ATLANTA EMA FINAL FY 2014 RYAN WHITE PART A PROGRESS REPORT

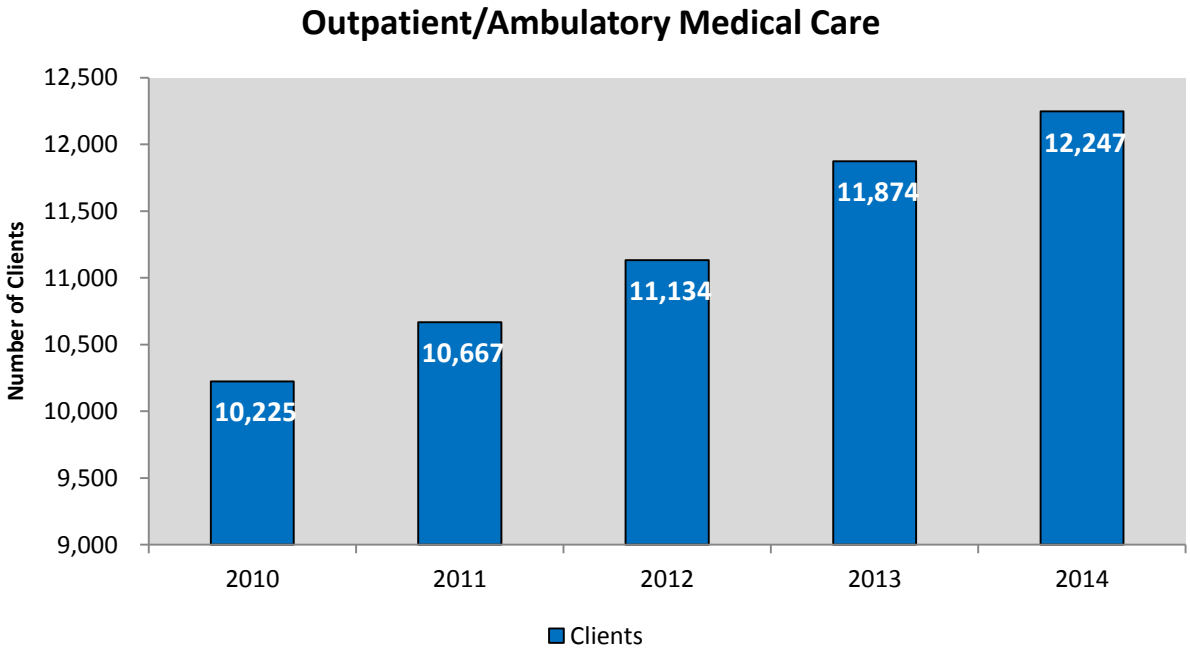
I. Final FY 2014 Program Implementation Plan

a. The updated version of the previously approved FY 2014 Implementation Plan showing actual spending, service utilization, and outcomes data for the reporting period (March 1, 2014 through February 28, 2015) has been uploaded in the EHB.

b. The Atlanta EMA did not allocate FY 2014 funds for medications; therefore, the Local Pharmacy Assistance Profile has not been completed.

c. Program successes and challenges –

- **SUCCESS:** The Atlanta EMA served a greater number of clients in FY 2014 including an increase in the number of clients receiving care and treatment positively impacting unmet need and increasing access to care. During FY 2014, 14,032 undulpicated clients received a Ryan White Part A service which represents a 3% increase over CY 2013 (n=13,626). Of these clients, 87% (n=12,247) received at least one Outpatient/Ambulatory Health Services visit (a 3% increase over CY 2013 n=11,874) with the average number of visits per client equaling 5.2.



Furthermore, 11,060 unduplicated clients had at least one viral load test during FY 2014 (total number of VL tests = 33,338 which averages 3 tests per client). Of these, 74.4% (n=8,232) had viral load results ≤ 75 and 67.8% (n=7,498) had viral load results ≤ 50. These numbers improved over FY 2014 where 10,513 unduplicated clients had at least one viral load test. Of these, 73.7% (n=7,745) had viral load results ≤ 75 and 67.2% (n=7,066) had viral load results ≤ 50.

- **SUCCESS:** In order to ensure programmatic and fiscal accountability, the Grantee's Project Officers work closely with agencies to monitor budgets, expenditures, and finances during the program year. If areas were identified where funds were not being used as first proposed (due to staff changes, changes in goals and objectives, etc.), staff worked with agency personnel to modify and revise contracts and budgets to ensure the efficient use of funds. When necessary, the Grantee worked with the Planning Council to redirect funds across Priority Areas to ensure that resources were allocated to address changing needs.

  The Grantee routinely conducted site visits to each of the funded service providers. Site visits were conducted to 100% of the funded agencies to monitor programmatic and fiscal compliance. During the visits, staff interviewed programmatic, fiscal, and data designees and conducted chart reviews to determine programmatic and fiscal compliance.

- **SUCCESS: Patient Navigation Pilot –** The Grantee received technical assistance from HRSA, provided by Cicatelli Associates, Inc. during FY 2013 regarding patient navigation programs. In FY 2013, the Planning Council prioritized limited FY 2014 funding to initiate a pilot program in the Atlanta EMA to increase access to care and to reduce HIV-related health disparities.

  The goal of the Atlanta EMA Patient Navigation Program is to increase client medical adherence and retention in HIV/AIDS care services among clients most at risk for non-medical adherence. The Patient Navigator Program focuses on clients who receive a preliminarily positive and/or new confirmatory HIV/AIDS diagnosis, and clients identified as most at risk for non-adherence to medical services. The program is voluntary and is designed to empower clients to engage in their own care by promoting client self-advocacy to successfully access services, and increasing their understanding of basic HIV/AIDS information in order to build their capacity to manage and promote their own medical care and support services. In the pilot year four sites participated: AID Atlanta, AID Gwinnett, Clayton County Board of Health, and DeKalb County Board of Health. The population of focus was young African American MSM.

  163 clients were served by Patient Navigators: African Americans accounted for 88% (n=143); Whites accounted for 11% (n=18); all other races represented 1% (n=2); 9% were Hispanic/Latino (n=14); 80% were male (n=139); 13% were female (n=23); 7% were transgender (n=11); 114 identified a risk factor of MSM and 49 identified high-risk heterosexual activity; 58 were 18-29 years old.

  Greater time will need to pass to determine the health outcomes of individuals who received patient navigation have achieved improved health outcomes.

- **SUCCESS: Legislation Revision –** The State of Georgia has received CAPUS (Care and Prevention in the United States) funding to implement a pilot HIV Health Information Exchange (HIE) to increase access to care, reduce new HIV infections and reduce HIV-related health disparities. Three Part A sites are participating in the pilot. The objective is to re-engage in care out-of-care persons accessing health care for reasons unrelated to HIV. In short, this system would send an alert to a medical provider when a client who is living with HIV disease but not in HIV care and treatment presents for services. One structural challenge in implementing the HIE was a Georgia law which prohibited (with certain exceptions) the Georgia Department of Public Health from sharing confidential AIDS

information with health care providers outside of the Public Health system. The CAPUS HIE Legal and Ethical Committee, which includes the grantee and members of the Planning Council assisted in drafting language to amend the Official Code of Georgia Annotated (OCGA) to allow for the sharing of confidential information necessary to support the HIE. In 2014 the Georgia General Assembly passed the legislation which states:

Code Section 24-12-21 of the Official Code of Georgia Annotated, relating to disclosure of AIDS confidential information, was amended by adding a new subsection to read as follows:

> "(h.1) The Department of Public Health may disclose AIDS confidential information regarding a person who has been reported, under paragraph (1) or (2) of subsection (h), to be infected with HIV to a health care provider licensed pursuant to Chapter 26 or 34 of Title 43 whom that person has consulted for medical treatment or advice."

The Act was signed by the Governor and took effect on July 1, 2014. With this substantial change, data should flow from the HIV case reports to the health departments in a timelier manner. Additionally, with this easing of legal constraints, the testing of named contacts as well as linkage to care functions can be partially driven by the health departments' now having access to this information WITH the personal identifying information necessary to perform public health duties.

- **SUCCESS AND CHALLENGE: The Ryan White Part A Clinical Performance 2014** – Atlanta Metropolitan Area provided a summary of clinical chart review results designed to monitor the quality of care provided by Ryan White Part A funded primary care sites as part of the Atlanta EMA's quality management plan. The purpose of the chart review was to examine the extent to which Ryan White Part A funded primary care sites were providing care that meets quality of care indicators adopted by the Part A Grantee and approved by the Metropolitan Atlanta HIV Health Services Planning Council (Planning Council), as well as the Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) Performance Measures. This is the fourth chart review project directed by Fulton County's Part A Office and the Planning Council in the past 12 years.

  All primary care sites funded by Part A in 2014 participated in this quality study. A total of **1,312** individual patient charts were reviewed across these sites for documentation of quality care during the study time period and back to initial diagnosis. The sample size was based on HIVQUAL sampling methodology. Demographic information, such as race, ethnicity, and age were also collected because these factors could potentially impact the care and subsequently the health of the client. (Health Disparities)

  Of the 1,312 charts reviewed for gender, 43% (n=562) were of female clients, 57% (n=743) were of male clients and <1% (n=7) were clients who identified as transgender. The majority of patients who had a chart reviewed by the chart extraction team were African American at 77% (n=1,015); 13% (n=174) were White, non-Hispanic; 7% (n=97) were a combination of those who identified as either Hispanic-White or Hispanic-Black (no other racial group identified as Hispanic); and less than 2% (n=15) were Asian/Pacific Islander, Native American, or more than one race; racial/ethnic identify was not available on approximately 1% (n=11) of reviewed charts.

EMA Indicator Performance and Benchmark Comparison

Percent Compliance for Clinical Performance Measures	*EMA Results (2014)*	*Benchmarks*[1]	*Source*
HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients			
Viral Load Suppression	80%	82%	2011 HIVQUAL Median
Prescribed Antiretroviral Therapy	94%	91%	2012 HIV Research Network
Medical Visits Frequency*	89%	65%	2012 In+Care Campaign
Gap in Medical Visits*	0.4%	15%	2012 In+Care Campaign
PCP prophylaxis	85%	80%	2011 HIVQUAL Mean
HAB HIV Clinical Performance Measures for All Ages			
Influenza vaccination	64%	67%	2011 HIVQUAL Median
Lipid Screening	81%	83%	2011 HIVQUAL Median
TB screening	98%	73%	2011 HIVQUAL Median
Viral Load Monitoring	67%	90%	2011 HIVQUAL Median
HAB HIV Clinical Performance Measures for Adolescent and Adults			
Cervical Cancer Screening	31%	63%	2011 HIVQUAL Median
Chlamydia screening	83%	61%	2011 HIVQUAL Median
Gonorrhea screening	83%	60%	2011 HIVQUAL Median
Syphilis screening	86%	86%	2011 HIVQUAL Median
Hepatitis B screening	99%	Not Available	Not Available
Hepatitis C screening	98%	98%	2011 HIVQUAL Median
HIV Risk Counseling	87%	Not Available	Not Available
Oral exam	19%	35%	2011 HIVQUAL Median
Pneumococcal vaccination	91%	73%	2011 HIVQUAL Median
Substance use screening	95%	92%	2011 HIVQUAL Median
Tobacco cessation counseling	69%	95%	2011 HIVQUAL Median
Archived HAB HIV Clinical Performance Measures			
ARV Therapy for Pregnant Women	53%	Not Available	Not Available
Hepatitis/HIV Alcohol Counseling	79%	Not Available	Not Available
CD4 T-Cell Count	90%	63%	2006 HIVQUAL Median
HAART	97%	100%	2006 HIVQUAL Median
Medical visits	93%	Not Available	Not Available
Adherence Assessment & Counseling	88%	56%	2006 HIVQUAL Mean
MAC prophylaxis	85%	85%	2007 HIVQUAL Mean
Mental health screening	98%	42%	2007 HIVQUAL Mean
Toxoplasma screening	82%	Not Available	Not Available
Atlanta EMA Indicators Only			
TB Screening	61%	100%	EMA Service Indicators
Problem list	99%	100%	EMA Service Indicators
Allergy documentation	99%	100%	EMA Service Indicators
Chlamydia Baseline Screening	61%	100%	EMA Service Indicators

[1] From EMA indicators approved 6/2013 and HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients available at http://hab.hrsa.gov/special/coreclinical.htm

*In+Care utilizes a 24-month measurement period rather than the 12-month measurement period of the 2014 Chart Review.

Gonorrhea Baseline Screening	61%	100%	EMA Service Indicators

The 2014 Ryan White Part A Clinical Performance Chart Review has found several significant improvements since the last review in 2010. However, there have also been a number of indicators that have underperformed compared to the 2010 findings. The table below shows all EMA Indicators and their findings in both the 2010 and 2014 reviews as well as the EMA goal set in the Quality Management Plan. The percentages indicated in bold type are the higher of the two. Those with an * indicate a higher result than the EMA Goal.

Results Comparison with 2010 and EMA Goals

Indicator	2010 Result	2014 Result	EMA Goal
HAB PERFORMANCE MEASURES FOR ADULT/ADOLESCENT CLIENTS			
PCP Prophylaxis	**92%**	85%	**95%**
HAB PERFORMANCE MEASURES FOR ALL AGES			
TB Screening	**64%**	61%	**100%**
Viral Load Monitoring	-	67%	**90%**
HAB PERFORMANCE MEASURES FOR ADOLESCENTS AND ADULTS			
Cervical Cancer Screening	-	31%	**90%**
Chlamydia Baseline Screening	32%	**61%**	**100%**
Gonorrhea Baseline Screening	32%	**61%**	**100%**
Hepatitis B Screening	99%	99%*	**95%**
Hepatitis C Screening	**100%**	98%*	**95%**
HIV Risk Counseling	**93%**	87%*	**85%**
Oral Exam	**40%**	19%	**75%**
Syphilis Screening	81%	**86%**	**90%**
Substance Use Screening	**97%**	95%*	**80%**
ARCHIVED HAB PERFORMANCE MEASURES			
ARV Therapy for Pregnant Women	**62%**	54%	**90%**
CD4 T-Cell Count	89%	**90%**	**90%**
HAART	86%	**97%***	**90%**
Medical Visits	90%	**93%***	**90%**
Adherence Assessment/Counseling	88%	88%	**90%**
Mental Health Screening	95%	**98%**	**100%**
ATLANTA EMA INDICATORS ONLY			
Problem List	98%	**99%**	**100%**
Allergy Documentation	**100%**	99%	**100%**

As the above table illustrates, nine (9) indicators showed improvement over the 2010 findings, with seven (7) that underperformed compared to 2010. Another six (6) indicators showed results that outperformed the EMA goals set in the quality management plan.

Agencies with results less than the EMA's average in any particular performance measure must develop a corrective action plan and provide progress reports to the grantee on the success of efforts to improve performance.

- **SUCCESS AND CHALLENGE: Health Insurance Program** – The implementation of the Affordable Care Act has presented challenges in the way in which our clients receive services. Georgia has not expanded Medicaid, further underscoring the importance of the Ryan White program as a provider of critical health care and support services. Planning in this period of uncertainty has been an ongoing challenge.

  Many clients who transitioned from Part A OAMC services to insurance coverage via the Affordable Care Act faced out-of-pocket expenses for medications that were greater than expected and often unmanageable. Many medications used to treat HIV have been placed in the highest pricing tiers, leaving clients unable to pay their medication co-insurance payments. In FY2013, the Atlanta EMA collaborated with the Georgia Ryan White Part B Program to develop a program to assist clients who enroll in an Affordable Care Act Health Insurance Marketplace Plan. In Fiscal Year 2014, funds were prioritized and allocated to assist clients with their share of the monthly insurance premium and out-of-pocket expenses such as co-payments, medication co-insurance payments, and deductibles.

  In allocating funding to support the Health Insurance Program the plan was to partner with the Georgia Department of Public Health (GDPH) to support their statewide program to assist clients who enroll in an Affordable Care Act Health Insurance Marketplace Plan with their share of the monthly insurance premium and out-of-pocket expenses such as co-payments, medication co-insurance payments, and deductibles. The GDPH was unable to implement their program in FY14; therefore, funds were allocated to three CBOs to assist clients throughout the EMA. The agencies were successful in enrolling clients in the Patient Access Network (a third-party payer) and as a result only $13,427 of the $284,000 was expended and the remainder of the funds were reallocated to support the Georgia ADAP.

- **CHALLENGE: Implementation of the ACA** – As previously mentioned, the implementation of the Affordable Care Act has presented challenges in the way in which our clients receive services.

  The EMA would like to change allocations to support a continuum of services such as the Massachusetts model where there is near universal access to care and Ryan White funding has been shifted from paying for care to paying for care to paying for insurance continuation, co-payments, and expanded support services to help engage people with HIV in care and support adherence. Massachusetts has observed decline in new HIV diagnoses and high viral load suppression which it attributes to the combination of expanded insurance coverage, ART access, and an extensive HIV community care network including Ryan White providers.

  Unless, or until, Georgia expands Medicaid such a shift in the care network will not be possible. Therefore, the EMA has established procedures to “vigorously pursue” third-party payers including the ACA: 1) agencies describe policies and practices in their funding application; 2) agencies are contractually required to check for third-party payment sources and enroll clients as appropriate; and, 3) the grantee checks compliance during site reviews.

  The Grantee continues to work with Ryan White Part A-funded agencies to assist them become part of the ACA Marketplace insurance plans so that they can bill for insurance reimbursements; however, 61% of the EMA’s Part A clients have incomes ≤ 100% FPL and are ineligible for coverage under ACA.

II. Planning Council/Body Activities

a. Planning Council/Body Accomplishments

- **Atlanta Area Outreach Initiative (AAOI) -** The African American Outreach Initiative, a care initiative of the Planning Council integrated efforts with the Atlanta/DeKalb High Impact Prevention Program to produce what is now known as the "Atlanta Area Outreach Initiative".

  The AAOI seeks to improve individual and community health outcomes, by facilitating access to care through HIV prevention, linkage, care, and retention. This educational forum focuses on getting individuals who are not in care linked to care as well as furthering prevention efforts.

  A signature item for the Initiative is the production of an eighty-nine page (89) resource book which includes current information on HIV/AIDS medical care, and support services, educational programs, and testing for agencies residing in Metropolitan Atlanta. Resource books are given to participants, providers, local agencies, and the media.

  Fulton County Government is the recipient of a National Association of Counties (NACo) 2015 Achievement Award in recognition of the Initiative.

- **Council Procedures Committee -** The Council Procedures Committee completed a two year review and revision of its by-laws. During the prior year the committee conducted an internal audit to insure compliance and agreement with HRSA regulations and Planning Council operations. Upon completion, the Committee worked on the next phase of the revision which modified the Planning Council's structure to include vice-chairs for each of the Council's committees. The revisions set forth that "to the greatest extent possible" the position of vice-chair will be filled by a Person Living with HIV. All committee vice-chairs serve as non-voting members of the Executive Committee, with voting rights in a chair's absence. The Committee approved the amended by-laws on November 20, 2014.

  A "two year" term limit was also added to the position of planning Council chair with the option of reappointment by the CEO. The by-laws set forth that to the greatest extent possible, this slot should also be filled with an HIV+ non-aligned consumer.

- **Quality Management Committee –** The Quality Management Committee reviewed the EMA's quality indicators adding a new legal indicator. Additionally the Committee reviewed Oral Health, Mental Health and Case Management standards and recommended updates to each. Primary Care, Nutrition, Substance Abuse, Universal Standards were also reviewed and modified in accordance with HAB measures.

- **Priorities Committee -** In response to the unknown impact of the Affordable Care Act for individuals transitioning from care under Ryan White Part A, the Priorities Committee established "Health Insurance Program" as a new priority category to address the need for assistance in paying premiums, co-pays and co-insurance.

- **Public Policy Committee -** With the advent of the Affordable Care Act the Public Policy Committee continued its efforts in educating consumers on ACA by developing informational factsheets about enrollment.

  The Committee also worked with the AIDS Research Consortium and Harvard Law Project to analyze all silver and gold plans to compile a comprehensive spreadsheet including medications, medication tiers, etc. This spreadsheet was shared with the grantee and service providers in order to assist consumers in determining which ACA plans would work best for their situations.

b. Planning Council/Body Challenges

Challenge	Nature of the Challenge	Plan to Overcome the Challenge	Implementation Progress
Care and Prevention Planning Integration	Care and Prevention Planning Integration: The initial guidance regarding integrated planning was limited resulting in a great deal of confusion regarding the method for achieving integrated planning.	The Planning Council began the process of integrated planning by strategically cross pollinating its planning bodies and activities. The Chair of the Planning Council Public Policy Committee served as Comprehensive Planning Chair of the Prevention planning group (JPPG). Likewise one of the Co-Chairs served as a member of the Planning Council. In that the referenced Co-Chair is also a staff person of Fulton County, the Co-Chair worked closely with the Planning Council Project Officer to establish joint consumer service projects.	The Chair of the Planning Council Public Policy Committee served as Comprehensive Planning Chair of the Prevention planning group (JPPG). Likewise one of the Co-Chairs served as a member of the Planning Council. In that the referenced Co-Chair is also a staff person of Fulton County, the Co-Chair worked closely with the Planning Council Project Officer to establish joint consumer service projects. Both the Metropolitan Atlanta HIV Health Services Planning Council and the Jurisdictional Prevention Planning Group continue to seek ways in which to Integrate planning and prevention.
Planning Council Training/ Technical Assistance	With the increase of Consumer involvement/leadership access to continuous training is challenging. HRSAs most recent update of the Ryan White Part A Manual has been extremely helpful but there should be additional efforts to offer national classes in	Recommend to the Ryan White Part A Project Officer the need to have more training options for Ryan White Part A Planning Councils.	

	the same manner as HUD and other federally funded projects.		
Planning Council Support	Planning Council Support does not have a national forum wherein to share best practices, and answer questions.	It would be beneficial to establish an affinity group consisting of all Planning Council Support staff which would allow for periodic communication and conference calls.	Speak with the Project Officer for the Atlanta EMA and request assistance in the development and implementation of a national affinity group.
Consumer Training	Consumers are taking a greater leadership role in the Atlanta EMA and presently there does not exist a current national "leadership development" model. Training materials for Consumers are dated and reflect "Titles" and not "Parts". This often times sends the unintended message that support does not exist for Consumer leadership.	Request technical assistance from HRSA.	A formal request will be made to HRSA to provide leadership training for Consumer members. Thought should also be given to developing a model and modules which will support both consumer training and planning council support, "train-the-trainer" opportunities.

III. Early Identification of Individuals with HIV/AIDS (EIIHA) Update

a. Activities of the EIIHA Plan that were implemented during FY14 included:

- **An updated estimate of HIV individuals** who are HIV positive and who do not know their HIV status is **9,453**. The estimate was calculated based on the number of living cases of AIDS and HIV (December 2013) **35,560** multiplied by .21/.79. This is based on the most recent formula provided by the CDC to estimate the number of unaware.
- **Activities targeting the FY14 EIIHA populations included:**
  - On-going testing in clinical and non-clinical sites:
    Outcome: Funding for counseling, testing and linkage was provided to 24 agencies.
    Challenge: Turnover in leadership positions at both the state and county level slowing program success.
  - Modification of the CAREWare database to include counseling, testing and linkage data:
    Outcome: Discussions for the modification of the CAREWare database continued along with proposed timeline between the Part A and B treatment programs.

Challenge: The Part A Database Administrator resigned and this project was put on hold. Interviews were conducted, but no candidate was identified. In addition, the Part B's database person resigned during the same time period preventing any coordinated CAREWare database changes.

Challenge: Inability to follow and report success on linkage to care in order to monitor success and identify specific areas for improvement as a result of modification of the centralized databases not being completed and no identifying information or coding being included on testing forms.

- Updating partners on availability of primary care and other core and supportive services:

  Outcome: Part A Project Officers are notified of any interruption or implementation of waiting list for services. FY15 Part A contract was modified to include "**Paragraph 35.6.** Contractor is required to notify County no less than 24 hours prior to the implementation of any cap on services, limitation of services to serving existing clients only, and/or limitation of new clients to residents of certain geographic areas" and "**Paragraph 35.7.** Contractor is required to notify other Part A service providers no less than 24 hours after the implementation of any cap on services, limitation of services to existing clients only, and/or limitation of new clients to residents of certain geographic areas.". Updates to other Part A partners are provided as indicated.
- Dissemination of information on the new Part A Health Insurance Program (HIP) including process for enrollment:

  Outcome: Part A Grantee solicited application for and awarded funding to three organizations to pay co-insurance fees for eligible clients. The referral tab in CAREWare was utilized among Part A agencies to facilitate and monitor enrollment. Process for enrollment was disseminated to all Ryan White funded agencies.

  Challenge: Almost immediately after implementation of the HIP, the Patient Access Network (PAN) Foundation began assisting eligible clients. Since Ryan White is the payer of last resort, PAN funds were utilized first and unexpended HIP funds were returned to the Grantee for redistribution. The Grantee followed the Planning Council's priority setting directions and redirected the funding to the State's AIDS Drug Assistance Program (ADAP).
- Implementation of the Patient Navigation Program to assist linkage coordinators with enrollment and retention in care:

  Outcome: Funding for patient navigators in the pilot program was approved for five (5) Part A funded primary care sites – Fulton County Department of Health and Wellness, DeKalb County Board of Health, AID Gwinnett, AID Atlanta, and Clayton County Board of Health. Patient navigators and supervisors were trained by Ciciatelli. Most patient navigators began working in September, 2014. The Southeast AIDS Education and Training Center (SEATEC) was funded as the evaluator for the pilot program.

  Challenge: One agency was not able to hire a patient navigator due to delays in setting up the position and the hiring process.
- Evaluation of unmet need data by zip code to determine locations with high community viral load to assist with focus of testing and outreach efforts along with the prioritization of Part A funding.

  Outcome: CY13 unmet need data were provided to Part A by the HIV Surveillance Office and analyzed by SEATEC. People in the Atlanta EMA

who are HIV infected, aware of their HIV status and not in care remains constant at 43%. Part A funding for medical transportation was increased in FY14 to facilitate access to treatment.

Challenge: Additional analysis of unmet need data by zip code with Prevention partners is needed to address identified populations.

- **Collaborations with other programs and agencies included:**
  - Participation of Planning Council members and Part A funded agencies continued on the DPH Community Planning Group and the Fulton County HIPP Planning Group.

    Challenge: Consistent participation among representatives is difficult due to changes in staffing and program priorities.

    Challenge: Vacancies in leadership positions for both the DPH and Fulton County programs delayed implementation of some activities. Positions are now filled.
  - Part A continued participation in conference calls for CAPUS and HIE updates.
  - Part A was limited in its assistance to Counseling, Testing and Linkage sites in verifying enrollment in primary care and monitoring of CD4 and viral load information due to vacant database position.

    Challenge: The CAREWare database modification was not completed as anticipated.
  - Part A continued its meetings with DPH and Part B leadership to implement a shared system for payment of premiums, co-pays and co-insurance for eligible clients enrolled in the ACA.

    Challenge: Delays in negotiation and contracting process with a vendor to provide the payment and monitoring process for the activities.

- **Activities of the overall EIIHA strategy included:**
  - Part A activities to promote seamless entry from CTL sites into primary care with comprehensive services to promote retention in care included:

    Outcome: Patient navigators were funded for five (5) primary care sites where linkage coordinators were placed to facilitate enrollment in primary care. Of those enrolled in the patient navigation program, 88% were African American and risk categories identified were 67% MSM and 29% heterosexual.

    Outcome: During CY14, 14,032 clients were served with 12,247 receiving primary care services; 10,511 were male; 10,979 were African American.

    Outcome: Chart reviews conducted between March-September 2014 on 1,312 clients in the Part A system indicated that 89% of clients were retained in care; 0.4% had a gap in medical visits; 94% were prescribed antiretroviral therapy; and 80% experience viral suppression.
  - Efforts to promote a coordinated system for CTL, prevention and treatment programs included co-location of patient navigators with linkage to care staff in primary care sites providing counseling and testing along with treatment services.
  - Activities to reduce health disparities and access to care was addressed by funding a comprehensive system of care geographically located throughout the EMA; funding to support the HIP to facilitate enrollment in the ACA

program; increased funding for medical transportation; monitoring of quality of care provided and evaluation of the HIV Care Continuum to identify and address areas for improvement.

b. The FY14 EIIHA Plan contributed to the goals of the National HIV/AIDS Strategy (NHAS) by conducting activities that identify, inform, refer and link HIV positive persons to**:**

1) reduce HIV infection through the provision of antiretroviral medications and risk reduction counseling in primary care sites and provision of other core services to promote retention in care;
2) increase access to care by funding geographically located primary care sites, implementation of the patient navigator program, utilizing MAI funds for the provision of primary care to African Americans and Hispanics, and increased funding for medical transportation;
3) improve health outcomes through funding for antiretrovirals and other primary care medications, medical case management, and funding of ancillary or supportive services for medical transportation, home delivered meals, peer counseling and support groups and legal assistance to address discrimination in housing and benefits; and
4) reduce HIV-related health disparities by targeting services to populations identified in analysis of epidemiological, unmet need, and utilization and quality of care data.

c. The FY14 EIIHA Plan incorporated and addressed activities surrounding the Unmet Need populations by identifying populations aware but not in care by race, gender, age, and risk factor along with geographic location by zip code to assist in the targeted counseling and testing and outreach efforts conducted by prevention and CTL funding and location of services to facilitate access to care through Part A.

- Patient navigator target populations were African American MSM and heterosexuals.
- Activities to re-engage individuals lost to care and bring them back into care (e.g., phone calls and letters after missed appointments) are part of the comprehensive provision at primary care and other core medical services in the EMA.
- Linkage to care is facilitated for individuals testing positive through Part A primary care sites, Part C early intervention clinics, and at HIV counseling and testing sites through co-location of services.

d. None.

e. Counseling and Testing data for January 1, 2013 – December 31, 2013 are included below:

i. Total number of publicly funded Test Events	**65,059**
ii. Total number of New HIV positive tests	**686**
iii. Total number of previously diagnosed HIV positive individuals	**424**
iv. Total number of new HIV positive individuals with results received	**662**
v. Total number of new HIV positive individuals linked to medical care	**311**
vi. Total number of previously diagnosed HIV positive individuals linked to medical care	**171**

vii. Total number of new HIV positive individuals who received partner services	**327**
viii. Total number of new HIV positive individuals linked and referred to prevention services	**297**
ix. Total number of new HIV positive individuals who received CD4 cell count and viral load testing	**Data not available**
x. Total number of previously diagnosed HIV positive individuals linked to and accessed CD4 cell count and viral load testing	**Data not available**

f. The three (3) target populations selected in the FY14 EIIHA Plan were: African American (AA)-MSM 15-30; AA MSM 30-45; and AA Heterosexuals.

a. Narrative:

i. Activities of the EIIHA Plan that were successfully implemented included:

- **An increase in the number of individuals** who are aware of their HIV status: 686 new positive HIV tests and 662 individuals received their test results.
- **An increase in the number of HIV positive individuals** who are in medical care through strategically placed linkage coordinators: 311 newly diagnosed and 171 previously diagnosed HIV positive individuals were linked to medical care.
- **Primary care retention rates were augmented through assistance of patient** navigators: 172 individuals participated in the patient navigation program. Services included addressing potential barriers to access and remain in care, directing questions or identified to appropriate staff, and describing available support groups and psychosocial support resources. The EMA's overall retention rate is 89%.
- **Reduce new infections** through the provision of ART: the EMA expended a total of $1,158,566 in CY14 for the provision of stop-gap medications for patients while awaiting enrollment into PAN, ADAP or other patient assistance programs. The EMA's overall viral load suppression rate is 80%.
- **Reduce HIV health-related disparities by** providing additional core medical and supportive services including medical transportation and childcare: oral health care was provided to 3,174; medical case management to 7,540; mental health services to 2,484; substance abuse outpatient services to 984; and medical nutrition services to 1,130; medical transportation services to 2,858 and psychosocial support services to 2,283.
- **An increase in collaboration and coordination** as a result of leadership in all HIV programs promoting and supporting opportunities for partnerships.

ii. Resources and partnerships that support the program successes included:

- Collaborations with the DPH Prevention Program, the Fulton County Department of Health and Wellness, DPH Surveillance Office, Parts B, C, and D grantees.
- Funding for the provision of core medical and supportive services to augment Part A funding.

iii. The major challenge faced in achieving an increase in collaboration and coordination was the staff turnover in leadership roles and the inability to rapidly recruit and hire staff and the training necessary for new staff.

b. All EIIHA Plan activities were successfully implement; however, as stated above staff turnover was a major challenge in maintaining and increasing collaboration and coordination.

g. Presentations or dissemination of the EIIHA Plan was provided to the Metropolitan Atlanta HIV Health Services Planning Council's Comprehensive Plan, Assessment and Quality Management Committees. The FY14 Progress Report will be shared with the full Planning Council at its July meeting.

IV. Administration Final Expenditures

A comparison of the approved Part A and MAI Administrative budget by Object Class Categories (personnel/fringe/travel/equipment/supplies/contractual etc.) with the actual expenditures along with an explanation of proposed administrative costs that were less has been uploaded in the EHB.

V. Certification of Aggregate Administrative Costs

The Certification of Aggregate Administrative Costs, signed by the Fiscal Officer, has been uploaded in the EHB. The Aggregate Administrative Expenditure percentage is 5.5%.

VI. Technical Assistance

a. **Technical Assistance Received –** None received.

b. **Technical Assistance Needed -** Identify HRSA technical assistance support that will help you address the challenges described in I-d., II-b. and III-a).

Throughout the jurisdiction agencies and organizations are challenged in relinking individuals who have been lost to care back into care. Current interventions have not proved sufficient in compelling these clients into choosing to return to care, and the hours invested by staff have not translated to a high return on the investment. It would be useful to have a better understanding of the predictors which would provide insight into those least likely to return to care so that an abbreviated linkage effort could be employed to provide education and information on how the client can be assisted when (s)he is ready.

VII. FY 2014 Women, Infants, Children and Youth (WICY) Report – This report, which demonstrates that the EMA has used a proportionate amount of grant dollars to provide services to women, infants, children and youth (WICY) living with HIV/AIDS has been submitted in the EHB.

VIII. Local Pharmacy Assistance Program (LPAP) Summary – Not applicable as the EMA dis not allocate funds to LPAP.

Appendix 1: Ryan White HIV/AIDS Program Part A Final Certification of Aggregate Administrative Costs has been submitted in the EHB.