
**2009-2010
Arkansas
Statewide Coordinated
Statement of Need
&
Comprehensive Plan**

HIV/AIDS Services Planning Document



**Arkansas Department of Health
Center for Health Protection
HIV/STD/Hep C Section
HIV Services Program**

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Section One: Where Are We Now?

Statement of Need

Language in Section 2617 (b) (6) of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) requires grantees to develop a Statewide Coordinated Statement of Need (SCSN). The SCSN planning process provides a collaborative mechanism to identify and address significant care and treatment issues related to the needs of people living with HIV and AIDS (PLWH/A), and to maximize coordination, integration, and effective linkages across all Ryan White Program Parts.

The SCSN also supports the planning and delivery of HIV care services in the state of Arkansas. The SCSN plays a valuable role in the comprehensive planning process by discussing key factors affecting care and service delivery, identifying cross-cutting issues and supporting the development of goals, measurable objectives and resource allocation decisions by the Ryan White Program grantees, planning groups and providers.

Arkansas' 2009 Statement of Need is organized into the following sections:

- *Developing Arkansas' Statewide Coordinated Statement of Need*—a description of participants and the collaborative process we used;
- *Arkansans living with HIV/AIDS*—a description of the latest trends in HIV epidemiology statewide and a discussion of emerging service populations and populations with special needs;
- *Unmet Need in Arkansas*—an estimation of the number of PLWH/A in Arkansas who are aware of their infection, but not receiving medical care, and information about people who receive their HIV diagnosis late in the course of their disease;
- *Arkansas Continuum of Care for PLWH/A*—a description of services currently provided to PLWH/A statewide; clinical outcomes and resources available;
- *Cross-Cutting Core Service Issues and Goals*—important service issues identified by the SCSN workgroup and shared goals related to those issues;

Developing the Arkansas SCSN

The Arkansas Department of Health (ADH) HIV Services Program (the Part B grantee) was responsible for convening partners across the Ryan White continuum of care, facilitating the development/update of the SCSN, and submitting the SCSN to the Health Resources and Services Administration (HRSA). The SCSN Work Group included representatives of all Ryan White grantees, PLWH/A and public agency representatives.

Prior to the SCSN Work Group meeting, all of the Ryan White Program Grantees submitted Summary Reports that provided an inventory of services provided, number of clients served, client demographics, number of units of service delivered and service costs. The SCSN Work Group met on December 12, 2008 and reviewed client utilization data, epidemiologic data, unmet need estimation data, clinical outcomes data and resources available in the state prior to undertaking an in-depth facilitated discussion of needs, gaps, cross-cutting issues and proposed broad goals for the delivery of HIV services in Arkansas.

SCSN Work Group Members:

Name	Agency
Bob Coffey	Consumer
Melvin Watson	Consumer
Steve Thomas	Consumer
Alma Prather Sledge	Friends for Life Corporation
Mike Melancon	Ft. Smith Fights AIDS (Part B)
Dr. Michael Moore, PhD	White River Rural Health (Part C/D)
Dr. Michael Cannon, MD	Arkansas AIDS Foundation (Part B)
Jon Allen, PA	University of Arkansas Medical School (HIV Clinic)
Cherry Whitehead-Thompson	Eastern Arkansas Family Health Center (Part A, Part B, Part C)
Debbie Biazio	NARAN (Part B)
Dr. Angela Smith	JCCSI (Part B, Part C)
Dorcas Young	Memphis TGA Grantee (Part A)
Derrick Newby	AETC/JCCSI
Dr. Michelle Smith	JCCSI (Part D)
Willie Rhodes	ADH, HIV Prevention
Alisha Smith, PharmD	HealthCare Pharmacy
Shari Robbins	JCCSI (Part C)
Bill Rodgers	Rural Health/Primary Care
Gail Gannaway	ADH-HIV/STD
Kevin Dedner	ADH-HIV/STD
Tiyanika Keller	ADH-HIV/STD
Tere Roderick	ADH-HIV/STD
Kim Newsom	ADH-HIV/STD
Andrea Bolan	ADH-HIV/STD
Donna Yutzky	Consultant/Facilitator

Overview of HIV/AIDS in Arkansas

HIV/AIDS Epidemiological Information ¹

¹ The source for the HIV and AIDS information is the *Arkansas HIV/AIDS Reporting System Database*.

- **HIV and AIDS incidence in Arkansas during CY 2006 and 2007**

A total of 686 new cases of HIV (HIV incidence) were reported to the Health Department in calendar years 2006 and 2007; this included 340 new cases in 2006 and 346 in 2007. At the same time, a total of 407 new cases of AIDS (AIDS incidence) were reported to the Health Department; 212 new cases in 2006 and 195 new cases in 2007. These cases were also reported to the Centers for Disease Control and Prevention. Comparing to the previous two years (2004 and 2005), HIV incidence in 2006 and 2007 increased by 1.8%, and AIDS incidence decreased by 3%.

- **Cumulative HIV prevalence in Arkansas**

As of 12/31/2007, HIV (not AIDS) prevalence was 2,594; this was an increase of 7.6% from 2006 (no. of cases- 2,411).

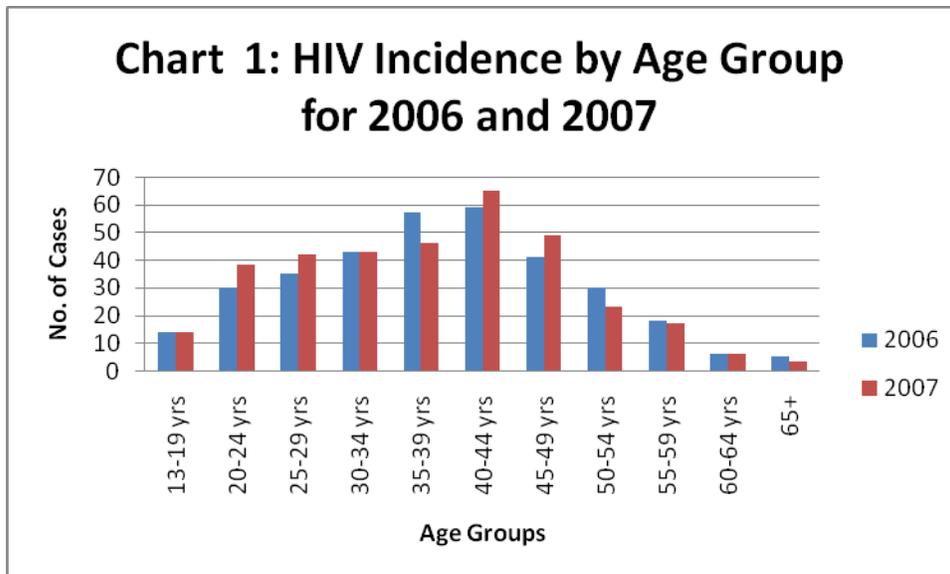
- **Cumulative AIDS prevalence in Arkansas**

As of 12/31/2007, AIDS prevalence was 2,466; this was an increase of 6.4% from 2006 (no. of cases- 2,318).

Demographic Distribution of Newly Diagnosed HIV cases for 2006 and 2007

Gender: Males had significantly higher number of cases than females in 2006 and 2007. In 2006, 66.5% of HIV cases were among males (n=226, total=340), and the cases increased to 77% among males in 2007 (n=266, total=346). A subsequent decrease (11%) in cases among females from 2006 to 2007 is noted (34% to 23%).

Age Groups: An increase in the number of cases is observed in the age groups of 20-29 years and 40-49 years (Chart 1). The 20-29 year group contributed to 19% of total HIV cases in 2006 (n=65, total=340) and 23% of total HIV cases in 2007 (n=80, total=346) -- a 4% increase in this age group. The 40-49 year group contributed to 30% of total HIV cases in 2006 (n=100, total=340) and 33% of total HIV cases in 2007 (n=114, total 346) - - a 3% increase in this age group. The rest of the age groups showed either a decrease or a steady number of HIV cases.



Race: Whites had the same rate of HIV cases in 2006 and 2007, i.e., 39% of the total HIV cases. Blacks had a decrease in HIV cases from 2006 (n=173, total=340; 51%) to 2007 (n=151, total=346; 44%) – a 7% decline in cases from the total HIV cases. On the other hand, cases among Hispanics and other/unknown race category have increased; for Hispanics, an increase of 2% of total HIV cases from 2006 (n=20, total=340; 6%) to 2007 (n=27, total=346; 8%); for other/unknown race category, an increase of 5% of total HIV cases from 2006 (n=15, total=340; 5%) to 2007 (n=34, total=340; 10%).

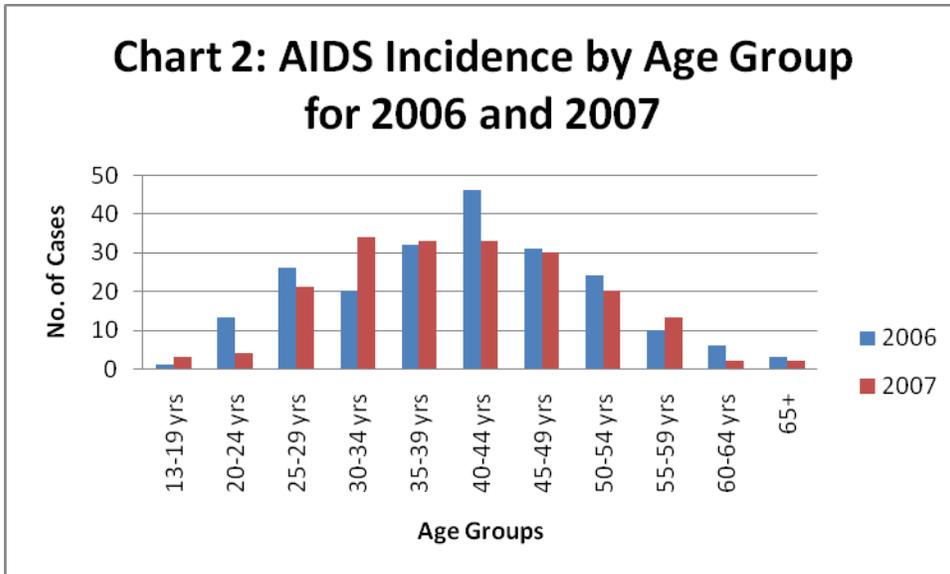
Geographic Distribution of Newly Diagnosed HIV cases for 2006 and 2007

Five of the 10 counties with highest case-rates for new HIV cases in 2007 were also ranked highest in 2006. Ouachita and Union counties being neighboring areas in the southwest region of the State were two of the highest HIV incidence counties in 2006 and 2007; the other 3 counties were scattered in the central (Pulaski county), northwest (Carroll county), and southeast (Monroe county) regions of the State. The five counties itself contributed to 38% of new cases in 2007 and 37% of new cases in 2006.

Demographic Distribution of Newly Diagnosed AIDS cases for 2006 and 2007

Gender: Males had significantly higher number of AIDS cases than females in 2006 and 2007. In 2006, 72% of AIDS cases were among males (n=153, total=212), and the cases increased to 74% in 2007 (n=144, total=195). A subsequent 2% decrease in cases among females from 2006 to 2007 is noted (28% to 26%).

Age Groups: A significant increase in the number of cases is observed in the age groups of 30-39 years and 55-59 years (Chart 2). The 30-39 year group contributed to 25% of total AIDS cases in 2006 (n=52, total=212) and 34% of total AIDS cases in 2007 (n=67, total=195) -- a 9% increase in this age group. The 55-59 year group contributed to 5% of total AIDS cases in 2006 (n=10, total=212) and 7% of total AIDS cases in 2007 (n=13, total 195) -- a 2% increase in this age group. AIDS cases in the rest of the age groups showed either a decrease or a relatively steady number of cases.



Race: Whites had 11% decline in AIDS cases from 2006 (n=95, total AIDS cases=212; 45%) to 2007 (n=67, total AIDS cases=195; 34%). Blacks had an increase in AIDS cases from 2006 (n=103, total=212; 49%) to 2007 (n=108, total=195; 55%) – a 6% increase in cases from the total AIDS cases. Percentage of cases among Hispanics and other/unknown race category also increased; for Hispanics, an increase of 3% of total AIDS cases from 2006 (n=9, total=212; 4%) to 2007 (n=13, total=195; 7%); for other/unknown race category, an increase of 2% of total AIDS cases from 2006 (n=5, total=212; 2%) to 2007 (n=7, total=195; 4%).

Geographic Distribution of Newly Diagnosed AIDS cases for 2006 and 2007

Four of the 10 counties with highest case-rates for new AIDS cases in 2007 were also ranked highest in 2006. Crittenden and St. Francis counties that are neighboring areas in the Delta region of the State were two of the highest AIDS incidence counties in 2006 and 2007; the other 2 counties were located in the central (Pulaski county) region and southwest (Union county) regions of the State. The four counties itself contributed to 47% of new cases in 2007 and 41% of new cases in 2006.

Trends and Changes of HIV/AIDS Cases in Arkansas

The number of people living with HIV/AIDS cases have steadily increased since the Arkansas Department of Health began receiving and recording data in 1984 (Chart 3). The cumulative total of HIV/AIDS reported cases from the inception through 2007 is 7,133 cases, which also included 62% (n=4,383) of reported AIDS cases (both living and dead); and the cumulative total of HIV/AIDS cases in this time period was 6,784. There was an increase of 5.1% of total reported HIV/AIDS cases from 2005 to 2006 and an increase of 5.2% of reported cases from 2006 to 2007. Approximately 62% of the cumulative total for 2006 and 2007 met AIDS case definition.

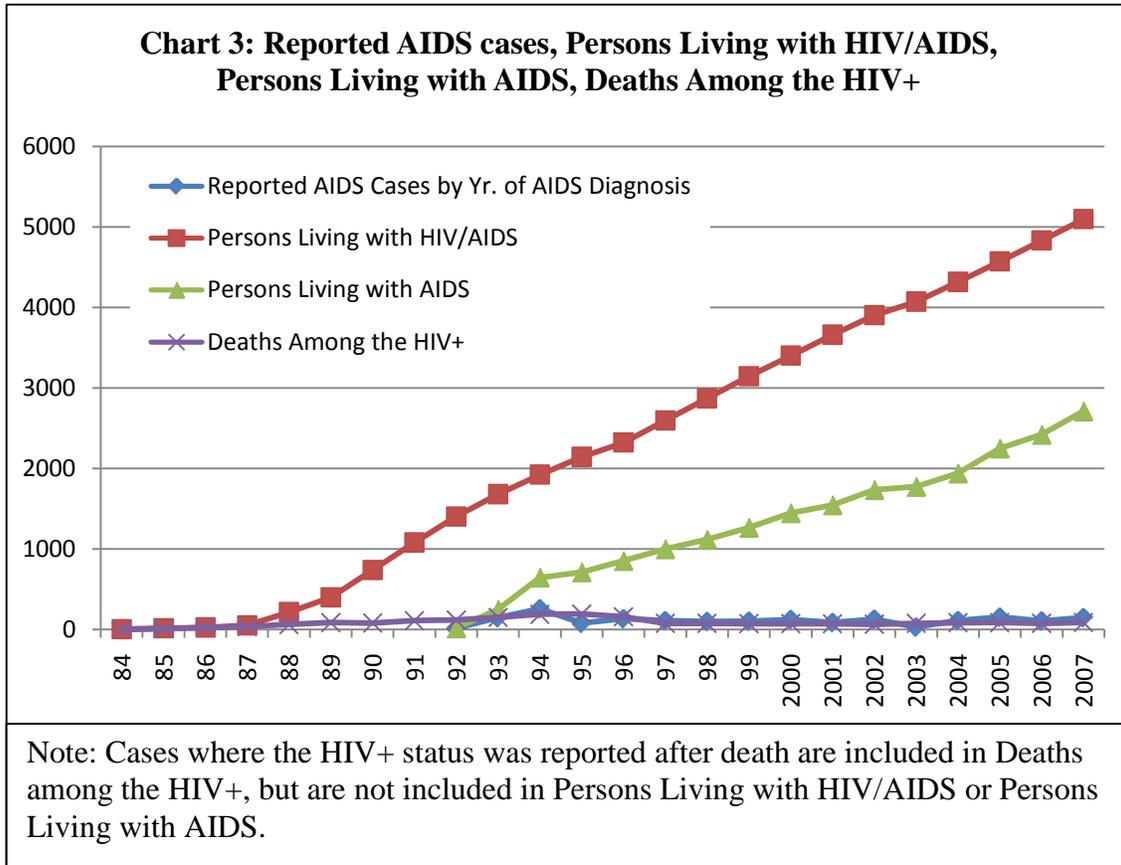


Chart 4 shows that although Whites comprise of 76% of Arkansas' (AR) general population, they comprised of only 40% of newly diagnosed HIV/AIDS cases in 2007 (n=136; total=340). On the other hand, Blacks comprise only 16% of AR population, but had 45% of new HIV/AIDS cases in 2007 (n=153; total=340). Hispanics and other race category comprise of 8% of AR population, but had 15% of new HIV/AIDS cases (n=51; total=340). More number of White people (52%) is living with HIV/AIDS compared to Blacks (43%), Hispanics (3%), or other races (2%) as of 2007.

Table 1 shows the change in population-adjusted case rates of people living with HIV/AIDS by Arkansas counties as of 2007 compared to 2006. The counties with highest case-rates remained almost the same for 2007 and 2006. In 2006, 39 highest living HIV/AIDS case-rate counties showed an increase in cases from 2005. However in 2007, among the 39 highest living HIV/AIDS case-rate counties, couple of counties showed a decline and seven counties showed no change in case-rates. There was an increase of 5.5% living HIV/AIDS cases from 2006 to 2007. There were 15 states more than the state average case-rate for both 2006 and 2007. The average case-rate for living cases of HIV/AIDS in the State was 165.4 in 2006, and 174.5 for 2007.

Chart 4: Population Comparison for 2007: General Population, Newly Diagnosed HIV/AIDS Cases, and Persons Living with HIV/AIDS

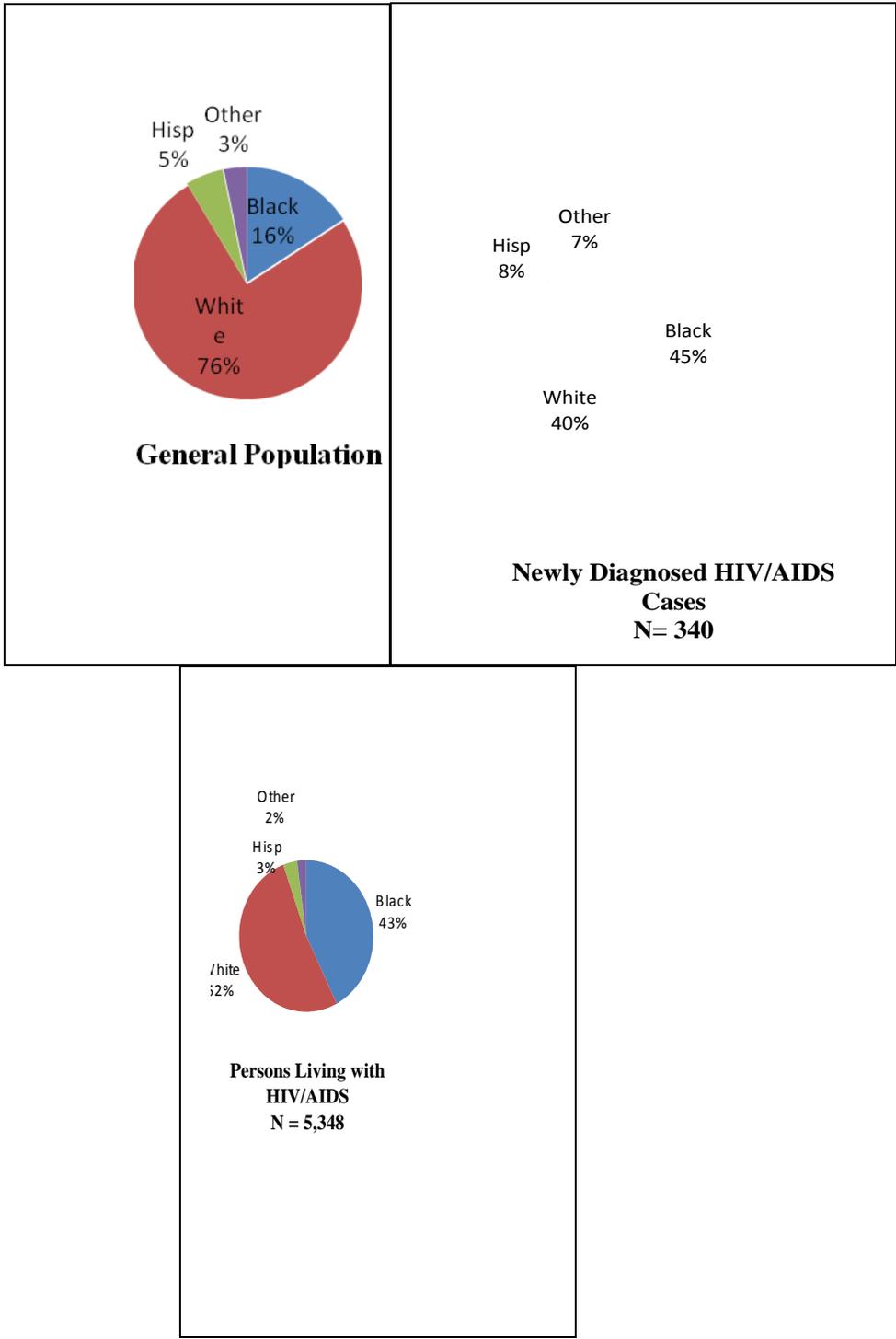


TABLE 1: POPULATION-ADJUSTED CHANGE IN CASE RATES OF PEOPLE LIVING WITH HIV/AIDS BY ARKANSAS COUNTIES AS OF DECEMBER 31, 2007 COMPARED TO AS OF DECEMBER 31, 2006

The Prevalence Rate of People Living with HIV/AIDS by Arkansas Counties as of December 31, 2007			% Change in Case Rate/100,000
COUNTY	No. of Cases	Rate/100,000	
PULASKI	1694	461.2	↑5.7%
CRITTENDEN	235	451.2	↑5.4%
UNION	164	371.3	↑6.5%
ST FRANCIS	89	323.2	↓1.1%
PHILLIPS	69	295.7	↑4.5%
MILLER	123	285.7	↑3.4%
MONROE	23	252.9	↑4.5%
JEFFERSON	186	230.6	↑8.8%
OUACHITA	57	213.4	↑9.6%
WASHINGTON	383	205.3	↑6.1%
GARLAND	195	204.9	↑4.8%
SEBASTIAN	243	202.0	↑3%
CHICOT	25	193.6	↑4.2%
MISSISSIPPI	90	189.4	↑2.3%
CARROLL	49	179.2	↑11.4%
LEE	19	167.0	No change
DESHA	22	155.1	↑22.2%
HEMPSTEAD	36	154.2	↑5.9%
CRAIGHEAD	127	143.9	↑7.6%
COLUMBIA	32	130.9	↑6.7%
NEWTON	11	130.8	↑10%
LITTLE RIVER	16	122.4	No change
ARKANSAS	24	120.7	↓7.7%
CLARK	27	117.8	No change
CROSS	22	115.4	↑4.8%
ASHLEY	24	105.1	↑9.1%
LAFAYETTE	8	101.3	No change
BRADLEY	12	99.1	No change
GREENE	39	97.3	↑21.9%
CONWAY	20	96.6	No change
NEVADA	9	95.0	↑12.5%
SEVIER	15	92.0	↑15.4%
INDEPENDENCE	32	91.7	↑3.2%
CALHOUN	5	90.0	No change
CRAWFORD	51	86.8	↑4.1%
POPE	50	86.7	↑4.2%

MONTGOMERY	8	86.3	↑14.3%
BAXTER	33	79.9	↑6.5%
HOT SPRING	25	78.8	↓7.4%
WHITE	57	78.6	↑5.6%
HOWARD	11	76.3	No change
STONE	9	75.1	↑12.5%
BENTON	145	74.0	↑6.6%
POINSETT	18	71.8	↑28.6%
FAULKNER	72	71.5	↑9.1%
FRANKLIN	13	71.1	↓7.1%
DREW	13	70.7	No change
YELL	15	68.7	↑7.1%
WOODRUFF	5	63.3	No change
JACKSON	11	63.1	↑10%
SEARCY	5	61.9	No change
IZARD	8	59.9	No change
DALLAS	5	59.9	No change
POLK	12	58.9	↑9.1%
LINCOLN	8	56.6	No change
PRAIRIE	5	56.0	No change
PIKE	6	55.3	↑20%
BOONE	20	54.9	↑5.3%
SALINE	50	53.2	↑4.2%
MARION	9	53.2	No change
MADISON	8	52.1	No change
SHARP	9	50.1	↑12.5%
LOGAN	11	48.0	No change
LONOKE	30	47.7	↑11.1%
SCOTT	5	43.8	No change
CLAY	7	42.4	↑16.7%
GRANT	7	40.0	↑16.7%
CLEBURNE	10	39.2	No change
RANDOLPH	7	37.9	No change
VAN BUREN	6	35.9	↑20%
FULTON	3	25.5	No change
JOHNSON	6	24.5	No change
CLEVELAND	2	22.6	No change
PERRY	2	19.2	No change
LAWRENCE	3	17.8	No change

Unmet Need

The objective was to determine the HIV and AIDS patients in Arkansas as of 12/18/2006 who are “in care” and “out of care” between 12-18-2006 and 12-18-2007. “In-Care” is defined as anyone who received CD4 count, viral load count, or treatment in a specific time period; and “Out-of Care” is defined as anyone who hasn’t received the above mentioned services.

Estimation Methods

The *HIV and AIDS Reporting System* (HARS) database was linked to the *LAB CD4*, *LAB Viral Load*, and the *CAREWare* databases.

Source	Observations
HARS	5117
CAREWare	1163
LAB CD4	1793
LAB Viral Load	973

Matching was carried out using two methods.

1st Method

The three databases (LAB CD4, LAB Viral Load, and CAREWare) were concatenated to a single file using the SAS software. A multi-stage stepwise matching and un-matching approach was used by four steps of variable combination. The four steps were as follows:

1. First Name, Last Name, and Date of Birth
2. Soundex of First Name, Soundex of Last Name, and Date of Birth
3. Soundex of Last Name, Soundex of Middle Initial, and Date of Birth
4. Soundex of First Name, Soundex of Middle Initial, and Date of Birth

2nd Method

Matching the HARS database with each of the three databases (LAB CD4, LAB Viral Load, and CAREWare) using Microsoft ACCESS software. The variables involved Last Name, and Date of Birth.

Assessment of Unmet Need

Both methods yielded same results with exact number of matches. The total number of HIV (2,638) and AIDS (2,480) as of 12/18/2006 was 5,117. The total number of HIV and AIDS patients in Care determined by the number of matches was 1,760 (34.4%); and the patients out-of Care as determined by the number of non-matches was 3,357 (65.6%)

Current Service Delivery System

The Arkansas Department of Health (ADH) contracts with four (4) consortia districts (ConsortiaCARE of Arkansas) to provide statewide coverage to persons with HIV/AIDS. Each consortium determines clients' eligibility for the Arkansas HIV Services Program. Program services include primary medical care, HIV related medications, mental health treatment, substance abuse treatment, oral health, case management, and support services. Consortia make appropriate referrals and assist with scheduling appointments.

The Department of Health contracts directly for physician, oral health and pharmacy services. ADH operates ninety-four (94) local health units in all seventy-five (75) counties of Arkansas. Twenty-two Public Health Investigators (PHI) provide diagnostic, partner notification/referral, and treatment services to individuals with STDs. The PHI staff provides referral for HIV positive clients in their counseling, testing and partner notification activities.

The HIV Services Section continues to administer the HOPWA (Housing Opportunities for Persons with AIDS) program. Arkansas Supportive Housing Network (ASHN) and Northeast Arkansas Regional AIDS Network administer short-term rental assistance, long-term housing assistance and utility assistance under a sub-grant agreement with ADH.

District I encompasses Pulaski, Lonoke, and Prairie counties. The Arkansas AIDS Foundation (AAF) provides Ryan White Part B care and services. There are 4 FTE of case management available for 388 clients. HIV care is available from the Jefferson Comprehensive Care System, Inc. (JCCSI) at a satellite clinic in College Station, the UAMS Infectious Diseases Program, and several private practice physicians. JCCSI is the grantee managing Part C (clinical HIV care and early intervention services) and Part D (services for women, infants and youth).

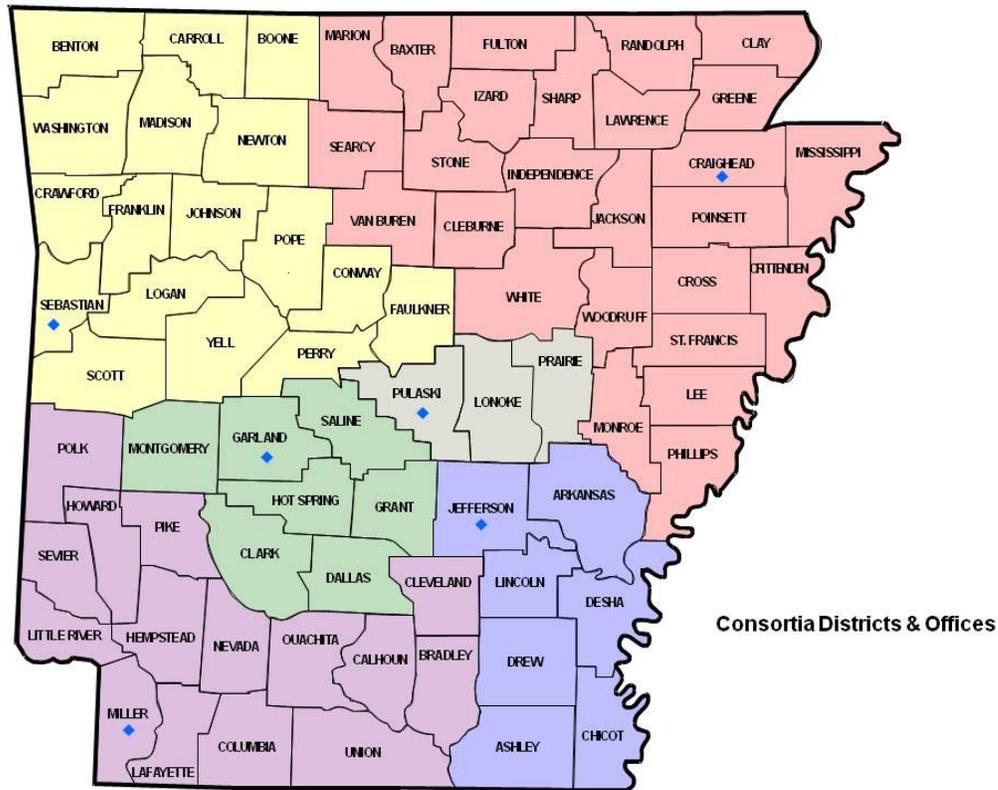
District II spans thirty-nine (39) counties (52% of Arkansas' 75 counties) in the western half of the State. Fort Smith Fights AIDS is the lead agency for Part B and provides access points with case management and supportive services available in offices in Fort Smith, Hot Springs and Texarkana. There are 4 FTE of case management available for 440 clients. HIV care is provided through the Area Health Education Centers (AHEC) in Fort Smith, Fayetteville, El Dorado and Texarkana and a network of public and private practice physicians throughout the Northwest part of the state.

District III covers seven counties in Southeast Arkansas. Jefferson Comprehensive Care Systems, Inc. (JCCSI) is the lead agency for Part B and has Part C and Part D funded programs. One FTE case manager provides services to 80 clients. JCCSI and other public and private practice physicians provide HIV care in the district.

District V covers twenty-six (26) counties in North Central/Northeast Arkansas. Northeast Arkansas Regional AIDS Network (NARAN) is the lead agency for Part B. Four FTE of case management provide services to 291 clients. Two (2) community health

centers are located in White and Crittenden counties. White River Rural Health Center has both Part C and Part D funded programs. White River Rural Health Center also has several satellite offices. The East Arkansas Family Health Center has Part A and C programs and is located in West Memphis.

Arkansas HIV Service Districts and Current Access Centers



Access to HIV Care and Treatment

People Living With HIV/AIDS in Arkansas Access to Care

On April 14, 2008, there are 5,221 people living with HIV/AIDS in the Arkansas HARS database. There are 1,190 active clients reported in the Part B database (CAREWare).

This represents 22.8% of people living with HIV/AIDS in Arkansas.

(As a point of reference, Oregon’s HIV Care & Treatment program reports 68% of people living with HIV/AIDS in the service area in Ryan White Program-funded HIV Medical Case Management and the Maine Part B Grantee reports 59% of people living with HIV/AIDS in the state are enrolled in the Part B program.)

CAREWare (CW) client payer status	% of clients in CW	Number of clients in CW²
Medicare	25%	298
Medicaid	16%	191
Privately insured	12%	143
Uninsured	47%	560

Current lab data:

Data Source	Dates	# Clients Receiving at least one lab	Total # Clients	% who had at least one lab
CAREWare (client in Part B CM) values entered	1/1/07 – 4/14/08	921	1,193	77%
Surveillance (statewide PLWH/A)	1/1/07 – 4/14/08	3,483	5,221	67%
Surveillance (statewide newly reported HIV+)	1/1/07 – 4/14/08	327	447	73%

² Numbers rounded up, will not add up to 100%.

Health of PLWH/A in Arkansas

Seven (7) Part B programs participated in an eighteen month HRSA quality management demonstration collaborative in 2005-2006 to look at collecting, trending and acting upon health outcomes data. The following chart shows how Arkansas' client-level health outcomes compare to these other states:

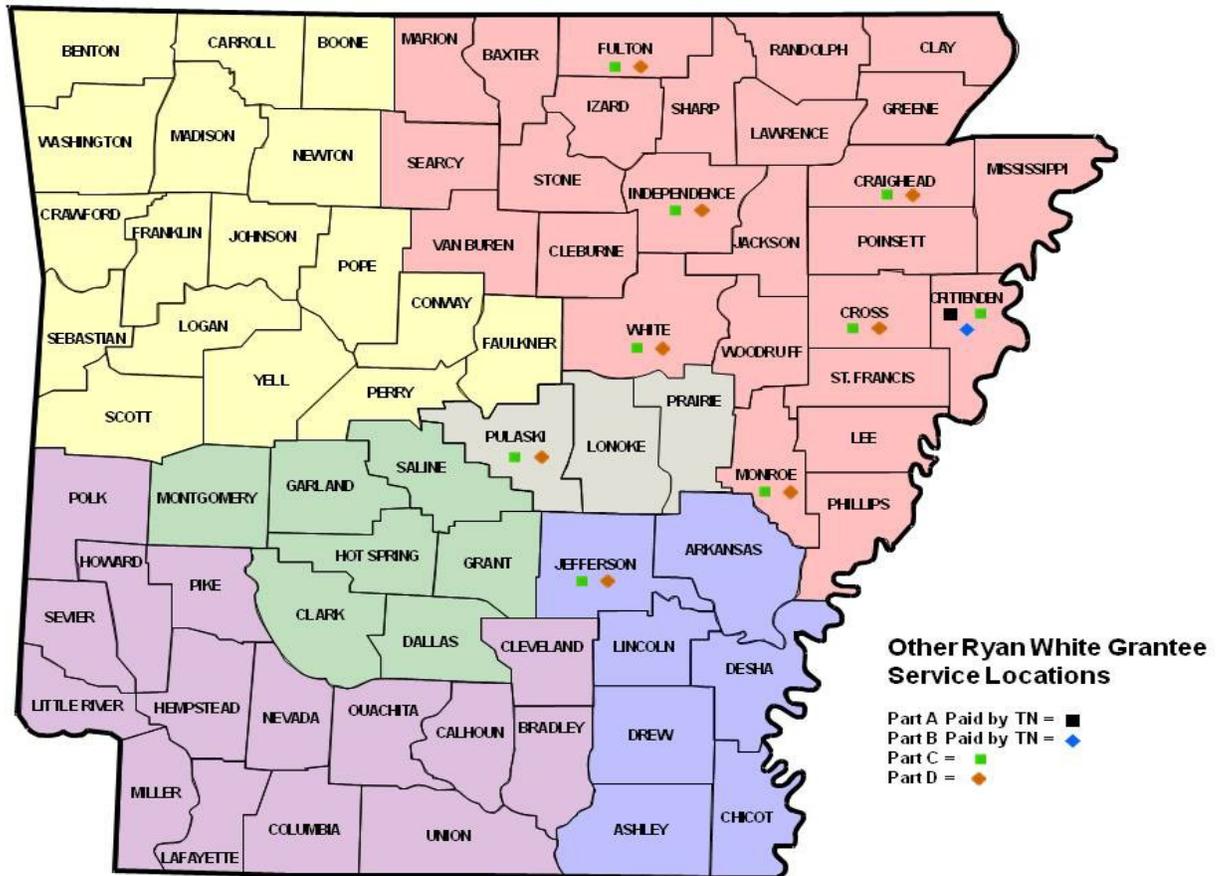
State	Newly reported HIV who also had an AIDS diagnosis within CY 2007	Newly reported HIV who progress to AIDS within 12 months of diagnosis	Newly reported HIV who die within 12 months of diagnosis
Alabama	29%	31%	2.7%
Florida	12%	22%	2%
Georgia	37%	24%	4.1%
Michigan	28%	33%	Not reported
Missouri	15%	18%	4%
Ohio	21%	16%	4%
Oregon	23%	19%	3.5%
Average	23.5%	23%	3.4%
Arkansas	32%	46%	5%

Another indicator of health outcomes is the percentage of clients with reported labs within the previous 12 months who have a viral load of 10,001 and above or a CD4 of 199 and below (both markers of disease progression.)

- Forty percent (40%) of people living with HIV/AIDS in Arkansas who had a viral load test reported in the past 12 months have a viral load of 10,001³ and above.
- Fifty percent (50%) of PLWH/A who had a CD4 test during the same period had a value of 199 or less⁴.

³ Data unavailable from other Part B states, except Oregon = 19%.

⁴ Data unavailable from other Part B states, except Oregon = 29%.



PLWH/A In The Ryan White Program in Arkansas

In 2007, Part B reports 1,194 unduplicated clients received care, with 294 new clients. Within the Part C programs: (1) White River Rural Health Center (WRRHC) reports 190 unduplicated clients, and 40 new clients; (2) East Arkansas Family Health Center (EAFHC) reports 128 unduplicated clients, and 18 new clients and (3) Jefferson Comprehensive Care System, Inc. (JCCSI) - Part C and Part D combined - reports 443 unduplicated clients, with 111 new clients, representing a 13.26% increase over 2006.

Client Characteristics

	Part B	WRRHC	EAFHC	JCCSI
Sex				
Male	75.5%	66%	22%	68.6%
Female	24.4%	32%	78%	30.7%
Race/ Ethnicity⁵				
White	50%	59.5%	13%	18.9%
AA	42.4%	33%	85.9%	75.4%
Hispanic	4%	5.3%		3.6%
AI/AN	<1%		<1%	<1%
Asian/PI	<1%			

	Part B	WRRHC	EAFHC	JCCSI⁶
Age⁷				
<2	<1%	0		
2-12	<1%	6.8%	<1%	2%
13-24	3.8%	9.5%	3.9%	1.6%
25-44	51%	56.8%	56%	41%
45-64	42.8%	26%	39%	54%
65+	1.4%			3%
	Part B	WRRHC	EAFHC	JCCSI
Mode of Exposure - Males⁸				
MSM	61.6%	36.5%	28.7%	45%
IDU	6.4%	11.9%	6.8%	9%
MSM/IDU	5%	3.2%	2.7%	4.6%
Hemophilia	<1%	<1%		
Heterosexual	25%	16.7%	54.7%	36%
Transfusion	<1%			<1%
Perinatal	<1%			
Other	<1%		2.7%	<1%
NS	<1%			

⁵ Blank boxes mean that no data was reported.

⁶ Combined Part C and Part D

⁷ Blank boxes mean that no data was reported.

⁸ Blank boxes mean that no data was reported

<i>Mode of Exposure - Females</i>				
IDU	12.7%	19%	5.4%	6.6%
Hemophilia		1.6%		<1%
Heterosexual	85.6%	43.5%	89%	84.6%
Transfusion				
Mother with/at risk				8% ⁹
Perinatal	1.4%			
Other	<1%			2.9%
NS	<1%			
<i>Income</i>				
<100% FPL	61.6%	82%	93%	93.6%
101-200%	29%	11.6%	6%	5.4%
201-300%	7.5%	2%	<1%	<1%
>300%	1.8%	1%		<1%
Unknown	<1%			
<i>Insurance</i>				
Private	12%			
Medicare	25%			
Medicaid	16%			
Other Public	1.2%			
No Ins.	45%			

⁹ Category included “Mothers with/at risk prenatal transfusion”

Key Services Delivered

Services Provided CY 2007	\$ Amount	# Units	# Clients
<i>Core Services</i>			
Outpatient/Ambulatory Outpatient	\$1,429,805.81	5387	999
Pharmaceutical Assistance	\$4,333,486.42	31,206	538
Substance Abuse Outpatient ¹⁰	\$6,562 ¹¹	435	249
Oral Health Care	\$390,967.52	704	368
Medical Nutritional Therapy	\$13,795.89	202	88
Health Insurance Premium Payment ¹²	\$373,117.25	1,774	257
Home Health Care	-	-	-
Hospice Services	-	-	-
Mental Health Services	\$17,932.04	374	282
Early Intervention Services	-	-	-
Medical Case Management ¹³	\$135,724	7,764	662
<i>Support Services</i>			
Non-Medical Case Management	\$593,923.42	24,795	1,271
Child Care Services	\$300		1
Emergency Financial Assistance ¹⁴	\$1,000		2
Food bank/home-delivered meals	\$38,934.93	859	151
Health Education/Risk Reduction ¹⁵	\$2,000	-	145
Housing Services	-	-	-
Legal Services	-	-	-
Linguistics Services	-	-	-
Medical Transportation Services	\$42,904.73	913	415
Outreach Services	\$296,335	-	295
Psychosocial Support Services	\$38,985.95	-	398
Rehabilitation Services			
Respite Care			
Substance Abuse - Residential			
Treatment Adherence Counseling			
Other (identify) Consumer Involvement	\$1,400		48
Other (identify)			

¹⁰ JCCSI only agency reporting.

¹¹ JCCSI – Part C & Part D combined.

¹² Part B funded only

¹³ Part C funded only

¹⁴ WRRHC only agency reporting.

¹⁵ WRRHC only agency reporting.

Arkansas AIDS Education and Training Center

The Arkansas AETC provided training to 1,027 trainees (814 providers) from July 1, 2007 – June 30, 2008; including Level I, Level II, Level III, Level IV, and Multi-levels.

Clinical Outcomes

Performance Measure	Provider	2004	2005	2006	2007
Percentage of clients with HIV infection who had 2 or more CD4 t-cell counts performed.	<i>WRRHC</i>		53%	48%	52%
	<i>EAFHC</i>	50%	48%	47%	53%
	<i>JCCSI</i>	34.8%	34%	54.4%	54.4%
Percentage of clients with AIDS who are prescribed HAART.	<i>WRRHC</i>		85%	89%	92%
	<i>EAFHC</i>	11%	19%	30%	52%
	<i>JCCSI</i>	76.9%	75.6%	82.6%	96.6%
Percentage of client with HIV infection who had 2 or more medical visits in an HIV care setting.	<i>WRRHC</i>		73%	68%	61%
	<i>EAFHC</i>	57%	55%	57%	60%
	<i>JCCSI</i>	71.7%	92.2%	92.4%	100%
Percentage of clients with HIV infection & a CD4 t-cell count below 200 cells/mm prescribed PCP prophylaxis.	<i>WRRHC</i>		85%	88%	92%
	<i>EAFHC</i>	N/A	N/A	N/A	N/A
	<i>JCCSI</i>	92.3%	75.7%	92%	96.2%
Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy.	<i>WRRHC</i>		N/A	N/A	N/A
	<i>EAFHC</i>	N/A	N/A	100%	67%
	<i>JCCSI</i>	N/A	N/A	N/A	N/A

Resources

	Part B	Part C/D	AETC
2007	\$7,901,902	\$1,751,350	\$195,000
2008	\$8,514,863	\$1,910,437	\$169,200

Cross-Cutting Issues and Gaps in Service

Barriers for PLWH/A not in care

Arkansas HIV Services Program currently estimates that 65.6% of people living with HIV/AIDS in the state are not in care. Barriers to accessing care include: (1) lack of payers for medical care, (2) lack of primary care providers with expertise in HIV treatment, (3) lack of information about Ryan White funded services in the state, (4) lack of access centers to Ryan White funded services in the state (currently there are only 6 access centers to Ryan White Part B services in the entire state, including ADAP), (5) stigma related to HIV and fear of disclosure within the African American and Hispanic communities, in particular, (6) belief that HIV is a “death sentence” and there is nothing

that can be done, (7) fear of treatment within the African American community, and (8) very high levels of substance use so people living with HIV who are also actively using are not motivated to seek out medical care.

Clients who have previously been in care and dropped out may find the administrative process to re-enter the care system to be burdensome or confusing. As with many health care programs, there are multiple documentation requirements for clients to access Ryan White care and services. Providers must have enough personnel resources to be able to assist clients in navigating the paperwork requirements. Feeling of personal failure may make it difficult for some clients who have dropped out of care to re-enter the care system. Asymptomatic clients may not feel compelled to seek services, especially in light of the shift toward thinking of HIV as a long-term chronic illness. Clients may find the medical system is overwhelming and drop out of care. Additionally, clients experiencing substance abuse and mental health problems, competing priorities, poverty, and homelessness and depression with feelings of helplessness and hopelessness will find it more difficult to re-engage in care. Finally, dealing with a long-term chronic disease can result in episodic burn-out and clients will drop in and out of care if they don't receive ongoing support services that promote self-management of a chronic disease.

Injection Drug Users and Substance Use/Abuse PLWH/A who are injecting drug users or who have other substance use problems and are in primary medical care require high levels of case monitoring and service coordination to reduce the interference of their drug use with HIV care adherence. Substance abuse treatment programs frequently do not have specific protocols and training to guide treating clients with HIV diagnoses and a need for pain management (medically prescribed). As both substance use and HIV are life-threatening chronic conditions, access to appropriate services must be assured for extended periods of time, and treatment must be adjusted to varying levels of acuity over time. Whether or not they are actively using, these PLWH/A need expedited access to detoxification and other substance abuse treatment services, as their readiness to engage in treatment may change dramatically over time. Persons in this population require primary treatment by specialists who understand the dynamics of both illnesses and who are prepared to deal with their potential interactions, such as co-infection with all forms of hepatitis, other infections related to unhygienic injection practices, and interactions between illegal drugs and HIV medications.

Mental Health Providers report seeing more clients with severe mental health issues. Mental illness is associated with higher levels of substance abuse, higher risk for progression of HIV related symptoms, and higher risk of HIV transmission to others. PLWH/A who also have mental health diagnosis require primary treatment by specialists who understand the dynamics of both illnesses, and who are prepared to deal with their potential interactions. Mental illness can adversely affect the ability of PLWH/A to follow scheduled medical treatment and to adhere to HIV treatment, but proper treatment of the mental health disorder can reverse that effect. Intensive case management and client advocacy services are generally needed to stabilize members of this population and maintain them in care.

Even with mental health services provided on-site at the three Part C clinic sites, there are insufficient financial and organizational resources to address the mental health needs of PLWHA in Arkansas, which impact access to and compliance with many types of services. The state mental health system is over-burdened and under-funded and only provides care to people with severe and persistent mental illness. For clients who suffer from varying levels of depression (that prevent them from accessing care and remaining in care), Ryan White providers must identify other funding sources to provide adequate mental health services.

Dual Diagnosis: Mental Health and Substance Abuse PLWH/A with mental illness and/or substance abuse diagnosis face multiple challenges to initiating, engaging and remaining in care. PLWH/A with mental illness and substance abuse are more likely to experience unemployment, homelessness, and poverty than the general population. Nationally, PLWH/A with mental health and substance abuse issues also have higher rates of incarceration than other PLWH/A, with each episode of incarceration having the potential to interrupt their treatment for HIV disease.

This population also faces gaps in medical care, case management services, client advocacy services, culturally competent mental health services, substance abuse treatment services, including out-patient and residential care, and basic needs like food, housing, and transportation. Finally, PLWH/A with mental health and substance abuse issues also have higher rates of incarceration than other PLWH/A, with each episode of incarceration having the potential to interrupt their treatment for HIV disease.

People within this population require primary treatment by specialists who understand the dynamics of both illnesses, and who are prepared to deal with their potential effects, particularly those related to drug interactions that may create a higher mortality risk when combined with certain antiretroviral medications. Mental illness and substance abuse can adversely affect the ability of PLWH/A to follow scheduled medical treatment and to adhere to HIV drug treatment regimes. High levels of case monitoring and service coordination are required to reduce the interference of psychiatric disorders, medications, and illegal drugs with HIV medical treatment. These services, particularly mental health services, must be designed and delivered in a manner that is culturally appropriate for ethnic and sexual minority populations. As both mental illness and substance abuse are chronic conditions, access to appropriate services must be assured for extended periods of time, and treatment must be adjusted to varying levels of acuity over time. Mental health and substance abuse treatment services must be able to be accessed quickly in the case of an emergency, and must be coordinated with primary HIV care. However, mental health and substance abuse providers do not have a systematic way of knowing the HIV status of their clients, so unless clients disclose their own status, treatment in relation to HIV-specific issues is difficult.

Transportation Because there are so few HIV service access centers for both HIV case management and HIV medical care in Arkansas, clients must travel long distances to see an HIV case manager or an HIV medical provider. Transportation barriers limit access to

and compliance with services for PLWHA, especially in rural areas of Arkansas where there is virtually no public transportation infrastructure. Part A reports that, Crittenden County in Eastern Arkansas and is part of the Memphis TGA, is having particular transportation problems because of general medical transportation problems within the TGA and clients are having difficulty accessing Part A services across the Mississippi River in Memphis. Additionally, it was reported that clients within Little Rock are experiencing difficulty getting to the HIV clinic at the University of Arkansas Medical School. To get to the UAMS clinic from within the metropolitan area often requires 2 buses and usually takes 2 hours one way. The only authorized dentist in the Oral Health Program (Part B funded) is “way outside” the city center and there is only one bus in the morning and one bus in the afternoon. There isn’t even access to the medical van for clients with disabilities since the dentist is outside the area the van services.

Because of the recent dramatic increase in gasoline prices this has service gap has become even more pervasive, which affects individuals with their own means of transportation as well as agencies that provide transportation assistance to clients.

Poverty Arkansas is a very poor state. Twenty percent (20%) of all Arkansans are under 100% of the federal poverty level (FPL) vs. 17% nationally. The median household income in Arkansas is \$39,279 vs. \$49,901 nationally. ¹⁶The majority of clients cared for in the HIV services continuum of care are poor. Over 83% of clients currently in the Ryan White Program (averaged across all Ryan White Parts) have incomes at or below 100% of the federal poverty level. The safety net at both the local and state level is eroding, and clients turn more frequently to their HIV service providers for assistance with multiple needs, some unrelated to HIV. There are simply not enough resources to meet the need, forcing HIV providers to reduce services provided and/or focus services only on clients with the most severe need. The risk in this is that the clients assessed with less need can very quickly become severe need clients without basic assistance. While the Ryan White Program is not intended to be a “poverty” program, poverty and the lack of resources by clients constitute the primary barrier to accessing and successfully remaining in HIV treatment.

Women/Children Providers report an increase in the number of women who are injection drug users, most often they are also sex workers. There is also an increase in the number of young women being diagnosed with HIV. Women need accessible primary care providers who have specialized knowledge of HIV and women’s health, as well as coordinated access to specialists for treatment of HIV related illnesses and common co-morbidities such as mental disorders and co-infection with hepatitis or STD. Medical providers report that pregnant women stop taking HIV medications after the birth of their child. The higher proportion of female PLWH/A with current or past history of IDU requires access to substance abuse treatment services, and may indicate greater levels of poverty and/or social isolation. Case management services are particularly important for this population to help coordinate care and keep clients engaged. Women need to receive HIV prevention and early intervention messages in conjunction with their HIV care, and in places where they congregate.

¹⁶ The Henry J. Kaiser Family Foundation “statehealthfacts.org” 2006 data.

African American women, in particular, are vulnerable to HIV because of lack of education about HIV transmission, prevention and treatment; intimate partner violence/power within relationships that make it difficult for African American women to insist on protection or fear of disclosure to their partner; and the norm within the culture of always putting the family first and taking care of their family before taking care of their own needs. Transportation is particularly difficult for African American women, especially for many of the single mother. African American women who participated on the SCSN Work Group report that often African American women are so overwhelmed with taking care of their families that they don't want to know about their HIV status and disease progression because it just adds one more challenge to a long list of challenges. It was reported by these women that African American women don't protect themselves because they aren't thinking about the future, they are so busy with dealing with the problems of the moment.

All services for female PLWH/A are often not gender and culturally appropriate, and childcare is not often available to clients while they are receiving other services. Additionally, providers report that when children leave the children's programs at Arkansas' Children's Hospital (where medicine and medical care is free), there are no programs for youth/young adults with HIV.

African Americans Arkansas has kept the pace with the national trend of HIV/AIDS and its ever increasing spread in minority communities. The population of Arkansas is approximately 16% African American; however, 38% (AIDS) and 41% (HIV) of the total cumulative cases from 1989-2006 are African American. There are numerous cultural issues within the African American community that are barriers to accessing HIV care and treatment services. There continues to be a belief that AIDS was "introduced" by the US Government and there is a fear of treatment at "mainstream" medical facilities.

Additionally, African American members of the SCSN Work Group reported that religion, stigma/shunning from the Black Churches and religious belief ("I'm going to be healed and taking medicine shows I don't have faith") or ("This is a curse from God and I deserve this punishment") are contributing factors in African American PLWH/A not accessing HIV medical care and treatment. Poverty in the African American community, a sense of identity of men and their masculinity, marriage norms (there are fewer available men than women and men truly believe it is their responsibility to be with many women), and homophobia that results in black men who have sex with men seeking partners outside the black community where it is more likely they won't be recognized or know so they seek out sex with white men all result in an increased HIV risk among African Americans.

Hispanics Hispanics comprise about 15% of the total US population, and according to the Centers for Disease Control (CDC), in 2006, 19% of US residents with AIDS were Hispanic.¹⁷ After African Americans, Hispanics had the second highest rate of HIV

¹⁷ CDC HIV/AIDS Fact Sheet: HIV/AIDS among Hispanics/Latinos. October 2008. Available at: <http://www.cdc.gov/hiv/hispanics/resources/factsheets/hispanic.htm> and

diagnoses at 51 per 100,000 men (3 times the rate for non-Hispanic White men) and 15 per 100,000 Hispanic women (5 times the rate for non-Hispanic White women). In 2006, the rate of new HIV infections among Hispanics was three times that of Whites.¹⁸ The most common modes of transmission reported among Hispanic men in the US were men who have sex with men (MSM), injection drug use (IDU), and high risk heterosexual sex; Hispanic women primarily reported high risk heterosexual sex and IDU.¹⁹ In a recent article, the CDC analyzed trends in HIV among Hispanics and found Hispanics to be disproportionately affected by HIV and that infection varied by place of birth.²⁰ Hispanics born in Puerto Rico were more likely than US-born or other foreign-born Hispanics to report risk of IDU. More Mexican-born Hispanics tended to be concurrently diagnosed than US-born Hispanics. Data on place of birth appears to be vital in understanding differences among subpopulations of Hispanics, including HIV testing behavior and access to care. The 2000 US Census estimates that of the 35 million Hispanics living in the US, 14 million (40%) were foreign-born.

In Arkansas, Hispanics comprise 5% of the general population but make up 8% of the HIV epidemic (an increase from 6% in 2006.) Providers report increasing numbers of Hispanics coming into care but they tend to come in much later and much sicker. At UAMS Hispanic PLWH/A are often first diagnosed in the emergency room and they come in with full-blown AIDS and very ill. Language, fear of deportation and the hostile immigration laws in the past few years are all significant barriers to accessing HIV medical care in Arkansas for Hispanic PLWH/A. Arkansas, in particular, has seen an increase in Hispanic workers brought in by large employers in the poultry industry. These workers cannot access medical care during a work day for fear of losing their employment and most Ryan White funded HIV services are not available in the evenings and on weekends. They can't afford to stop work or take time off for an appointment. Hispanics also migrate and move in and out of systems frequently.

Ageing Client Population People with HIV are living longer with the success of current treatment modalities. While this is good news, it also brings with it some new challenges for HIV service providers. An ageing client population means that HIV providers are faced with learning to deliver services that meet the needs of an elderly population. Now HIV-positive individuals who are ageing have to deal with complicating illnesses that are the result of ageing, not just side effects of HIV treatment, such as diabetes, heart disease, and osteoarthritis. Complicating this issue are the effects of long-term HIV therapy that are not well understood. The ability of HIV providers to manage this changing need will be largely dependent upon their ability to collaborate with the health and human service providers with expertise ageing and disease-specific needs.

Additionally, clients who went back to work are now retiring and finding that they are not eligible for any HIV programs because of income eligibility, even though they may not have enough retirement funds to cover the cost of gaps in coverage (such as the Coverage

Espinoza, L., Hall, I., Selik, R., and Hu X. Characteristics of HIV Infection Among Hispanics, United States 2003-2006. *J Acquir Immune Defic Syndr*. Vol 49, No. 1, Sept 1, 2008.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

²⁰ *Ibid.*

Gap in Medicare Part D.) Consumers report that PLWH/A over 50 are experiencing eligibility gaps.

There is also concern about why there are so few clients accessing the AIDS Drug Assistance Program (services include assistance paying for insurance and co-pays) above 300% FPL when the eligibility threshold is 500%. A consumer on the SCSN Work Group states that clients who are working and making money in the middle range (up to \$52,000/year) don't know that there are services they can access. It's an education and information issue.

Incarceration Nationally, the incidence of HIV is 5 times higher among the incarcerated population than the general population, and an estimated 25% of HIV-positive individuals filter through correctional facilities each year. The incarcerated population is also disproportionately likely to have hepatitis C, mental disorders, substance abuse problems and other co-occurring issues that increase risk of HIV and can complicate HIV treatment.

Clients who move in and out of the state correctional facilities are particularly vulnerable to being out of HIV care and treatment. The providers report that there is a shortage of awareness both within the HIV care and treatment community about what resources are available in both prisons and local jails and within the corrections community about what services are available in the HIV care and treatment community. There is no formal mechanism for assisting clients to transfer to and from corrections facilities and there is no post-incarceration case management currently offered by the HIV care and treatment providers.

PLWH/A with histories of incarceration often face several co-morbidities, including poverty, substance abuse, and mental illness. They also face many unique challenges in accessing and remaining engaged in medical care and support services. Ex-offenders have particular difficulty securing employment and stable housing due to the stigma attached to being an ex-convict, landlord policies prohibiting criminal backgrounds, poor or nonexistent credit, rental and employment histories, and lack of funds for deposits and rent. When entering the jail system, inmates are taken off of public insurance programs, and upon release must go through a re-application process that can delay accessing HIV medical care. Many former inmates also struggle with active mental health and/or substance abuse issues and have limited family and community support systems in place.

While the state and some larger county jail systems have their own established testing, counseling and treatment services, funding is limited. In general, corrections facilities are closed communities and communication with outsiders is controlled, restricted and limited, presenting unique challenges to outside agencies that could provide prevention services or consultation for HIV care and treatment. Barriers to identification of HIV and medical treatment of PLWH/A in corrections facilities include lack of tracking information on specific diseases like HIV and hepatitis, the short-term nature of many incarcerations (especially in county jails), facility restrictions on access to inmates, and inmate concerns about stigma, cultural competence of staff or health providers, and their

own safety and confidentiality. PLWH/A in the corrections health system may also face the loss of insurance during incarceration as well as potential interruptions in care. Opportunities for health care and education may be limited due to budget, staffing, administrative and policy issues. There is no additional earmarked funding for health care of people with higher cost or complex conditions such as HIV.

Medical Services Medical providers report that they see clients coming in and out of care on a regular basis. They talked about how mobile clients are and how they move between medical clinics and “jump” from provider to provider. Medical providers “share” many clients and there are clients who simply disappear for a period of time and then re-appear.

There are not enough physicians across the state providing medical care to PLWH/A. There is a lack of coordination and communication between the Part B Intake/Enrollment sites (6 sites) and private physicians throughout the state. Within Part B, there are 1194 clients who receive medical care at 12 clinic sites (some with multiple physicians) across the state (that have 20 or more clients.) There is a lack of funding for HIV medical care and a high percentage of PLWH/A are uninsured (45% of Part B clients are uninsured.) The UAMS HIV clinic (approximately 500 clients) does not have any HIV case management on-site and is not a Ryan White Program contractor, except for a new Hep C contract with Part B. This is a critical medical site that has not been funded by any Ryan White funds in the past.

There is a need to build formal, ongoing relationships between medical providers, the pharmacist at the primary ADAP pharmacy, HIV case managers and clients. The Part B HIV case managers are currently the “gate keepers” for accessing all Ryan White funded services, including prescription drug refill requests.. Clients aren’t currently allowed to communicate directly with the pharmacist. Consumers on the SCSN Work Group expressed the desire to be able to talk to their pharmacist, to be able to do their own refill requests and for treatment adherence questions and education. There is a need to create a system where clients can contact the pharmacist directly while building in checks and balances on possible prescription drug purchasing abuses. Medical providers reported that the current Prescription Drug Service program allows clients to get a 3 month re-fill so it’s often 3 months of no contact and clients are refilling their prescriptions simply to stay active in the ADAP program but end up not taking their medications (either they stopped taking a medication because it makes them feel bad or they feel so good they stop.) All of the medical providers and case managers on the SCSN Work Group reported many stories of clients stockpiling drugs. One example shared by the pharmacist and one medical provider discussed how the provider had taken a picture of the stack of drugs one client had stockpiled and the pharmacist then calculated that there was over \$20,000 in drugs that had gone unused.

Provider Specific Issues

WRRHC:

In our 18 county district, there are many individuals living with HIV who are unaware of their HIV status, and many HIV+ individuals are not provided comprehensive primary

and HIV medical care due to barriers such as lack of physicians to care for HIV patients, transportation issues, and long distances to access care. The Arkansas Department of Health estimate that there are over 650 individuals in our service area who are infected with HIV and many do not know their status or are not enrolled in treatment.

WRRHC strives to identify HIV+ individuals in our district through case finding to bring them into care, strengthen linkages with other agencies that provide services to HIV+ individuals, and provide comprehensive primary medical, HIV medical, and social services for clients in need.

EAFHC:

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- Over half of EAFHC's client population is uninsured, living below the federal poverty level and require extensive and costly medical services.
- Research shows that African-Americans are less likely to get tested for HIV as long as they feel healthy and are not experiencing symptoms. African-Americans typically come into care once they are already at an AIDS status and very ill; which increases acuity rates for this population.
- Standards of care for HIV patients is fluid and therefore imperative to have an effective, efficient, and comprehensive Continuous Quality Improvement Program (CQI) for measuring medical protocol.

JCCSI (Part C):

The population of the state of Arkansas is approximately 16% African American; however, 38% (AIDS) and 41% (HIV) of the total cumulative cases from 1983-2007 are African American (DHHS, 2007). In comparison, from a state level to a local level, African Americans comprised 32% of JCCSI service area and comprised, on average, 65% of the HIV cases and 59% of the AIDS cases in JCCSI service area from 2003-2005. The poverty rate is 12.6% nationwide, 14.4% in non-metro areas, 17% in cities, 9.3% in suburbs, and 15.8 in Arkansas (Income, Poverty, and Health Insurance Coverage in the United States: 2005). Seven of JCCSI ten counties exceed the Arkansas poverty rate and eight of the ten counties exceed the national poverty rate. Poverty affects all aspects of life, not the least of which is health outcomes. The South's rural environment, inequalities in health care resources and the increased stigma associated with HIV/AIDS and STDs contribute to the increased risk of individuals acquiring HIV and STDs and if infected, not seeking, or acquiring essential care and treatment services.

JCCSI (Part D):

Part D is the "bridge" that connects and retains our clients to other Ryan White funded programs. Continued federal support through Part D funds will enable our project to reduce access barriers to HIV services for women, youth, infants and families and bridge gaps through continued comprehensive HIV primary health care and support services. A gap in services faced by our program involves providing services to children and youth accessing care at Arkansas Children's Hospital. With our limited funds, we cannot offer

support services to these children which would increase their appointment compliance, medication adherence, and introduce them to other kids in support groups. Also, support groups for this population does not meet consistently because of the low turn-out. Additional funds to allow us to provide services to surrounding counties would benefit both our current and potential clients.

With Part D's continued flat funding, lack of state funding, and mandatory 1% rescission, our project faces the challenge of providing comprehensive services to a growing number of clients with limited funds. There are two challenges that we expect to face in the upcoming year. First, is the issue of the decrease and flat-funding. Dental and case management services for our UAMS clients was discontinued as stated in our previous application and without additional funds we cannot provide these services. Second, transportation for our Little Rock clients has been altered. Our transportation company terminated our contract citing high gas prices and low revenue. We are now providing bus vouchers to ensure medical appointment compliance. We intend to explore other options; however our limited funds increase the difficulty in finding suitable alternatives. Women, African Americans and Hispanics continue to experience a disproportionate burden of this infection.

System Issues The Part B HIV Continuum of Care Quality Improvement Initiative Transition Advisory Group conducted a self-assessment exercise where the members were asked to indicate their perceptions of the current HIV continuum. Access to drug therapies and integration of public health programs were perceived most positively by the group. In general, gaps in access to HIV services were considered to exist both in geographic areas of the state and for some population groups. The following comments were made regarding system weaknesses.

- There are not enough physicians throughout the state with parts of the state providing no choice of providers or with no providers at all.
- Obtaining medical care in rural areas and/or getting access to medical care is difficult in many parts of the state.
- There are not enough HIV clinics available throughout the state. Many areas have an HIV clinic once a week or every other week, leaving clients vulnerable should they get sick.
- Poor access for non or underinsured clients. Areas with the greatest need have the least services.
- Some patients must travel large distances to obtain medical care.
- Disparity in access geographically especially in the Southeast and the Delta areas.
- Very limited substance abuse treatment, mental health treatment, oral health and hospice services access statewide.
- Limited networking between HIV programs and the Department of Health local health units.
- Supportive services access is very limited and a major barrier to entry. Staff are very passive regarding patient contact.

- Access is problematic. The geographic locations of the HIV case managers requires many clients (or the case managers) to travel large distances to receive services.
- Need for increased access sites and clinical sites.

Broad Goals

- Increase the number of Medical Providers with HIV expertise in the state.
- Increase outreach to the African American communities throughout the state.
- Improve the current Prescription Drug Services Program.
- Increase community and stakeholder participation in statewide HIV planning.
- Increase consumer advocacy throughout the state.
- Increase HIV Services and HIV Prevention collaboration.
- Create a program that provides transition case management for clients coming out of corrections.
- Create a client education program about services available and chronic disease self-management.

Section Two: Where Do We Need To Go?

HIV Services Vision Statement

The Vision Statement developed by the Arkansas Quality Improvement Transition Planning Work Group states: “Our vision is to create a cost-effective, accessible system of care for HIV-infected individuals in all areas of Arkansas that provides comprehensive services seamlessly and through which patients receive timely quality services from compassionate providers.”

Overall System Goals

- Improve access to HIV care and treatment and reduce health disparities.
- Improve the health outcomes for PLWH/A in Arkansas.
- Increase accountability to clients and the community in Arkansas.
- Meet the requirements of the Ryan White Treatment Modernization Act.

HIV Continuum of Care

Beginning in the 1990s, six (6) districts were formed and operated throughout the state in order to ensure accessibility to HIV-related services and collaboration of efforts within the community. The ultimate goal was to create a well-defined network of community resources to provide a continuum of care for persons living with HIV infection.

Presently, Arkansas Department of Health (ADH) contracts with four (4) providers to provide statewide coverage in those six (6) districts to persons with HIV/AIDS. Program services include primary medical care, HIV related medications, mental health treatment, substance abuse treatment, oral health, case management, and support services. Contractors make appropriate referrals and assist with scheduling appointments.

The Department of Health contracts directly for physician, oral health and pharmacy services. ADH operates ninety-four (94) local health units in all seventy-five (75) counties of Arkansas. Twenty-two Public Health Investigators (PHI) provide diagnostic, partner notification/referral, and treatment services to individuals with STDs. The PHI staff provides referral for HIV positive clients in their counseling, testing and partner notification activities.

The HIV Services Section continues to administer the HOPWA (Housing Opportunities for Persons with AIDS) program. Arkansas Supportive Housing Network (ASHN) and Northeast Arkansas Regional AIDS Network administer short-term rental assistance, long-term housing assistance and utility assistance under a sub-grant agreement with ADH.

District I encompasses Pulaski, Lonoke, and Prairie counties. The Arkansas AIDS Foundation (AAF) provides Ryan White Part B care and services. There are 4 FTE of

case management available for 388 clients. HIV care is available from the Jefferson Comprehensive Care System, Inc. (JCCSI) at a satellite clinic in College Station, the UAMS Infectious Diseases Program, and several private practice physicians. JCCSI is the grantee managing Part C (clinical HIV care and early intervention services) and Part D (services for women, infants and youth).

District II spans thirty-nine (39) counties (52% of Arkansas' 75 counties) in the western half of the State. Fort Smith Fights AIDS is the lead agency for Part B and provides access points with case management and supportive services available in offices in Fort Smith, Hot Springs and Texarkana. There are 4 FTE of case management available for 440 clients. HIV care is provided through the Area Health Education Centers (AHEC) in Fort Smith, Fayetteville, El Dorado and Texarkana and a network of public and private practice physicians throughout the Northwest part of the state.

District III covers seven counties in Southeast Arkansas. Jefferson Comprehensive Care Systems, Inc. (JCCSI) is the lead agency for Part B and has Part C and Part D funded programs. One FTE case manager provides services to 80 clients. JCCSI and other public and private practice physicians provide HIV care in the district.

District IV covers twenty-six (26) counties in North Central/Northeast Arkansas. Northeast Arkansas Regional AIDS Network (NARAN) is the lead agency for Part B. Four FTE of case management provide services to 291 clients. Two (2) community health centers are located in White and Crittenden counties. White River Rural Health Center has both Part C and Part D funded programs. White River Rural Health Center also has several satellite offices. The East Arkansas Family Health Center has Part A and C programs and is located in West Memphis.

The 2006 reauthorized law changed how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending medical services for people living with HIV/AIDS. In 2007, the ADH Ryan White Part B Program (HIV Services Program) undertook an extensive quality improvement initiative to improve the quality, effectiveness and efficacy of the HIV service delivery system in Arkansas.

A pilot is being undertaken to implement a service access model that assists people living with HIV/AIDS to successfully access HIV care and treatment services. An RFA was completed the week of December 8, 2008 to procure applications from service providers in seven newly defined catchment areas in Eastern Arkansas (Districts III and IV) to provide a package of core medical and support services (Health Insurance Premium and Cost Sharing Assistance, Mental Health Services, Medical Nutrition Therapy, Substance Abuse Service-Outpatient, Laboratory Services, Non-Medical Case Management, Food Bank/Home Delivered Meals, Medical Transportation, and Outreach Services). Final notification of successful applicants will happen in February 2009. During this pilot, a Care Coordination model will be developed with new Standards of Care, standardized forms and Policies/Procedures developed and tested, with the ultimate goal of replicating this model statewide. Medical Case Management, provided by licensed RN's, will be introduced into the Care Coordination Model in 2010.

Section Three: How Will We Get There?

Strategic Plan

Goal #1: Increase client access to Core Medical Services

- Objective 1.A: Develop and pilot a regional Service Access Center model (with psychosocial case management provided by Service Access Specialists) in eastern Arkansas that results in the expansion of the number of access sites available in the region (from two access sites to seven access sites.)
- Objective 1.B: Implement an Oral Health Initiative to assist at least 500 clients currently enrolled in the Part B program who have not received any oral health services in over 12 months to receive an Oral Health Assessment that includes an exam, x-rays, cleaning and a plan for additional needed dental services.
- Objective 1.C: Develop a Medical Case Management Program housed in the Service Access Centers.

Goal #2: Develop Medical Care Coordination System

- Objective 2.A: Develop a Transition Case Management Program for clients coming out of corrections facilities.
- Objective 2.B: Develop new Service Access Specialists Standards of Care, Policies & Procedures and forms.
- Objective 2.C: Develop new Medical Case Management Standards of Care, Policies & Procedures and forms.
- Objective 2.D: Provide Service Access Specialist training at least once annually.
- Objective 2.E: Provide CAREWare training at least once annually.
- Objective 2.F: Develop a common Intake Form across all programs and RW Parts.

Goal #3: Improve the AIDS Drug Assistance Program

- Objective 3.A: Hire an ADAP Coordinator.

- Objective 3.B: Create a Prescription Drug Services Work Group to:
- Develop ADAP Policies & Procedures
 - Develop a Treatment Adherence Program with the Pharmacist and Medical Case Managers
 - Change prescription refill approval process to allow clients to directly communicate with their pharmacist
- Objective 3.C: Create capacity to pay all medical visit and drug co-pays through the Pharmacy Contract.

Goal #4: Increase Medical and Dental Provider Capacity Statewide

- Objective 4.A: Meet with AMDOPA (Arkansas Medical Dentist and Pharmacists Association, the African American professional organization for medical providers) and do a presentation on our program at their Spring conference.
- Objective 4.B: Work with UAMS to get residents to work in the HIV Clinics to learn about HIV.
- Objective 4.C: Develop a physician education program about HIV Client Services in collaboration with the AETC to help get more providers willing to sign agreements with the state as well as make sure providers know about the services available for clients.
- Objective 4.D: Do a mailing about HIV Client Services to physicians, local health units, emergency rooms, satellite clinics and homeless shelters.

Goal #5: Enhance HIV System of Care

- Objective 5.A: Develop new Medical Care Coordination Model to include Medical Case Managers and Service Access Specialists.
- Objective 5.B: Develop organizational capacity in community based organizations who contract with the program by providing technical assistance and training to the organization's staff and Board of Directors.
- Objective 5.C: Pilot co-location of Service Access Specialists in key medical sites.
- Objective 5.D: Develop a Treatment Adherence Program
- Service Access Specialist – screen
 - Medical Case Managers – provide counseling, education and assistance
 - Pharmacist – provide counseling, education and assistance

Objective 5.E: Evaluate Hep C problem in the state and develop a plan to expand the Hep C program funded by Part B at UAMS.

Goal #6: Increase Community and Stakeholder Participation in Statewide HIV Services Planning

Objective 6.A: Reconvene a statewide Part B Planning Group.

Objective 6.B: Convene a statewide Consumer Advocacy Group.

Objective 6.C: Continue to convene and provide staff support (and lunch) to the Cross-Parts Collaboration.

Objective 6.D: Produce a statewide HIV conference meeting that has a clinician track, a PLWH/A track and an HIV case management track in 2011.

Objective 6.E: Assist in the planning, production and participate in the four state regional conference being developed by the Part D grantee in 2010.

Goal 7: Increase Collaboration between HIV Care and HIV Prevention Programs

Objective 7.A: Meet with Arkansas Community Planning Group (they meet quarterly.)

Objective 7.B: Have a meeting with three existing groups to discuss how best to position an HIV care planning group: Arkansas Community Planning Group, Minority Health Coalition, Governor's Task Force on AIDS.

Objective 7.C: Create a joint statewide Consumer Advocacy Committee.

Objective 7.D: Produce a jointly sponsored statewide HIV conference.

Objective 7.E: Set up regular meetings between the two managers at ADH.

Goal 8: Provide smooth, seamless coordination of HIV Services across all Ryan White Parts

Objective 8.A: Collaborate with Part C/D and identify gaps; using Part B funding to "gap fill."

Objective 8.B: Develop a Common Intake across all Ryan White Parts.

Objective 8.C: Work with other Ryan White funded programs to develop a plan to measure key clinical measures across all Ryan White Program grantees.

Goal 9: Develop Education/Training Program

Objective 9.A: Develop a client self management education program/ client trainings.

Objective 9.B: Create a client newsletter to keep clients informed about the HIV Services Program, updates on HIV treatment and client self-management education.

Objective 9.C: Create targeted service-specific client brochures and fact sheets and mail them to all actively enrolled clients (for example, the Oral Health Initiative brochure about the importance of maintaining good oral health.)

Goal 10: Develop a targeted outreach program to the African American community

Objective 10.A: Convene an African American Outreach Work Group to develop a formal Outreach Plan.

Objective 10.B: Bring champion black ministers and women from groups in churches to planning table.

Objective 10.C: Develop inserts about HIV Services Program to put in church bulletins at African American churches.

Goal 11: Develop a statewide Outreach Program

Objective 11.A: Meet with Hometown Health and develop a plan to get information about HIV services out to the 74 Hometown Health Coalitions across the state.

Objective 11.B: Develop information campaign and send package to:

- AMA
- Physicians
- Local Health Units
- Emergency Rooms
- Satellite clinics
- Homeless shelters

Section Four: How Will We Monitor Our Progress

Quality Statement

The Arkansas HIV Services Program is committed to developing and continually improving a quality continuum of HIV treatment and supportive services statewide that meets the identified needs of people living with HIV/AIDS (PLWH) and their families. The Quality Management (QM) Program supports this mission by gathering and reporting on the data and information needed to measure both program and service quality and then implementing improvement activities based upon the data analysis.

The following goals guide the QM program implementation:

- Clients in the Ryan White Program will have improved health outcomes.
- Medical services funded by the Ryan White Program will meet Public Health Standards (PHS).
- Clients will successfully access HIV care and treatment services.
- All Ryan White Funded services will comply with Health Resources and Services Administration (HRSA) and Arkansas Department of Health (ADH) standards and policies/procedures.
- The QM Program will analyze program data, communicate results, identify opportunities for improvement and implement improvement activities.

Quality Infrastructure

The HIV Services Program resides in the HIV/STD/Hepatitis C Section located within the Infectious Diseases Branch of the Center for Health Protection.

The Management Program Analyst of the HIV Services Program oversees the Quality Management Program. The QM team includes the following staff:

- HIV/STD/Hepatitis C Section Chief
- HIV/STD/Hepatitis C Assistant Section Chief
- HIV Services Program Manager
- CAREWare Data Manager
- ADAP Program Analyst
- Surveillance Unit for HARS Data Base
- Input from Arkansas HIV Quality Management Task Force
- Input from the Arkansas Ryan White All Parts Planning Group
- Input from the HIV Services Planning Group
- Input from the HIV Services Consumer Advisory Group

This team is responsible for implementing the QM plan, gathering and reporting the data from the various databases, evaluating program elements and reporting on the findings, developing and implementing the PDSA/improvement change activities, and providing input and feedback to the overall QM program.

Arkansas HIV Quality Management Task Force

The Arkansas Ryan White Quality Management Task Force will be created in Spring 2009 to centralize and coordinate quality management efforts by Ryan White contractors statewide. The group will be made up of representatives from contractors with Part B programs; medical providers; and consumers. The group will meet on a regular basis and is responsible for reviewing the Quality Management Plan, reviewing data and outcomes reported by the Program, providing advice about improvement activities and sharing information about quality improvement activities being undertaken in the contracted agencies.

Participation of & Communication with Stakeholders

Stakeholder	Type of Involvement	Communication
Consumers	<ul style="list-style-type: none"> • Participate in HIV Services Planning Group, the Consumer Advisory Committee and on QM Task Force; • Participate in surveys; • Give feedback to providers; • Review reports on-line. 	<ul style="list-style-type: none"> • Reports on QM Program outcomes at the QM Task Force, HIV Services Planning Group and the Consumer Advisory Group; • Reports & survey results posted on web site.
Contractors	<ul style="list-style-type: none"> • Provide data on services provided; • Participate in QI processes such Case Management Improvement Initiative; • Participate on QM Task Force and the HIV Services Planning Group; • Meet Standards of Service. 	<ul style="list-style-type: none"> • Statewide meetings and trainings; • Technical assistance on-site and via teleconference; • Summary report on the CM Chart Review they perform sent to them; • Reports at QM Task Force and HIV Services Planning Group ; • Reports & survey results posted on web site.

Consumer Advisory Committee	<ul style="list-style-type: none"> • Provide input and advise; • Participate in discussions about data and information; • Make suggestions; • Review written reports. 	<ul style="list-style-type: none"> • Written & verbal reports at meetings; • Reports & survey results posted on web site.
HIV Services Planning Group Members	<ul style="list-style-type: none"> • Provide input and advise; • Participate in discussions about data and information; • Make suggestions; • Review written reports. 	<ul style="list-style-type: none"> • Written & verbal reports at meetings; • Reports & survey results posted on web site.
HIV Services QM Task Force	<ul style="list-style-type: none"> • Provide input; • Shared knowledge and education about QM methodology & issues; • Networking and collaboration toward standardization statewide. 	<ul style="list-style-type: none"> • Reports at meetings. • Reports & survey results posted on each program's web sites.
HIV Services Program staff	<ul style="list-style-type: none"> • Provide data. • Provide analysis of data. • Provide suggestions on improvement. • Implement improvement activities. • Review program reports. • Assist in writing grant applications. 	<ul style="list-style-type: none"> • Staff meetings. • Reports. • Participation at the QM Task Force, the HIV Services Planning Group, the ADAP Formulary Advisory Group and the Consumer Advisory Group.

Program Goals for 2009-2010

Goal #1 - Clients in Ryan White Program will Have Improved Health Outcomes.

Goal 1.1: Collect health outcomes data from CAREWare and HARS, analyze and report in QM report.

Goal 1.2: Develop standardized report of fill rates from Pharmacy.

Goal 1.3: Implement and monitor Oral Health Initiative.

Goal # 2- Medical Services Funded by Ryan White will Meet Public Health Standards.

Goal 2.1: Complete clinical chart review for 2009, analyze results and prepare final report.

Goal 2.2: Collect, analyze, and report clinical performance outcomes data for HRSA Group One clinical measures.

Goal # 3 - Clients will Successfully Access Care and Treatment.

Goal 3.1: Implement, monitor and evaluate outcomes of Service Access Pilot Program.

Goal 3.2: Implement annual Statewide Needs Assessment.

Goal 3.3: Expand contract with current lab to increase number of labs and number of medical visit and prescription drug co-pays paid for.

Goal 3.4: Implement, evaluate and monitor Oral Health Initiative.

Goal 3.5: Hire evaluation contractor to analyze response rate of the outreach program that was undertaken in 2008 to attempt to find clients from surveillance data base who did not have a reported CD4 or VL in the previous 12 months.

Goal 3.6: Develop Medical Case Management Program indicators as part of (in conjunction with pilot project).

Goal # 4- All Ryan White Funded Services will comply with HRSA and ADH Standards, Policy and Procedures.

Goal 4.1: Develop and implement client satisfaction survey.

Goal 4.2: Continue to update and improve CAREWare.

Goal 4.3: Update chart audit protocol and continue to conduct site visits.

Goal 4.4: Create a provider chart audit protocol to increase QI activities in contractor sites.

Goal 4.5: Conduct annual case management training (to include CAREWare training.)

Goal 4.6: Develop capacity building initiative for non-profit contractors.

Goal 4.7: Update case management standards, policy and procedures and forms (including additional standards, policy and procedures and forms for pilot project).

Goal #5 - Quality Management Program will Analyze Program Data, Communicate Results and Identify Opportunity for Improvements.

Goal 5.1: Develop and distribute 2009 quality management report of outcomes.

Goal 5.2: Develop data request form for staff who will be pulling data from various databases.

Goal 5.3: Develop QM team and convene monthly.

Goal 5.4: Develop QM Task Force and convene quarterly.

Goal 5.5: Draft 2009-2010 QM plan to present to QM Team and QM Task Force.

Goal 5.6: Develop and convene statewide Consumer Advisory Committee.

Goal 5.7: Develop and convene Statewide HIV Services Planning Council.

Goal 5.8: Continue to convene the ADAP Formulary Committee.

Implementation Plan: Data Collection Activities

1. CAREWare is installed in all Part-B funded provider locations and is generating real-time, unduplicated data reported via a secure central server.

Data Reported	Time Line	Source
Case Management services utilization	Reported & reviewed in monthly.	HIV Services Program Staff
Support Services utilization data	Reported & reviewed in Monthly.	HIV Services Program Staff
Health outcomes data	Reported & reviewed in Bi-annually.	HIV Services Program Staff
Quality Assurance data	Reported & reviewed in Bi-annually.	HIV Services Program Staff

2. HIV/AIDS Reporting Systems (HARS) data base (surveillance data)

Data Reported	Time Line	Source
HIV & AIDS status of clients	Bi-annual reports	Surveillance Staff

2. HIV/AIDS Reporting Systems (HARS) data base (surveillance data)		
Data Reported	Time Line	Source
Number of labs / year for all PLWH/A in state	Bi-annual reports	Surveillance Staff
Number of labs / year for CAREWare clients	Bi-annual reports	HIV Services Program Staff and Surveillance Staff
Lab values for all PLWH/A in state	Bi-annual reports	Surveillance Staff
Lab values for CAREWare clients	Bi-annual reports	HIV Services Program Staff and Surveillance Staff

3. Provider site visit & client file review		
Data Reported	Time Line	Source
Compliance with HIV Case Management Standards	All sites reviewed annually	HIV Services Program Staff
CAREWare data quality	All sites reviewed annually	HIV Services Program Staff
Compliance with accepted fiscal standards	All sites reviewed annually	HIV Services Program Staff and ADH Internal Audit Staff

4. Client Satisfaction Surveys		
Data Reported	Time Line	Source
Client Satisfaction	Annually	Contractor to be hired

5. Special evaluation projects		
Data Reported	Time Line	Source
HIV Needs Assessment	Annually	Contractor to be hired

6. Clinical Chart Review		
Data Reported	Time Line	Source
Clinical Performance Measures based on Public Health Standards	Annually	HIV/STD Nurse Consultants

Implementation Plan: Performance Measures

Quality Management Question #1: Are PLWH/A Health Outcomes Improving Because of Ryan White Program?			
Outcomes	Indicators	Data Elements	Data Sources & Methods
a. Disease progression among CARE Act clients is slowed or prevented over time.	Changed CD4 counts and viral loads as measured over a six month period of time.	Test results needed to calculate changes in CD4 counts & viral loads for individual clients semi-annually. (Percent below 350 CD4 and Percent above 10,000 VL)	Source: <i>HARS</i>
	Changed percent of individuals newly reported with HIV infection who do not have an AIDS diagnosis.	New HIV diagnosis with AIDS diagnosis at time of initial report measured semi-annually.	HARS
	Changed percent of individuals newly reported with HIV who progress to AIDS within 12 months	New HIV diagnosis with AIDS diagnosis at end of 12 months measured semi-annually.	HARS
	Changed percent of individual newly reported with HIV who died within 12 months	New HIV diagnosis who die within 12 months measured semi-annually.	HARS
	Changed percent of clients that enter ADAP with HIV+ diagnosis only at time of enrollment	New ADAP enrollees in the previous 6 months who are HIV Positive only measured semi-annually.	CAREWare
1b. Client Level Adherence to HIV	Changed percent of clients in ADAP who	Active clients in ADAP who receive	CAREWare

Quality Management Question #1: Are PLWH/A Health Outcomes Improving Because of Ryan White Program?			
Outcomes	Indicators	Data Elements	Data Sources & Methods
Treatment Improves	refill their prescriptions monthly	Meds paid for by ADAP who had a refill in the previous quarter	

Quality Management Question #2: Do Ryan White Funded Services Adhere Public Health Standards?			
Outcomes	Indicators	Data Elements	Data Sources & Methods
a. Percent of clients with AIDS that are prescribed HAART increases	Number of clients with AIDS who were prescribed a HAART regimen in the previous 6 months	Client with CDC defined AIDS diagnosis who received meds in ADAP and are prescribed HAART	Source: ADAP
b. Percent of clients who get CD4 T Cell counts increases	Percentage of clients with HIV infection who had 2 or more CD4 T cell counts performed in the previous 12 months	Active clients in ADAP who receive Meds paid for by ADAP who had a 2 or more CD4 T Cell counts performed at least 3 months a part in the 6 months prior to the previous quarter	CAREWare & HARS
c. Percent of pregnant women who are prescribed Antiretroviral therapy increases	Percentage of HIV infected women who were prescribed ARV in the previous 12 months	HIV infected pregnant women who received meds paid for by ADAP who were prescribed ARV in the charts reviewed	Clinical Chart Review
d. Percent of clients who had 2 or more medical visits per year increases	Percentage of HIV infected clients who had 2 medical visits in the previous 12 months	i. Clients that had 2 or more medical visits with a provider with prescribing privileges in the charts reviewed ii. Client who received a a medical visit paid for by Ryan White	Clinical Chart Review and CAREWare
e. Percent of clients with and AIDS	Percent of HIV infected clients with a	Clients with an AIDS diagnosis who had a	Clinical Chart Review

Quality Management Question #2: Do Ryan White Funded Services Adhere Public Health Standards?			
Outcomes	Indicators	Data Elements	Data Sources & Methods
diagnosis who were prescribed PCP prophylaxis increases	CD4 T cell count below 200 who were prescribed PCP prophylaxis in the previous 12 months	prescription for PCP prophylaxis in the charts reviewed	

Quality Management Question #3: Are Clients Successfully Accessing Care?			
Outcomes	Indicators	Data Elements	Data Sources & Methods
a. Proportion of clients accessing primary health care services increases over time.	Change in the number of clients with reported “primary source of medical care” and primary care provider.	Number and percent of clients with “no primary source of medical care” and no primary care provider in record and the number and percent of HIV-positive clients with record of “primary source of medical care” and primary care provider.	Source: CARE Ware & Provider Site Visit. Reported by case managers.
b. Proportion of clients who have health insurance increases over time.	Change in the number of clients with reported “primary source of insurance” and health insurance.	Number and percent of clients with “no primary source of insurance” and no health insurance in record and the number and percent of HIV-positive clients with record of “primary source of insurance” and health insurance.	Source: CARE Ware & Provider Site Visit. Reported by case managers.
c. Proportion of clients who are successfully retained in the Ryan White	Change in the number of clients reported active in database.	Number and percent of clients active and number and percent of clients no longer active	Source: CARE Ware & Provider Site Visit. Reported by case managers.

Quality Management Question #3: Are Clients Successfully Accessing Care?			
Outcomes	Indicators	Data Elements	Data Sources & Methods
Program.		in database.	

Quality Management Question #4: Do Ryan White Funded Services Comply With ADH Standards, Policy and Procedures?			
Outcomes	Indicators	Data Elements	Data Sources & Methods
a. Eligibility will be documented for all clients receiving Ryan White Program services: <ul style="list-style-type: none"> • HIV status • Income 	All client files in all Ryan White Program funded programs document HIV Status and income eligibility determination and include the allowable documentation.	Percent and number of client files completed and allowable documentation attached.	Source: CAREWare and Provider Site Visit.
b. Non-Medical Case management services meet the ADH case management standards for clients.	Change in the percent of indicators for standards criteria being met by local case management programs.	Percent of a case management site's activities that meet standards requirements.	Source: CAREWare & Provider Site Visit.
c. CAREWare data is accurate.	Increase in the overall average for criteria that measure accuracy and completeness of data compared to the client paper file.	Percent of CAREWare data that match the paper charts.	Source: CAREWare & Provider Site Visit
d. Clients will be satisfied with the Ryan White Part B services they receive.	A majority of clients responding to the client satisfaction survey will indicate they are satisfied with the services they have received.	Number and percent of client responses to questions about their satisfaction with specific services.	Source: Annual written survey mailed to Ryan White clients.

Quality Improvement Capacity Building

The HIV Services Program will continue to build QI capacity within its' program by undertaking the following activities:

- All contracted providers will receive annual training on quality management and quality improvement.
- All of the funded providers are contractually required to perform a client chart review once a year, utilizing a standard protocol provided to them by the program. These results will be reported to the program by the providers in March of each year. The program then compiles the results and produces a report of all the results that is sent to each provider, is included in the annual Quality Management Report presented to the HIV Services Planning Group, the Consumer Advisory Committee and is posted on the program's web site.
- The results of all evaluation activities (such as the Case Management Client Satisfaction Survey) are published in a printed report that is presented to the HIV Services Planning Group and the Consumer Advisory Committee, are sent to all the contracted providers and are posted on the program's web site.
- The program's site visits and chart reviews are summarized in a report for each provider site visited and the results are summarized in the annual Quality Management Report.
- The program convened a Transition Team in the fall 2007 to assist in planning to increase access sites throughout the state and to develop a Service Access Center pilot in eastern Arkansas. This pilot program will include targeted data collection activities to monitor the success of increasing access for PLWH/A to HIV care and treatment services and will undertake an ongoing quality improvement process throughout the pilot timeframe.
- ADAP staff meet regularly to review the ADAP QI data and work as a team to develop strategies for improvement.

Quality Improvement Initiatives 2008-2010

1. Service Access Improvement Initiative (Pilot Project)

The Arkansas Department of Health, HIV Services Program has undertaken an extensive quality improvement initiative to improve the quality and effectiveness of the HIV service delivery system in Arkansas. A "Transition Advisory Group" was convened that is working with the Department to provide input, advice and recommendations on transitioning the current HIV continuum of care to a model that meets the requirements of the newly re-authorized Ryan White HIV/AIDS Treatment Modernization Act.

The Vision Statement developed by this group states: “Our vision is to create a cost-effective, accessible system of care for HIV-infected individuals in all areas of Arkansas that provides comprehensive services seamlessly and through which patients receive timely quality services from compassionate providers.” The Arkansas HIV Services Program also requested technical assistance from the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA). The first phase of this technical assistance was completed during the week of April 14-18, 2008 during which the consultant met with the HIV Services Program staff for four days. A thorough analysis of the current system was undertaken, in addition to multiple data queries from the two program databases (CAREWare and ADAP) and the surveillance database (HARS).

A report of all the findings was presented to the Transition Advisory Group in May 2008 and recommendations were made for a pilot in eastern Arkansas to increase service access points through out the eastern part of the State. An RFA was completed the week of December 8, 2008 to procure applications from service providers in four newly defined catchment areas to provide a package of core medical and support services (Health Insurance Premium and Cost Sharing Assistance, Mental Health Services, Medical Nutrition Therapy, Substance Abuse Service-Outpatient, Laboratory Services, Non-Medical Case Management, Food Bank/Home Delivered Meals, Medical Transportation, and Outreach Services). The applications are due in January 2009, and contracts should be issued by June 1, 2009. The Quality Management Plan includes goals related to data collection to monitor the progress of the pilot project and will be reported in the QM report and the 2010 application.

2. Oral Health Initiative

This is an initiative to assist at least 500 clients currently enrolled in the Part B program who have not received an oral health service in over 12 months to receive an oral health assessment that includes an exam, x-rays, cleaning and a plan for additional services. Reimbursement package has been developed, new client brochure about the importance of oral health has been developed and a new provider enrollment package has been developed. The client notification package is being mailed by the end of December 2008. The current provider package is being mailed the week of December 8, 2008 and the new provider package will be mailed as the consultant working on the project solicits new providers through private networks and Community Health Centers. Outcome data will be reported in the 2009 QM report.

3. Clinical Performance Measurement

The HIV/AIDS Nurse Consultants will be performing Clinical Chart Reviews in key medical sites through out the state. They are utilizing the HRSA developed Part C medical protocol and tool. The first site visits will begin in January 2009 and the results will be reported in the QM report.

4. Expanded Medical Services

HIV Service program is in the process of expanding the states ability of expanding lab services around the state. This may entail a statewide contract with these services being contracted directly by ADH.

5. Case Management Improvement Initiative

New case management standards, forms and updated policy and procedures will be developed beginning in January 2009 (to be effective April 1, 2009), as part of the overall system improvement. Additionally CAREWare has been revised effective December 2008 and new categories and units will be implemented effective April 1, 2009 that will allow the program to better report case management performance outcomes. The service access pilot will include stronger language in the contracts around case management performance related to standards and policy and procedures. Ultimately all providers will be required to respond to an RFA and comply with the new contract requirements.

Quality Management Program Evaluation

Building on activities in 2007 (installing CAREWare at all Ryan White Program offices, site visits, and discussions of data monitoring systems) and various meetings with stakeholders, the new Arkansas HIV Services Quality Management Program will evaluate the success of its' activities by undertaking the following activities:

- The QM Team will assess the effectiveness of the QM Program by regularly reviewing the data described in previous sections of this QM Plan;
- Reviewing and revising performance indicators to assure that the most accurate measures are being trended to help determine the quality of services being delivered;
- Review and improve the site visit protocol
- Review and improve the contract language and requirements; and
- Recommend and implement the evaluation projects based on questions that arise from the data analysis.

The results of the evaluation projects will be used to make system improvements. Additionally the QM program will regularly report on QM Plan implementation outcomes to the QM Task Force, the HIV Planning Group and the Consumer Advisory Committee that results in feedback that not only holds the program accountable but provides good input and advice from the entire community of experts.