI Service Description	Part B	Part C	Part D	HOPWA
Servicios de la Raza Fabian Ortega, Manager of Social Services 303.458.5851 FAX 303.455.1332 4055 Tejon Street Denver, CO 80211 http://www.serviciosdelaraza.org	Provides medical case management and medical transportation for minority PWLH/As in the Denver TGA, to promote their linkage to and retention in care. Primarily serves Latino participants. Provides Bilingual Mental Health Therapy.				
Sisters of Color United for Education Belinda Garcia, Executive Director 303.446.8800 FAX 303.446.8799 2895 W. 8th Avenue Denver, CO 80204 http://www.sistersofcolorunited.org belinda.garcia@sisersofcolorunited.org	Provides mental health services for women minority PWLH/As in the Denver TGA, to promote their linkage to and retention in medical care. Primarily serves African American participants.				

Agency	Part A/MAI Service Description	Part B	Part C	Part D	HOPWA
The Council: **Mile High Council on Alcoholism and Drug Abuse** 303.825.8113 FAX 303.825.8166 655 Broadway, Suite 200 Denver, CO 80203 http://www.milehighcouncil.org	Provides substance abuse treatment services for PWLH/As in the TGA.	X			
University of Colorado Hospital Steven Johnson, Executive Director 720.848.0816 FAX 720.848.0192 1635 N. Ursula St. P.O. Box 6510 Mail Stop B163 Aurora, CO 80015 http://www.uch.edu	Provides HIV medical care, local drug reimbursement, and mental health treatment for PWLH/As in the Denver TGA.	X	X		
Women's Lighthouse Project Shannon Conn, Program Director 303.344.1878 FAX 303.568.0019 womenslighthouseproject@aol.com	Provides non-medical case management services for women PWLH/As in the Denver TGA.				

Barriers to Care

Needs Assessment Findings

Addressing unmet need:

Determination of demographics and location of persons who know their HIV status and are not in care: During FY 2008, the TGA continued its efforts to identify and locate individuals who know their HIV status and are not in care. With its 2008 Needs Assessment, the TGA Planning Council intended to identify reasons why people are out of care as well as potential solutions to this problem. Both PLWH/As and service providers agreed that there are six main reasons why people are out of care, as listed below.

1. Meeting **basic living needs** is critical for PLWH/As. When they struggle to house or feed themselves, HIV-related medical care is not a priority.

2. **Health beliefs and literacy** should be addressed. Health literacy refers to the ability to process and understand health information for the purpose of making health decisions. Many PLWH/As believe that receiving care means taking HIV medications and that they do not need to see a doctor for their HIV if they feel well. This suggests that they may be misunderstanding information communicated by doctors and other service providers.

3. **Taking a break** from HIV, medications, and the system was a major theme reported by PLWH/As. Being out of care allows them to feel a "sense of normalcy" and to get on with their lives. Doing what they need to do to be in care feels like a 24/7 job to many PLWH/As. Some felt that seeking medical care was so time consuming that it was difficult to have a job and receive medical services.

4. There is still a **knowledge gap**. Many PLWH/As do not know where to go to find services or what services are available. Currently, many PLWH/As depend on peers for information because they feel the information they receive from agencies is not complete or up to date.

5. Limited **financial resources** affect PLWH/As' ability to stay in care. Some cannot afford the co-pays for medical care, medications, and transportation to and from care. While assistance is available, they have difficulty accessing that assistance in part because of transportation and paperwork barriers.

6. Other **untreated conditions** such as mental illness and drug use interfere with the ability to seek HIV care. When treatment for these other conditions is completely separate from treatment for their HIV, the burden of navigating the system to seek care increases substantially. A coordinated system that treats the whole person rather than just HIV could help to increase participation in care.

Reasons for delaying entry into care. In the needs assessment, participants who delayed entry into medical care were asked to report the reasons why they did not seek care. The survey results showed that many people do not think they needed medical care because they do not feel

sick. This was the most frequently endorsed reason for both the in care and out of care groups. A number of focus group participants explained that the shock of learning their HIV status kept them away from seeking medical services, while others reported that drug use or mental health conditions interfered with their ability to seek medical care. Other causes that focus group participants reported for delaying their entry into care included lack of insurance or financial resources to pay for the services and a lack of knowledge as to what to do or where to find services.

Reasons for currently being out of care. When asked why they had been out of care in the past two years, almost one-third of participants said they did not need care because they were not sick (See Table 1.g.1). Service providers also identified a similar barrier to care in their focus group and thought that one way to have people who don't feel sick get into and stay in care is to develop trusting relationships with PLWH/As. Another frequently reported challenge keeping PLWH/As out of care is the burdens imposed by the lack of coordinated services. PLWH/As feel it is a 24/7 job to keep up with all the appointments and regimens associated with being in-care. Side effects of medications, complications associated with other untreated conditions, and a lack of financial resources to pay for medical services and transportation were also reported as reasons for staying out of care.

Table 1.g.1. Reasons for Being Out of Care within the Past 24 Months

Reasons for being out of care	**N**	**Out of Care %**
I did not think that I needed medical care then because I wasn't sick	38	31.4
I didn't want to take the medications	26	21.5
I get scared or nervous about going to a doctor or nurse about HIV	16	13.2
I couldn't pay for medical care and/or medications	14	11.6
I did not want to receive medical care	16	13.2
I was in jail	14	11.6
My doctor or nurse told me that I did not need medical care at that time	13	10.7
I did not know where to go for medical care	4	3.3
I had not found a doctor I was comfortable with seeing for treatment	2	1.7
I did not have transportation to get to medical care appointments	1	0.8
I used alternative treatments	1	0.8
I couldn't get an appointment	0	0.0
I did not have child care for medical care appointments	0	0.0
Other	27	22.3
Missing	9	7.4

How do you keep people in medical care? In the out of care survey, participants were asked to report which services would help them stay in medical care for their HIV (See Table 1.g.2.). Only 8% of participants said there was nothing that could be done to help them stay in care, suggesting that options do exist to encourage more PLWH/As to seek medical care. Insurance and help with basic needs were the most frequently endorsed solutions. Given that 63% of this sample has been homeless at some time and that 68% are low or very low on food security, it is not surprising that help with basic needs was identified as an important type of assistance for

helping them to get into and to stay in care.

Table 1.g.2. Factors that Could Help PLWH/As Get into or Stay in Care					
Factor	**N**	**%**	**Factor**	**N**	**%**
Insurance	48	39.7	Referrals or advice	19	15.7
Help with basic needs (like housing or food)	38	31.4	Help identifying a doctor sensitive to my culture or needs	15	12.4
Case manager	29	24.0	Acute illness	12	9.9
Substance use treatment	28	23.1	Nothing	10	8.3
Better quality of services	23	19.0	Buddy/Peer to help me get care	7	5.8
Transportation	22	18.2	Child care	4	3.3
More outreach services	19	15.7	Other	20	16.5

Within the focus groups, a persistent theme in the sessions was the lack of coordinated services not only in terms of location but also how services are compartmentalized. Participants mentioned that many PLWH/As have co-dependencies that need to be treated as one big problem, not many small issues to be treated by a number of different doctors. Participants also reported the need to travel to multiple locations to receive the services needed. They suggested that having all services available under one roof would make seeking medical care much easier. Similarly, information about services available should be accessible on a 24 hour/7 days a week basis. Participants suggested that a website or a hotline could be created with updated information on services available as a tool for improving the lives of PLWH/As.

The need for respectful and culturally competent providers was also presented as an issue, although participants varied in how they described their needs. MSM and transgender participants indicated that hospital settings feel unwelcoming and make them feel hesitant about seeking services. They noted that having welcoming settings that feel like a house, inside and outside, would make them feel at ease. Female and transgendered participants believe that currently available services are highly oriented towards the male gay community. They feel stigmatized and left out of the system because of who they are in terms of being racial and gender minorities.

A recurring suggestion from focus group participants for addressing the cultural competence and comfort issue was to use peer counselors or people "like them." This recommendation was supported by participants' perception that PLWH/As know a lot about available services and feel comfortable talking with other PLWH/As. Participants thought that using peer counselors would help more people stay in care and the peer counselors could also benefit from the arrangement in terms of increased self esteem, having a sense of purpose and potentially improving their financial situation if it were a paid position.

Efforts to find people not in care and get them into primary care: In response to the findings of the 2008 Comprehensive Needs Assessment and prior needs assessment research, the Denver TGA emphasizes three key strategies to bring into care those who know their status but are not receiving primary care or treatment.

- (1.) Comprehensive Array of HIV Services Focused on Primary Care. The Denver TGA first helps to bring new participants into primary care by prioritizing a comprehensive ar-

ray of core services. To highlight this commitment, more than half (54%) of Part A funding in FY 2009 is allocated for outpatient/ambulatory care and AIDS drugs. Service provision in these two core categories are the hallmark of the HIV system of care in the Denver TGA. All supportive services feed into primary care and AIDS pharmaceutical assistance, ensuring that new participants receive assistance with medical care and treatment adherence. As a result, the TGA averages 80% adherence to HIV drugs at all funded primary care sites, compared to the national average of 75%.

- (2.) Timely Support through Key Points at Which HIV Infection is Identified. Another strategy for bring participants into care is based on the recent advent and implementation of rapid HIV testing. This technology is currently used to diagnose HIV infection by several organizations and hospitals, including community-based entities. Organizations are realizing that timely responses and support are crucial to ensure participants a successful and seamless entry into the HIV continuum of care. One of the main roles of peer advocates and case managers begins at this juncture. Recent funding increases in this service category have enabled the Denver TGA to put a supportive system in place that particularly addresses the needs of women being brought into care.
- (3.) MAI-funded Outreach. A third strategy for finding new participants and linking them to primary care involves outreach supported by the MAI stream of funding. The goal of the MAI program is to identify minority PWLH/As who are not in care and to help them integrate into the Part-A funded system of service provision.

  Under this program, non-medical case managers conduct outreach campaigns to find diagnosed individuals who are out of care. These individuals are assisted in accessing the primary care system and learning to navigate within it. All new participants receive a mental health assessment and short-term follow up treatment if necessary, to provide the support needed to help them adjust to care. New participants are also linked into substance abuse treatment services if applicable as well. This preliminary mental health and substance abuse treatment is designed to help participants attain the stability needed to maintain adherence to primary care regimens.

  The MAI outreach model is designed not as a separate long-term care system for people of color, but rather as a mechanism for integrating minority PWLH/As into the overall continuum of care. Each year, once an incoming group of participants is fully engaged in the Part A-funded system, non-medical case managers begin outreach efforts to find new participants. Participants who need additional mental health or substance abuse treatment are referred to providers within the main Ryan White system. A long-term goal of the program is to reduce the total minority unmet need population in the Denver TGA by approximately 28% over three years.

Unique Service Delivery Challenges

One unique service delivery challenge in the Denver TGA concerns transportation. Because of its sheer size—the TGA encompasses 3,760 square miles—transportation is a necessity for many PLWH/As seeking HIV services. Public transportation in Colorado is not as sophisticated as in other EMAs/TGAs. During the last election, the Denver TGA voters approved the largest transportation project the state has ever undertaken in expanding light rail lines throughout the Denver metro area. Unfortunately, the benefits of this project will not be experienced for

another decade. Transportation assistance therefore remains critical to the successful provision of Part A-funded HIV care.

Transportation concerns in the TGA have been particularly affected by the relocation of two primary care providers. In FY 2007, University Hospital and Children's Hospital both moved to the east side of the TGA, to occupy the former Fitzsimmons military campus. This move improved primary care access for about 11% of Ryan White participants who live in Arapahoe County, where the hospitals are now located. Formerly these participants had to travel to central Denver to be seen at University Hospital, the indigent care provider for all non-Denver County residents in the state. At the same time, however, another 10% of participants must now travel significantly farther to their appointments. The participants comprise approximately 260 individuals who live in Jefferson County (on the west of the TGA) and 100 WICY participants who are seen at Children's Hospital, the WICY primary care provider. The Jefferson County participants live on the far west side of the TGA and must now travel to the far east side for treatment; similarly, the Denver WICY participants live in the center of the TGA and must now travel to the far east side.

A second unique service delivery challenge stems from in-migration to the TGA. Denver has witnessed a recent in-migration of PLWH/A from neighboring states. According to reports gathered during the needs assessment process, this in-migration is due to ADAP cost crises in regional states. A finding of the 2005 Denver TGA Needs Assessment, for instance, concerned the in-migration from states including New Mexico, California, Oregon, Arizona, and Wyoming. Respondents from these last two states, representing 3% and 5% of the in-migration among survey respondents, stated that budget cuts in ADAP forced their relocation.

Along with transportation and in-migration, another service delivery challenge concerns treatment for undocumented immigrants. Undocumented immigrants face three unique barriers to care in Denver. First, they are often monolingual Spanish speakers, so they find it difficult to access services provided only in English. In addition, they often maintain a strong distrust of the service system, which makes them resistant to seeking out care. Finally, in some instances, undocumented immigrants do not qualify for health care services offered by the two main Part A primary care providers.

This third barrier arises from necessary administrative mechanisms maintained by both large provider hospitals. If participants have private insurance, they are free to seek services at either location. If they do not have private insurance, Medicaid, or Medicare, and they are medically indigent, then the following restrictions apply. To be seen at Denver Health, located in the City and County of Denver, participants must provide a Denver residential address. Non-Denver County residents are seen at University Hospital. Both providers serve medically indigent people through the Colorado Indigent Care Program (CICP), a statewide rating system that allows for reimbursement of services for individuals who are not eligible for Medicare and Medicaid. However, undocumented immigrants are not eligible to obtain CICP ratings. Within the Denver Health system they can access the Colorado Health Skip program, but cannot be seen at University Hospital. Undocumented immigrants without health insurance living outside of Denver therefore historically have had no access to Part A-funded primary medical care at either of the two main ID clinics.

This third barrier is currently being addressed by the expansion of Outpatient and Ambulatory Health Services to include free-standing community clinics. As discussed in section above on the Continuum of Care, the TGA has begun funding a network of Spanish-speaking clinics specifically to address care needs for undocumented immigrant populations. In addition to

providing a much-needed option for health care where it does not currently exist, the clinics will also help to reduce the other two barriers to care mentioned above. The clinics will be staffed by Mexican American personnel who share not only the language but also the culture of many of the target participants. This shared linguistic and cultural heritage will help to reduce participant distrust and increase their willingness to continue in care.

SECTION 2: WHERE DO WE NEED TO GO? ENHANCING THE DELIVERY SYSTEM

In its process of establishing the 2009 – 2011 Comprehensive Plan for the TGA, the Planning Council identified the following vision and values for the continuum of care. These vision and values statements will guide the process of implementing systems change to accomplish the Planning Council's mission.

Planning Council Mission

The mission of the Denver HIV Resources Planning Council is defined as follows:

Mission Statement

To assist in the coordination of high quality, culturally proficient delivery of HIV/AIDS services in the Denver Transitional Grant Area.

To achieve this mission for 2009 – 2011, the Planning Council has chosen to focus on four primary focus areas: (1) Linkage to Care; (2) Eliminating Health Disparities; (3) Retention in Care; and (4) Adherence/Medical Self-Management.

Linkage to Care

Linking participants to medical care remains the priority area of focus for the TGA. Within both Part A- and MAI-funded programs, providers are tasked with ensuring that HIV positive individuals are brought into the continuum of care and linked with appropriate medical treatment. Outreach through MAI non-medical case management is designed specifically to identify out-of-care minority PLWH/As and to help these individuals integrate into the larger system of Part A-funded care. For non-minority participants, linkage to medical care also represents the first priority when the individual is introduced into the health system.

Eliminating Health Disparities

As participants are linked into care, the TGA places strong emphasis on assuring parity of service provision. Historically, women and minority populations have accessed the continuum of care at rates that equal or exceed their representation in the overall PLWH/A population. This is true both for primary medical treatment and for service provision within other core and support categories. The Planning Council remains committed to continuing this record of success in maintaining parity, particularly as the face of the epidemic changes and new vulnerable populations emerge.

Retention in Care

While linkage to care lies at the forefront of the TGA strategy, retention in care also persists as a predominant focus area necessary for ensuring that PLWH/As experience positive health outcomes. Individuals who seek regular HIV care and remain adherent to treatment regimes are able in many cases to experience significant improvement in health outcomes. Once participants become integrated into the continuum of care, the objective of the medical case management system is to ensure follow up with medication protocols and regular primary care visits. In addition, participants are routinely assessed for other core service needs, such as mental health or substance abuse treatment, that might promote lifestyle stability and ensure treatment adherence. Support services further enable clients to access stabilizing resources such as housing and financial assistance that make it easier to remain in care.

Adherence/Medical Self-Management

Adherence and medical self-management are crucial for ensuring that participants take responsibility for their health care and develop a stake in promoting positive health outcomes. Medical regimens for the treatment of HIV have become more consistent as research and pharmaceutical technologies have progressed. Providers are able to educate participants regarding how to maintain medication protocols that promote health stability over the long term. Through all of its service priorities, and particularly the core service categories, the TGA emphasizes a focus on participant empowerment and self-efficacy in remaining adherent to care.

Vision and Values for Systems Change

In identifying methods for addressing its key focus areas outlined above, the Planning Council considered three main questions:

1. What do we stand for?
2. What is our unique contribution?
3. How do we show value and efficacy of the future of the system of care?

Through their responses to these questions, Planning Council members emphasized four recurrent values that form the framework for a unified vision of coordinated care.

Evidence-Based Decision Making

Central to the vision of the future of care in the Denver TGA is the fundamental value that all decisions regarding allocations and service prioritization be based on evidence derived from three main sources. The first of these is needs assessment data gathered on an annual basis, with comprehensive needs assessments conducted every three years. The second source of evidence is client-level data collected through RWCAREWare. And the third is performance measurement of client-level and program Quality Indicators. The emphasis on a sound data-driven process of decision making serves to uphold the vision of a *quality* system of HIV care that prioritizes the continued improvement of health outcomes.

Coordinated System of Care

A second main value identified by the Planning Council is the notion of a coordinated system of care. In addition to ensuring that TGA providers communicate effectively with one another, the Planning Council is committed to maximizing efficiencies and avoiding the duplication of efforts. Providers are encouraged to collaborate with other Part A-funded agencies and with providers outside of the Ryan White system. The Planning Council intends to coordinate the Part A system of care and planning processes with other Ryan White parts, HOPWA, Medicaid, and other related systems of care whenever possible. The values of coordination and collaboration support a vision of an integrated state-wide system of care that participants can navigate effectively.

Responsiveness

A third central value identified by the TGA is that of responsiveness within the system of care. A responsive system is one that upholds a vision of flexibility in meeting the needs of the changing epidemic. As the model of HIV changes from a terminal to a chronic disease, corresponding shifts must occur in care provision. The value of responsiveness upholds a vision of an adaptive system that provides cost-effective care while genuinely meeting the needs of those it is designed to serve.

Equity

Finally, the system of care is based on a fundamental value of equity, both in representation and access to care. In terms of representation, diverse consumer input is viewed as central to each stage of the decision-making process regarding service provision. With respect to system access, the value of equity serves to ensure that competent health are is a visible reality for all PWLH/As. A equity-based system helps to counter the marginalization of disenfranchised populations and to ensure that barriers to care are recognized and proactively addressed.

SECTION 3: HOW WILL WE GET THERE? STRATEGIC PLANNING WITH ACTION STEPS

Long-Term Goals (3 Years): Systems, Planning, Evaluation, and Service

To support its identified vision and values for the HIV care system, the following long-term goals were identified by the Planning Council to be carried out over the next three years, from 2009 – 2011. These goals center around refining the Planning Council structure to better address the primary focus areas identified in Section 2:

1. Linkage to Care
2. Eliminating Health Disparities
3. Retention in Care
4. Adherence/Medical Self-Management

Goal #1: Implement a Quality Improvement and project management structure to address critical issues within TGA

- **Objective #1**
Between March 1, 2009 and December 31, 2009, Finalize/review Quality Improvement Plan for TGA, utilize new Workgroup infrastructure to assure broad involvement of stakeholders and consumers

- **Objective #2**
Between January 1, 2010 and June 30, 2010, finalize Quality Improvement Performance Measures, utilize new Workgroup infrastructure to assure broad involvement of stakeholders and consumers

- **Objective #3**
Between January 1, 2009 and February 28, 2009, Create a process where the Leadership Committee identifies and prioritizes emerging issues and establishes workgroups to develop solutions

- **Objective #4**
Between January 1, 2009 and February 28, 2009, establish a structure for Leadership Committee to determine timelines, chair person(s), and reporting mechanisms between the workgroups, Leadership Committee and Planning Council

- **Objective #5**
Between January 1, 2009 and December 31, 2011, evaluate the Quality Improvement and project management structure at the end of each year, utilizing direct feedback from Workgroups and the NQC Part A Quality Management Program Assessment Tool

Goal #2: Establish workgroups to take on critical TGA initiatives

- **Objective #1**

Between January 1, 2009 and July 31, 2009, create Workgroups to address current PC Processes:

- Needs Assessment
- Priorities/Resource Allocation Process
- Medical Home Health Care Standards

- **Objective #2:**

Between January 1, 2009 and June 30, 2009, plan and prioritize future workgroups (based on main focus areas) to address emerging needs and identified quality improvement initiatives:

- Peer Mentoring/Leadership –Redefinition of Rebuilt + (In process)
- Barriers to care for Recently Released Positives – Redefinition of POCLC
- Information Sharing within TGA
- Defining Medical/Nonmedical Case Management
- Define outreach/MAI structure and focus
- Create Model for TGA's future

Goal #3: Strategically improve the functioning of the Planning Council

- **Objective #1**

Between January 1, 2009 and March 31, 2009, create a Development Committee whose sole purpose is to ensure efficient and effective operations of the Planning Council

- **Objective #2:**

Between March 1, 2009 and June 30, 2009, create protocol to strategically recruit membership with a focus on the development of future leaders

Goal #4: Ensure that strong communication exists between MOHR, Planning Council and Providers

- **Objective #1**

Between January 1, 2009 and April 21, 2009, turn present MDASC format into an information sharing and gathering forum lead by Leadership Committee and MOHR

- **Objective #2**

Between January 1, 2009 and April 21, 2009, develop a networking component to MDASC to ensure strong communication across TGA providers

Short-Term Goals (Annual): Care and Treatment

In addition to the long-term goals presented above, the following short-term goals were identified by the TGA as care and treatment goals for FY 2009. All of the objectives listed below will be completed during the timeframe March 1, 2009 – February 28, 2010.

Service Priority 1: Outpatient/Ambulatory Health Services

The goal of the Denver TGA's first service priority is to provide primary care services to 2,500 eligible persons living with HIV/AIDS (PLWH/As) in the Denver TGA and to maintain 0% disparity among women and people of color in FY 2009. Objectives outlined to meet this goal are: to increase access to HIV/AIDS primary care to eligible PLWH/As in the Denver TGA through five primary care sites, and to serve a minimum of 400 women and 600 people of color. An additional objective for meeting this service goal is to serve 300 unmet need clients. For Service Priority 1: Outpatient/Ambulatory Health Services, the Denver TGA will allocate **43.14**% of all funds awarded. This includes **$333,927** to treat an additional **300 of the 2,625** PLWH/As identified through our HRSA/HAB Unmet Need Framework.

Service Priority 2: AIDS Pharmaceutical Assistance (Local)

The goal of the Denver TGA's second service priority is to supplement three HIV/AIDS-specific pharmacies at three of the funded primary care sites to dispense ADAP formulary medications to ADAP-eligible clients and to provide drug adherence strategies for all Ryan White eligible clients in FY 2009. The objectives established to meet this goal are: to serve a minimum of 1,500 eligible PLWH/As, including 400 women, 900 people of color, and 150 unmet need clients. For Service Priority 2: AIDS Pharmaceutical Assistance, the Denver TGA will allocate **11.04**% of all funds awarded. This amount includes **$71,237** to treat an additional **150 of the 2,625** PLWH/As identified through our HRSA/HAB Unmet Need Framework.

Service Priority 3: Oral Health Care

The goal of the Denver TGA's third service priority is to provide routine and emergency dental care to eligible PLWH/As in the Denver TGA in FY 2009. To meet this goal, the following objectives have been established: to serve a minimum of 800 eligible PLWH/As, 120 women, and 300 people of color; and to serve 75 unmet need clients. We currently serve 832 clients. For Service Priority 3: Oral Health Care, the Denver TGA will allocate **11.99**% of all funds awarded. This includes **$72,534** to treat an additional **75 of the 2,625** PLWH/As identified through our HRSA/HAB Unmet Need Framework. Additional funds will allow the Denver TGA to eliminate the only waiting list for services.

Service Priority 4: Medical Case Management

The goal of the Denver TGA's fourth service priority is to provide a range of services that are consumer-centered, flexible, cost-efficient, and quality-driven, and that link consumers to health care, medication, psycho-social support, housing, mental health treatment, substance abuse treatment, and other services to ensure timely, coordinated access to appropriate levels of health care. We currently serve 2,060 clients. The objectives developed to support this goal are: to provide medical case management services to 2,268 PLWH/As in the Denver TGA through four CBOs in FY 2009; to serve a minimum of 400 women and 925 people of color; and to serve 171 unmet need clients. For Service Priority 4: Medical Case Management, the Denver TGA will allocate **10.95**% of all funds awarded**.** This amount includes $55,506 to treat an additional **171 of the 2,625** PLWH/As identified through our HRSA/HAB Unmet Need Framework.

Service Priority 5: Mental Health Services

The goal of the Denver TGA's fifth service priority is to provide a range of programs, developed through systemic team approaches, designed to support and assist PLWH/As at all stages of HIV disease, including newly-diagnosed clients and PLWH/As who need counseling, psychiatric assessment and medication, spiritual/emotional support, and/or grief and bereavement counseling. We currently serve 829 clients. The objectives that have been defined in support of this goal are: to provide comprehensive mental health services to 800 eligible PLWH/As in the Denver TGA in FY 2009; to provide mental health services to 160 women clients; to provide mental health services for 160 clients in communities of color; and to serve 150 unmet need clients. For Service Priority 5: Mental Health Services, the Denver TGA will allocate **5.73**% of all funds awarded. This amount includes **$69,328** to treat an additional **150 of the 2,625** PLWH/As identified through our HRSA/HAB Unmet Need Framework.

Service Priority 6: Substance Abuse Services – Outpatient

The goal of the substance abuse outpatient care service priority is to provide treatment and/or counseling services to PLWH/As in the Denver TGA that specifically addresses substance and/or alcohol abuse issues, for the purpose of improving clients' health by increasing their access to and maintenance of primary care treatment and their adherence to prescribed anti-retroviral drug therapies. We currently serve 259 clients. To meet our goal, the following objectives have been established: to provide substance abuse treatment to 250 PLWH/As in the Denver TGA through seven providers in FY 2009; to serve a minimum of 30 women and 120 people of color; and to serve 60 unmet need clients. For Service Priority 6: Substance Abuse Services - Outpatient, the Denver TGA will allocate **4.17**% of all funds awarded. This amount includes **$57,307** to treat an additional **60 of the 2,625** PLWH/As identified through our HRSA/HAB Unmet Need Framework.

SECTION 4: HOW WILL WE MONITOR OUR PROGRESS? TRACKING EFFECTIVE IMPLEMENTATION

Implementation of the 2009-2011 Comprehensive Plan will be tracked using the monitoring tool presented below. Action step responsibilities and timelines are delineated on the monitoring tool. The Planning Council Executive Committee will maintain responsibility for follow up to ensure milestones are met.

Long-Term Systems Planning Goals

Goal 1: Implement a Quality Improvement and project management structure to address critical issues within TGA			
	Activity	**Who**	**Due Date**
1.	Finalize/review Quality Improvement Plan for TGA, utilize new Workgroup infrastructure to assure broad involvement of stakeholders and consumers.	Planning Council Staff, Leadership Committee, MOHR	December 31, 2009
2.	Finalize Quality Improvement Performance Measures, utilize new Workgroup infrastructure to assure broad involvement of stakeholders and consumers.	Planning Council Staff, Leadership Committee, MOHR	June 30, 2010
3.	Create a process where the Leadership Committee identifies and prioritizes emerging issues and establishes workgroups to develop solutions	Planning Council Staff and Leadership Committee	February 28, 2009
4.	Establish a structure for Leadership Committee to determine timelines, chair person(s), and reporting mechanisms between the workgroups, Leadership Committee and Planning Council	Planning Council Staff and Leadership Committee	February 28, 2009
5.	Evaluate the Quality Improvement and project management structure at the end of each year, utilizing direct feedback from Workgroups and the NQC Part A Quality Management Program Assessment Tool.	Planning Council Staff, Leadership Committee, MOHR	December 31, 2009, 2010, 2011

Goal 2: Establish workgroups to take on critical TGA Initiatives			
	Activity	**Who**	**Due Date**
1.	Create Workgroups to address current PC Processes:	Planning Council Staff and	July 31, 2009

	• Needs Assessment • Priorities/Resource Allocation Process • Medical Home Health Care Standards	Leadership Committee	
2.	Between January 1, 2009 and June 30, 2009, plan and prioritize future workgroups (based on main focus areas) to address emerging needs and identified quality improvement initiatives: • Peer Mentoring/Leadership –Redefinition of Rebuilt + (In process) • Programming for Recently Released Positives – Redefinition of POCLC • Information Sharing within TGA • Defining Medical/Nonmedical Case Management • Define outreach/MAI structure and focus • Create Model for TGA's future	Planning Council Staff and Leadership Committee	June 30, 2009

Goal 3: Strategically improve the functioning of the Planning Council			
	Activity	**Who**	**Due Date**
1.	Create a Development Committee whose sole purpose is to ensure efficient and effective operations of the Planning Council	Development Committee	March 31, 2009
2.	Create protocol to strategically recruit membership with a focus on the development of future leaders	Development Committee and Planning Council Staff	June 30, 2009

Goal 4: Ensure that strong communication exists between MOHR, Planning Council and Providers			
	Activity	**Who**	**Due Date**
1.	Turn present MDASC format into an information sharing and gathering forum lead by Leadership Committee and MOHR	MOHR, Planning Council Staff and MDASC Leadership	April 21, 2009
2.	Develop a networking component to MDASC to ensure strong communication across TGA providers	MOHR, Planning Council Staff and MDASC Leadership	April 21, 2009

Short-Term Service Provision Goals

Goal 1: Outpatient/Ambulatory Care—To increase access to HIV/AIDS primary care to eligible persons living with HIV/AIDS (PLWH/As) in the TGA and to maintain 0% disparity among women and people of color			
	Activity	**Who**	**Due Date**
1.	Increase access to HIV/AIDS primary care to 2,500 eligible persons living with HIV/AIDS (PLWH/As) in the TGA through five primary care sites	MOHR	2/28/2010
2.	Serve a minimum of 400 women	MOHR	2/28/2010
3.	Serve a minimum of 600 people of color	MOHR	2/28/2010
4.	Serve 300 unmet need clients	MOHR	2/28/2010

Goal 2: AIDS Pharmaceutical Assistance (Local)—Supplement three HIV/AIDS-specific pharmacies at three funded primary care sites to dispense ADAP formulary medications to ADAP eligible clients and provide drug adherence strategies for all Ryan White eligible clients			
	Activity	**Who**	**Due Date**
1.	Provide local AIDS pharmaceutical assistance to a minimum of 1,500 eligible PLWH/As	MOHR	2/28/2010
2.	Serve a minimum of 400 women	MOHR	2/28/2010
3.	Serve a minimum of 900 people of color	MOHR	2/28/2010
4.	Serve 150 unmet need clients	MOHR	2/28/2010

Goal 3: Oral Health Care—To provide routine and emergency dental care to eligible PLWH/As in the TGA			
	Activity	**Who**	**Due Date**
1.	Provide oral health care services to a minimum of 800 eligible PLWH/As	MOHR	2/28/2010
2.	Serve a minimum of 120 women	MOHR	2/28/2010

3.	Serve a minimum of 300 people of color	MOHR	2/28/2010
4.	Serve 75 unmet need clients	MOHR	2/28/2010

Goal 4: Medical Case Management—Provide a range of consumer-centered, flexible, cost-efficient and quality-driven services that link consumers to health care, medication, treatment adherence counseling, mental health care, substance abuse treatment, and other services and ensure timely, coordinated access to appropriate levels of client care			
	Activity	**Who**	**Due Date**
1.	Provide medical case management services to 2,268 PLWH/As in the TGA through 3 community based organizations (CBOs)	MOHR	2/28/2010
2.	Serve a minimum of 400 women	MOHR	2/28/2010
3.	Serve a minimum of 925 people of color	MOHR	2/28/2010
4.	Serve 171 unmet need clients	MOHR	2/28/2010

Goal 5: Mental Health Services— Provide a range of programs, based on systemic team approaches, that are designed to support and assist PLWH/As at all stages of HIV disease, including those newly diagnosed and PLWH/As who need counseling, psychiatric assessment and medication, spiritual/emotional support, and/or grief/bereavement counseling			
	Activity	**Who**	**Due Date**
1.	Provide comprehensive mental health services to 800 eligible PLWH/As in the TGA	MOHR	2/28/2010
2.	Provide mental health services to 160 women	MOHR	2/28/2010
3.	Provide mental health services for 160 clients in communities of color	MOHR	2/28/2010
4.	Serve 150 unmet need clients	MOHR	2/28/2010

Goal 6: Substance Abuse Services (Outpatient)—To provide treatment and/or counseling to PLWH/As in the TGA to address substance and/or alcohol abuse in order to improve health by increasing access to and retention in primary care as well as adherence to prescribed anti-retroviral drugs

	Activity	**Who**	**Due Date**
1.	Provide substance abuse treatment to 250 PLWH/As in the TGA through 7 providers	MOHR	2/28/2010
2.	Serve a minimum of 30 women	MOHR	2/28/2010
3.	Serve a minimum of 120 people of color	MOHR	2/28/2010
4.	Serve 60 unmet need clients	MOHR	2/28/2010