

2017-2021

Integrated HIV Prevention and Care Plan Statewide Coordinated Statement of Need



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Introduction

On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS) for the United States, with an accompanying Federal Implementation Plan. The vision of the NHAS calls for the United States to “*become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance will have unfettered access to high-quality, life extending care, free from stigma and discrimination.*”

Since its inception as the nation’s first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015, the Office of National AIDS Policy (ONAP) updated the plan July 30, 2015 with sights on optimally addressing it’s three primary goals: (1) reducing the number of people who become infected with HIV; (2) increasing access to care and optimizing health outcomes for people living with HIV; and (3) reducing HIV-related health disparities.

The Update looks toward 2020 with the following statements in mind:

- There is still an HIV epidemic and it remains a major health issue for the United States.
- Most people can live long, healthy lives with HIV if they are diagnosed and get treatment.
- For a variety of reasons, certain populations bear a disproportionate burden of HIV.
- People across the Nation deserve access to tools and education to prevent HIV transmission
- Every person diagnosed with HIV deserves immediate access to treatment and care that is non-stigmatizing, competent, and responsive to the needs of the diverse populations impacted by HIV.

To successfully achieve the goals towards 2020, Arkansas’s integrated HIV Prevention and Care plan seeks to maximize opportunities and efforts on both spectrums to implement a comprehensive HIV model statewide. The following plan outlines continued measures for ensuring, regardless of the economical or governmental environment, that all Arkansans are identified, tested, and linked into care.

Background Information

Arkansas's HIV epidemic is continuing to trend upwards in communities of color. African American men, African American women, and Hispanic/Latino (men and women) constituted nearly 60 percent of all new infections, while the combined population represents only 21.8% of the state's total population. African American Men who have Sex with Men (MSM), the highest risk population, represented 56% of all new infections statewide. In contrast, the epidemic is showing signs of reaching a plateau in white MSM, a historically high risk group. White MSM comprises about 47.7% of all new infections statewide for 2014, a 1% increase from 2012. Overall there are more than 5,579 Arkansans having been diagnosed and are living with HIV and AIDS according to 2015 state surveillance statistics.

Through the Centers for Disease Control and Prevention (CDC) funding announcement PS12-1201, the Arkansas Department of Health received funding support to develop an Enhanced Comprehensive HIV Prevention Plan that would outline local strategies to achieve the goals outlined in the National HIV/AIDS Strategy (NHAS). The development of a localized enhanced plan should call for effective planning and implementation of HIV prevention and care services. Information about who is infected as well as affected, their backgrounds and both low and high risk factors should lay the foundation for local and regional prevention and care planning and would cover the entire state of Arkansas.

More than three decades into the HIV epidemic, great progress has been made both domestically and internationally in controlling the spread of infections, although more still needs to be done, especially among African American communities, which have been disproportionately impacted with new HIV infections.

As recommended by the United States Preventive Services Task Force (USPSTF), routine screening must be implemented in order to increase rates of early diagnosis and significantly address some of this disparity. Moreover it is crucial that following diagnosis there is a clear and distinct care continuum pathway utilizing a combination of the state's expanded Medicaid program known as Arkansas Works in 2016, Ryan White Services, ADAP and or private insurance options. As a result of these structural and environmental determinants, we as public health practitioners must be steadfast in addressing these challenges as we seek to meet communities' needs.

Without a doubt, social and economic determinants such as poverty, stigma, homophobia, transphobia, lack of education, conservative political environment and cultural unresponsiveness all obstruct the quality of life for those living with HIV in Arkansas. As a rural southern state, Arkansas lacks critical transportation infrastructure necessary to access health services.

The experience of living with HIV has advanced tremendously with advent of breakthrough biomedical prevention tools, scalability of high impact interventions, and access to a cadre of combo and solo drug regimens which are now extending lifespan's by achieving long term viral

suppression. Although each of these developments have now changed the way Arkansans can discuss, prioritize and organize prevention and clinical care services locally, access is still a tremendous barrier as it is estimated that a beginning monthly treatment regimen for an Arkansan is \$2100. According to the CDC, the projected lifetime cost per person for optimal HIV care can top \$385,200.

Arkansas's future progress in reducing new HIV infections and increasing viral suppression will require bold leadership in increasing the community information viral load through visible and dynamic public awareness campaigns (such as our own Know Now campaign) to achieve measurable health outcomes.

The Statewide Coordinated Statement of Need includes acronyms that are used throughout sections of the 2017-2021 Integrated Plan. (See Glossary)

From There to Now, Three Decades of HIV & AIDS in Arkansas

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 is also supported via guidance provided by both the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). The SCSN is a collaborative mechanism to identify and address significant care and treatment issues related to the needs of people living with HIV and AIDS (PLWH), 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 comprehensively planning for an integrated HIV Prevention and Care Plan process by discussing key factors affecting care and service delivery, identifying social determinants of health issues and supporting the development of goals, measurable objectives, strategies and resource allocation decisions by the Ryan White Program grantees, planning groups and providers.

Arkansas' 2017-2021 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; (See page 7)
- 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; (See page 12)

- Unmet Need in Arkansas—an estimation of the number of PLWH/A in Arkansas who are either aware or not aware of their infection, and also may or may not be 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;
- Intersectional 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) Infectious Disease Branch was responsible for convening partners across the Ryan White continuum of care, facilitating the development/update of the Statewide Coordinated Statement of Need (SCSN), and submitting the document to the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA). The SCSN Work Group included representatives of all Ryan White grantees, People Living with HIV/AIDS (PLWH/A) and public agency representatives.

The purpose of the SCSN is to identify broad goals and critical gaps in life extending care needed by PLWHA who are both in and out of care. The Early Intervention of Individuals Living with HIV/AIDS (EIIHA) Initiative is a legislative requirement that focuses on (1) individuals who are unaware of their HIV status; (2) how to bring HIV positive individuals into care’ and (3) linking HIV negative individuals to services in an effort to keep them HIV negative.

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 May 26, 2016 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.

Overview of HIV/AIDS in Arkansas

Racial and Ethnic Health Disparities in New HIV Infections

According to data for 2015 from the Arkansas Center for Health Statistics, a division of ADH:¹

In 2015, there were 197 new cases of HIV infection reported to the Arkansas Department of Health.

Race/Ethnicity

- 56% of the cases were African American, however, African Americans made up only 16% of the total Arkansas population.

¹Information maintained by the Arkansas Health Statistics Branch, a division of the Arkansas Department of Health. Accessed January 26, 2016

Gender

- African American and Hispanic/Latino women comprised 21% of new HIV infections in women
- African American and Hispanic/Latino men comprised 58% of all new HIV infections in men, however, only 11% of the general population of men in Arkansas.
- African American men alone comprised 56% of the new HIV infections, though they are only 8% of the general population of men in Arkansas.

Age

- African American and Hispanic/Latino women between the ages of 20 – 39 comprised 53% of the new infections in women.
- African American and Hispanic/Latino men between the ages of 20 - 39 comprised 36% of the new HIV infections in men.

The disproportionate impact of HIV infection among persons of color includes significant trends in higher mortality rates and diagnosis of AIDS upon initial HIV testing (or within twelve months of receiving an HIV diagnosis). Additionally, HIV infection has a disproportionate effect on African American men, who demonstrate much higher incidence and prevalence rates overall.

The two elements of concern that will impact the implementation of the Integrated Plan are:

- Socio-economics and stigma that creates barriers to HIV testing, access to care and treatment, as well as the scalability to implement programs in the populations most at risk.
- Linkage to care for reducing new HIV infections. People living with HIV who are not in care are more likely to engage in high-risk behaviors, putting themselves and others at greater risk for HIV transmission.

HIV Prevention Program

The Arkansas Department of Health HIV Prevention Program administers Centers for Disease Control and Prevention (CDC) funds. In partnership with the Arkansas HIV Planning Group (HPG), hereafter referred to as the HIV Planning Group (HPG), statewide assessments and prevention plans are developed and the impact of various programs are studied. On June 9th and 10th, 2016, a statewide planning meeting was held to a) review the HIV epidemiology across the state; b) discuss the priorities for funding through a future RFA; and c) to continue recruiting participation and leadership of the HIV Planning Group. The HPG membership voted to begin a bi-monthly meeting cycle to meet member scheduling requirements and associated planning levels.

The goals of the 2017 HIV Integrated Plan Working Group are:

- i. Review Prior efforts of HIV and Ryan White Jurisdictional Plans
- ii. Continue Partnerships with HPG other working groups/ community groups
- iii. Incorporate Consultant's efforts
- iv. Incorporate community input from HPG Planning Retreat

Meeting these program goals require a strategic implementation of preventions and interventions by agencies engaged in the delivery of HIV related programming and services.

HIV Planning Group (HPG)

In 2015, the Branch integrated HIV prevention and care planning activities to increase Program Coordination and Services Integration (PCSI). One initiative to increase community engagement was established through the HIV Planning Group. Governance documents guide the efforts of the HPG and reflect a representative membership and voting members. These include CDC-funded prevention programs (both directly and indirectly funded), Ryan White Treatment Modernization Act-funded care and support services programs (Parts B, C, and D), collaborating state agencies, community-based organizations (CBOs), faith-based programs, and interested community members. Participation from consumers living with HIV/AIDS is ensured, with the bylaws mandating that a significant effort be launched to reach out to those living with HIV.

Four of the HPG's committees (Condom, Public Relations, Membership, and Needs Assessment) meet during a portion of the HPG meetings as well as between meetings. The group will schedule additional meetings off site as needed to fulfill future planning obligations.

Applications for membership in the HPG are available during public open sessions or by request. The community planning principles of parity, inclusion, and representation guide the selection of HPG members. Persons selected as Co-Chair serve a two-year term. The membership of the HPG reflects, as much as possible, the demographic characteristics of the HIV epidemic in Arkansas. The following criteria are utilized to assist in the selection of members:

- Infected or affected by HIV;
- Expertise in the following HIV-related program service areas: HIV clinical care; case management; HIV counseling and testing services; partner services; comprehensive risk counseling and services; evidence-based health education/risk reduction programs; mental health counseling; substance use prevention and/or treatment; and housing;
- Representative of a geographical area of high incidence and prevalence; and/or
- Representative of priority populations: persons with HIV, African American Men who have Sex with Men (AAMSM); African American Women who have Sex with Men (AAWSM); African American Men who have Sex with Women (AAMSW), White Men who have Sex with Men (WMSM); Injection Drug Users (IDU); and Hispanics/Latino(a)s.

Within the two year period of 2014-2015, the HPG spearheaded the formation of several micro workgroups via the Community Connector's Program to further address specific population needs and provide recommendations to meet those needs.

Engagement Process

Following the engagement process recommendations of the "HIV Planning Guidance," the Arkansas Department of Health Infectious Disease Branch invited community members and key stakeholders to the

HIV Planning Group Retreat held in June 2016. During that meeting, micro focus groups were formed to further assess the comparability and viability of service gaps, challenges and goals of the planning process. Secondly, a consultant was subsequently contracted to assist with the researching and updating the SCSN. In the third and final phase, the IDB internal working group reviewed all of the documents to form the Integrated Plan which was voted on by the HIV Planning Group and submitted to CDC for review.

Updating Process

The creation of the Integrated HIV Prevention and Care Plan comes under the guidance of the ADH Infectious Disease Branch. The HPG 2016 retreat provided an opportunity to review additional historical data, guidance addendums, and further review of assessed needs.

Epidemiology of HIV in Arkansas

Reporting of HIV infection in Arkansas began in 1989 and ongoing surveillance efforts across the state capture required information about those persons testing positive. This data includes race, age, gender, and information related to high-risk behaviors. Standardized case report forms are used to collect socio-demographic information, mode of exposure, laboratory and clinical information and vital stats.

HIV data may underestimate the number of recently infected individuals because some infected persons have not been tested and do not know they are infected. In addition, newly diagnosed cases may be reported to the health department at any point during the clinical spectrum of the disease. Therefore, HIV infection provides an estimate of the number of person known to be HIV infected.

(See Appendix for Epidemiology-Unmet Need Estimates of HIV in Arkansas)

Incidence and Prevalence-2015

In 2015, there were 197 new cases of HIV reported in Arkansas. Of these 197 new cases of HIV:

- 78% were male; 22% were female
- 49% were under the age of 30; 51% were aged between 30-49
- 34% were White, 56% were African American and 7% were Hispanic or Latino
- Approximately 40% of new reports had an AIDS status (2015 HIV Surveillance Annual Report)

Arkansas is trending with national statistics which cites African Americans and Hispanic populations as disproportionately impacted communities. According to the Demographic Research Unit at the University of Arkansas at Little Rock (UALR), only 15.4% of the population in

Arkansas is African American and 6.4% are Hispanic or Latino. This is quite significant given that of the new cases of HIV in 2015, 56% were African American and 7% were Hispanic or Latino. Conjointly, males are also disproportionately affected; the Demographic Research Unit at UALR reports that 49.1% of the Arkansas population is male, however, males accounted for 78% of the new HIV cases in 2015.

Primary prevention/interventions (interventions focused on HIV-negative persons) are most relevant when based on recent and prioritized modes of transmission or risk factors. The best method and data on which to base those interventions is on persons recently tested for HIV, even though they may not be newly infected.

AIDS Incidence is defined as the number of new AIDS cases reported during the period specified. This includes persons who were originally diagnosed as HIV, non-AIDS, and progressed to AIDS sometime during the year. It also includes those reported as HIV, non-AIDS in previous year who progressed to AIDS in the specified year.

HIV-NA Incidence is defined as the number of new HIV, non-AIDS cases reported during the period specified.

HIV/AIDS Incidence is defined as the sum of new HIV-NA cases and new AIDS cases reported during the period specified. Within the each year, each case is only shown once (can be either an HIV-NA case or AIDS case).

Figure 1: Arkansas HIV/AIDS Incidence Rates 2015

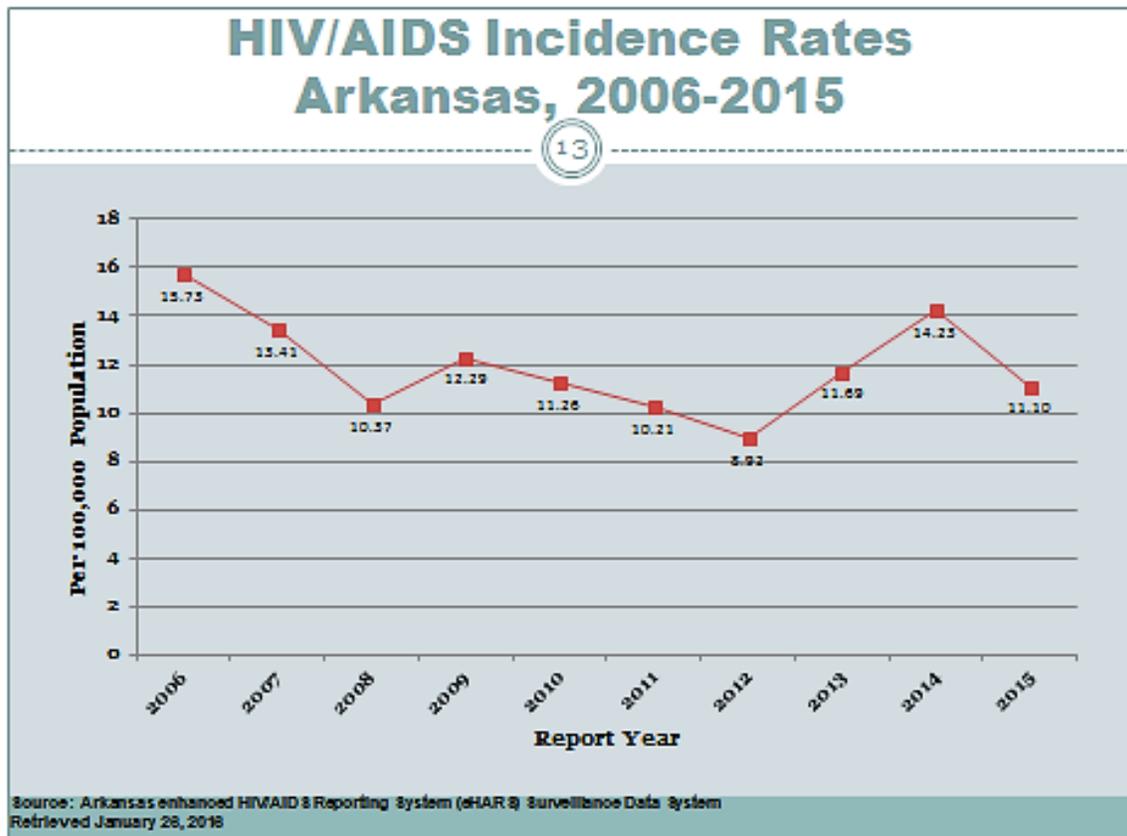
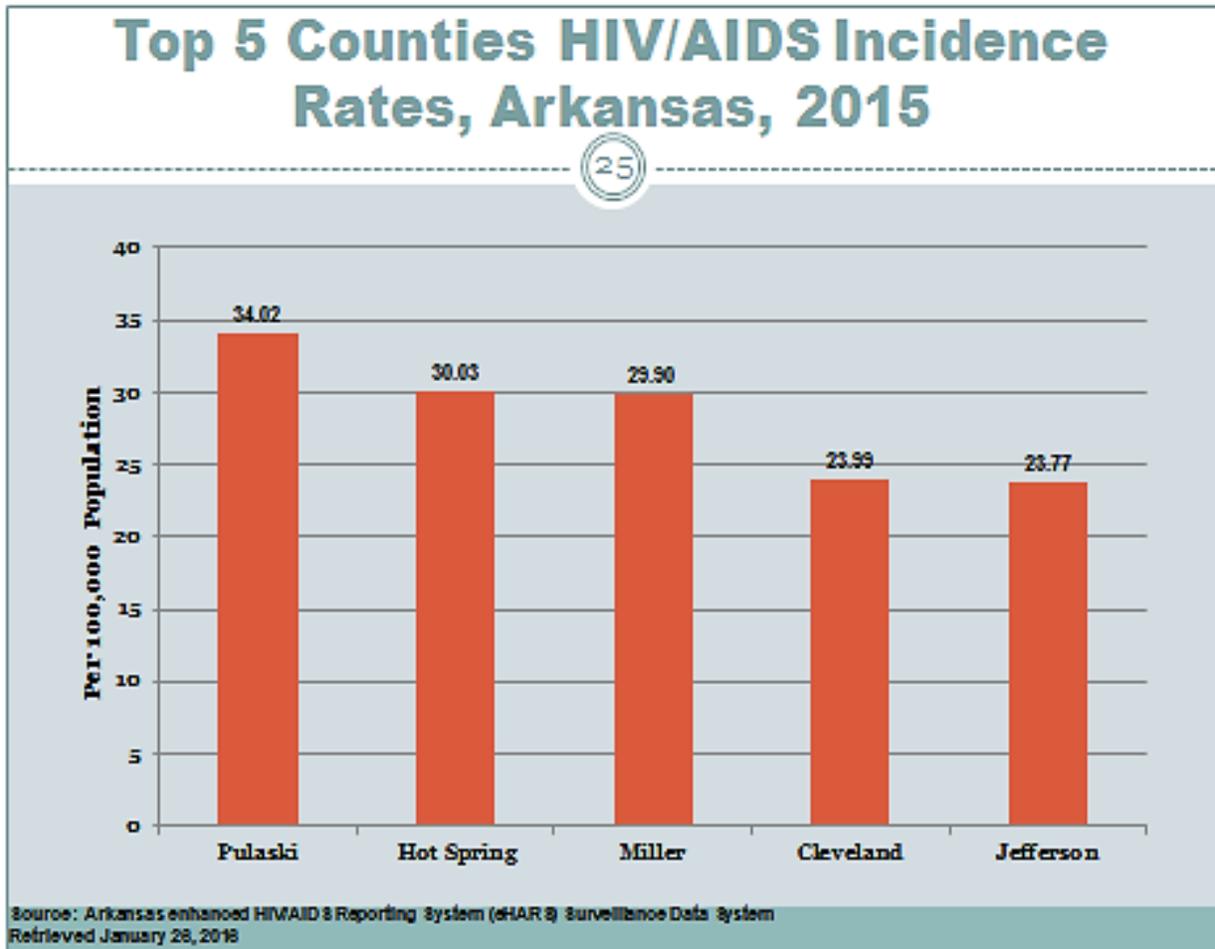


Figure 2 below illustrates the top five Counties HIV/AIDS incidence 2015 rates in Arkansas. This graph focuses on specific counties of the state where disproportionate case rates are being reported. Additionally, Figure 2 could facilitate discerning areas in which to focus testing efforts. On one hand, testing could be targeted in areas shown to have high incidence rates for 2015. Alternatively, testing efforts could be concentrated in regions that may not have high incidence rates but have high proportions of the populations that are disproportionately affected by HIV.

In utilizing either methodology, it is anticipated that Figure 2 would aid in finding previously undiagnosed HIV positive individuals.

Figure 2: Top 5 Arkansas Counties HIV/AIDS Incidence Rates 2015



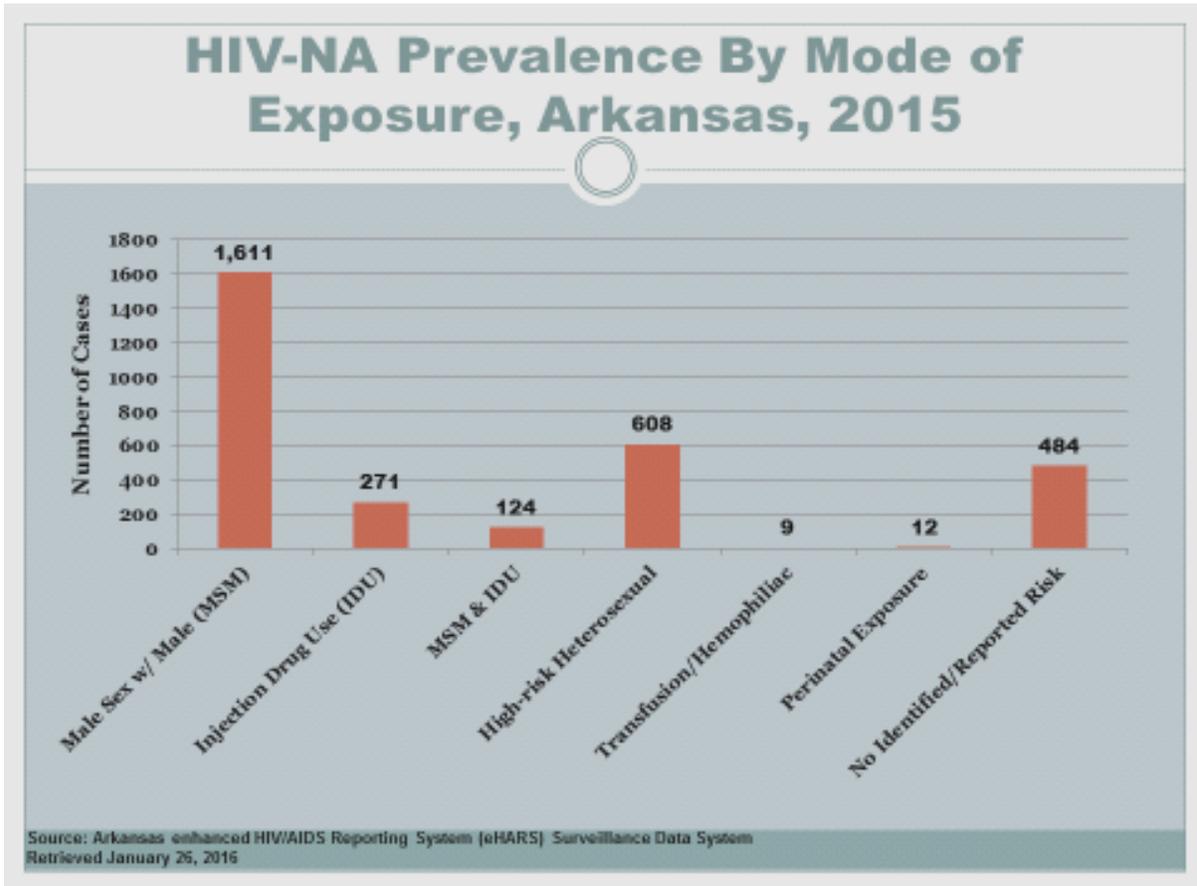
Prevalence as of December 31, 2015

As of December 31, 2015, there were **5,579** persons living with HIV infection in Arkansas. Of these cases:

- 77% were male and 23% were female
- 42.2% were African American and 49.3% were White

Figure 3 below concludes the reported modes of transmission or risk factor of persons living with HIV across Arkansas. The chart highlights that male sex with male (MSM) as a significant identifier with also a notable sector of individuals reporting No Identified or Reported Risk factor.

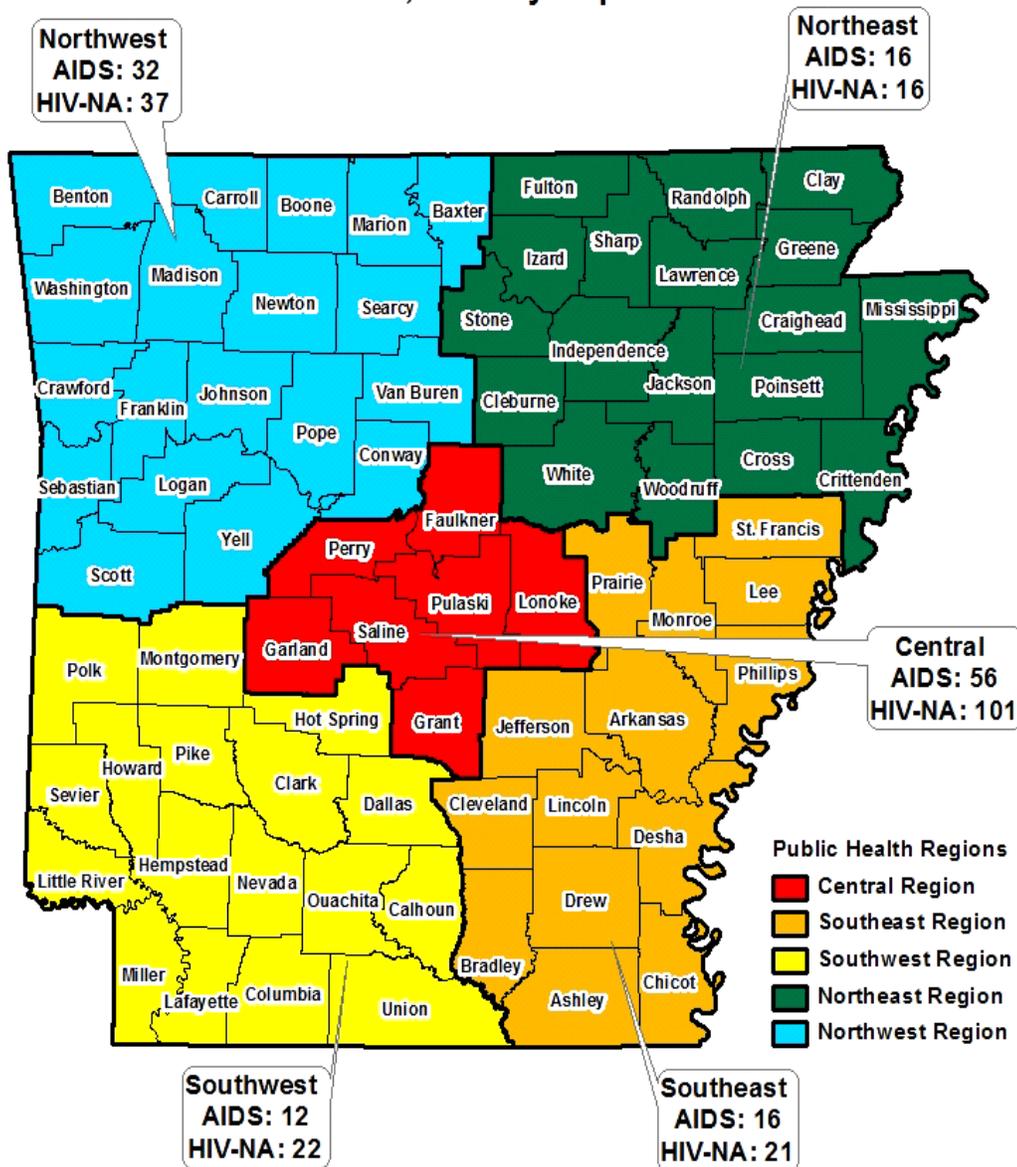
Figure 3: HIV-NA Prevalence By Mode of Exposure, Arkansas, 2015



To further assist in developing targeted High Impact Prevention and intervention efforts, this map offers a geographical snapshot of 2015 HIV/AIDS Incidence Rate by the designated six Public Health Regions (see Figure 4 below).

Figure 4

HIV/AIDS Incidence by Public Health Regions Arkansas, 2015 by Report Date



Date: February 2, 2016
 Source: Arkansas Department of Health
 Map created by: Marwa Sadawi

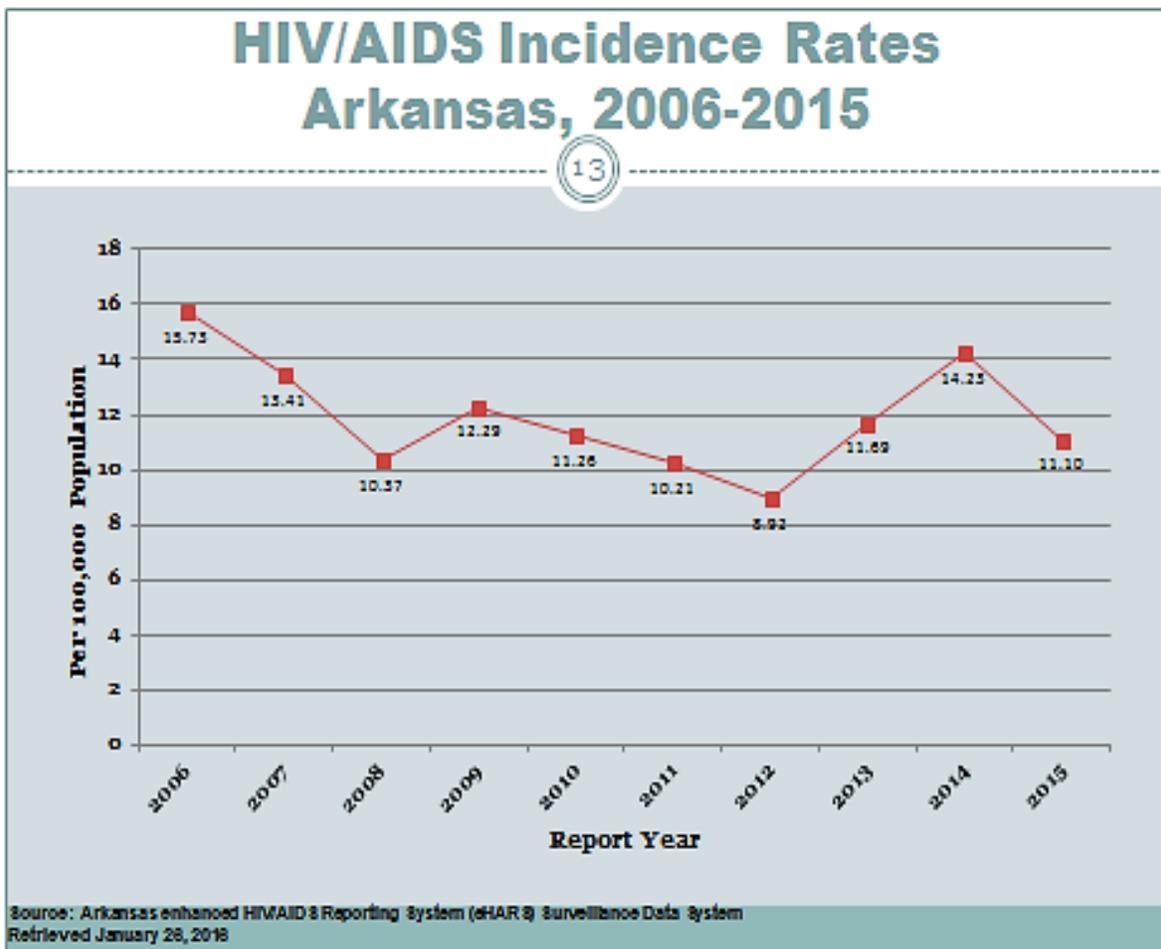
Data Source: Arkansas STD*MIS Surveillance Data System
 Retrieved January 26, 2016

Trends in HIV Infections

Surveillance data offers insights on trends for the past ten-year period by age, race, and risk categories are provided in Figures 5, 6 and 7, respectively. These trends illustrate the scope of HIV infection to support and guide our planning processes, initiatives, new program designs as well as selection of innovative intervention strategies to reduce new HIV infections across Arkansas.

Figure 5 below illustrates the 2006-2015 HIV/AIDS Incidence Rates over the last ten years showing peaks in 2006, lowest point in 2012 and the current status of 11.10 in 2015.

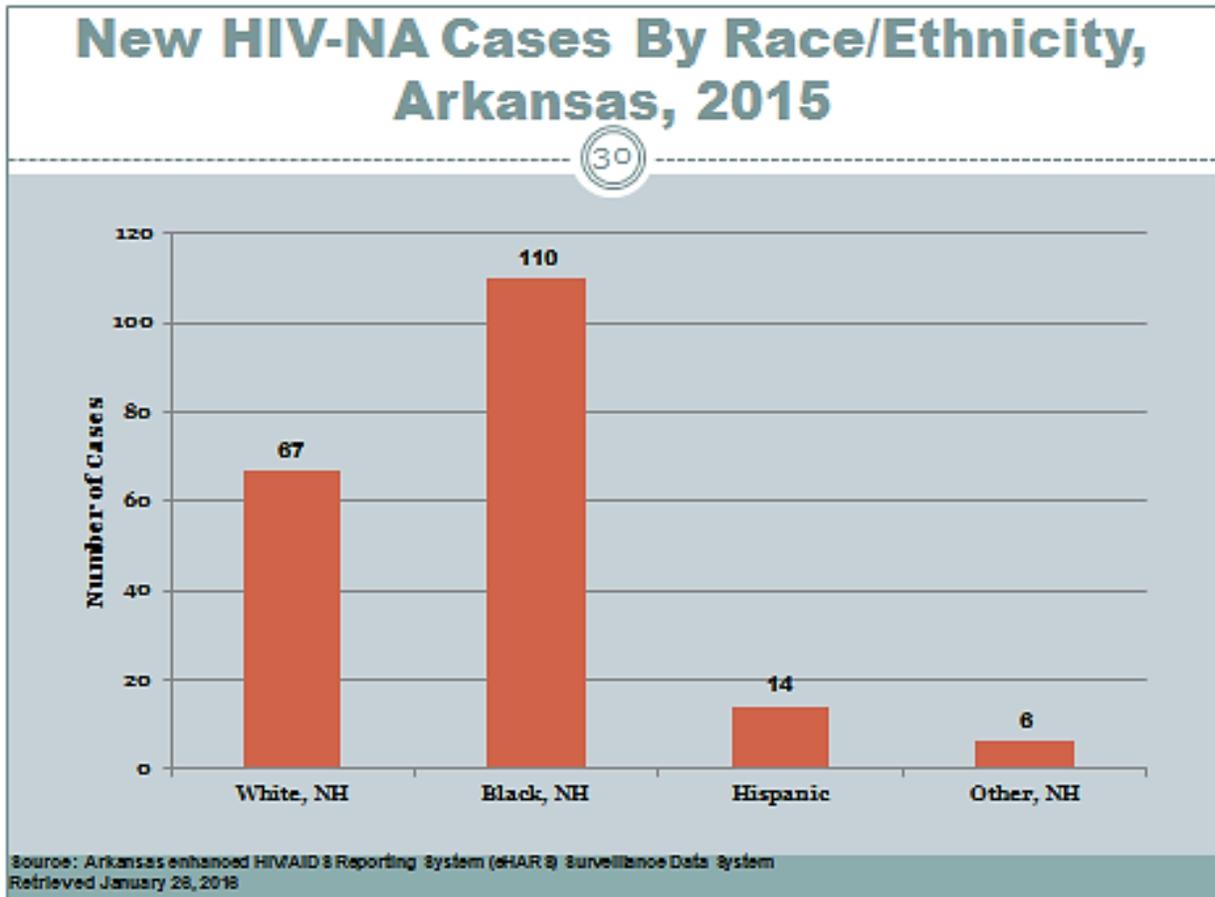
Figure 5: Arkansas HIV/AIDS Incidence Rates 2015



As of December 2015, a disproportionate impact of HIV-NA infections continues to be exemplified in Figure 6 below. In the state, a wide disparity has remained among Black, non-Hispanic population comprised of 15.8% of the state's population they accounted for 55.8% (n=110) of the PLWHNA. The Hispanic population comprised 5.5% of Arkansas's population

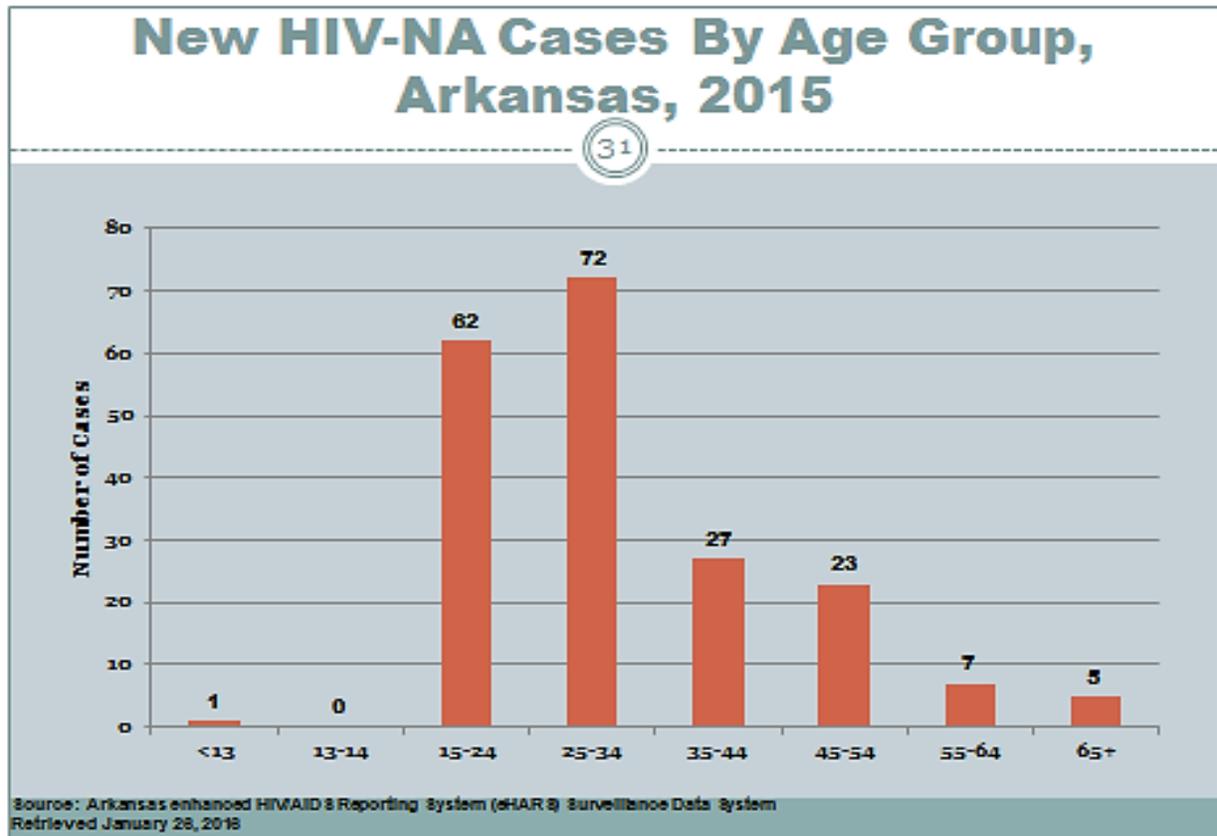
and accounted for 7.1% (n=14) of PLWHNA. The White, non-Hispanic population comprised 76.7% of the population in Arkansas and accounted for 34.0% (n=67) of the PLWHA. The other races comprised 2.0% of the population in Arkansas accounted for 1.4% (n=6) of the PLWHNA.

Figure 6: New Arkansas HIV-NA Cases by Race/Ethnicity 2015



In CY 2014 and 2015, the majority of new HIV cases were among individuals 15 to 34 years at the time of their disease diagnosis (68.1%, n=134). When the age ranges of this group were examined individually, it was observed that 15-24 at diagnosis comprised 31.5% (n=62) of the new HIV diagnoses, 25-34 year olds at diagnosis comprised 36.6% (n=72) of the new HIV diagnoses, 35-44 year olds at diagnosis comprised 13.7% (n=27) of the new HIV diagnoses and 45-54 year olds at diagnosis comprised 11.7% (n=23). In the state of Arkansas, 60.8% of the state's population were 44 years of age or younger and this this population comprised 88.8 (n=161) of the new cases of HIV. In contrast, persons aged 45 years or older comprised of 39.2% of the state's population and this age group at diagnosis comprised 11.7% (n=23) of the new HIV diagnosis; an incidence rate of 11.7 per 100,000. The Arkansas enhanced HIV/AIDS Reporting System (eHARS) served as the data source (see Figure 7 below).

Figure 7: New Arkansas HIV-NA Cases by Age Group



Resources

A description of existing resources for HIV prevention services, care and treatment contracts directly with physician, laboratory services, mental health, oral health, and pharmacy services. These service providers constitute the Arkansas Ryan White Part B Provider Network.

Number of medical providers	26
Number of medical service sites	46
Number of dental service providers	30
Number of dental service sites	35
Number of mental health service providers	10
Number of mental health service sites	30
Number of hepatitis C service providers	10
Number of hepatitis C service sites	18

Further analysis of the network shows the following:

Ten (10) Hepatitis C providers and Eighteen (18) service sites

One (1) medical service provider with more than two physicians and several service sites across the state

Ten (10) individual private practice physicians

Six (6) dental service providers with more than two dentists and several service sites across the state

Twelve (12) individual private practice dentists

Two (2) mental health groups

Six (6) individual mental health providers

Three (3) University of Arkansas for Medical Sciences Area Health Education Centers (AHECS)

Six (6) medical facilities that provide both medical and dental services

Current Partners Include

- *ARCare
- *Jefferson Comprehensive Care Systems, Inc.
Arkansas Hope
Part of the Solution, Incorporated
HEAL (Healthcare, Advocacy, Education & Leadership)
NWA Equality Center
- **Community Connectors
UAMS College of Public Health
UAMS Research and Evaluation Division
HIV Arkansas
Consortia Care of Arkansas
South Arkansas Fights AIDS
- *Greater Delta Alliance for Health
- *Arkansas Human Development Corporation

* *State Funded Prevention grantees are funded to provide HIV testing and counseling in Arkansas.*

** *Funded to provide innovative approaches to HIV testing and counseling, linkage to care, and educational outreach.*

Gaps

Prioritize and address gaps that need to be met to increase impact on the HIV epidemic.

- Without adequate funding the program may not successfully identify individuals who are positive and refer them to care.
- HIV Stigma is a major driver that should be addressed across all sectors of the population, especially within the African-American community. This dilemma directly impacts many people from receiving care, partner disclosure and sharing their positive status with family members.
- The need to increase sexual health education in rural areas of Arkansas is paramount. Among men who have sex with men (MSM), transgender individuals and African-American women, there is need for education regarding their susceptibility to high risk factors. Additionally, increased efforts regarding public health awareness is needed to reach the general population on how to access testing sites, convenience of rapid testing with onsite results and the critical need of knowing one's status.
- Improved access to services at the Arkansas Department of Health STI clinics. Most clinics operate from 8 a.m. to 4:30 p.m., and given work or school responsibilities, this presents a barrier to accessing services. To enhance services access, designated clinics should consider being open at least one evening weekly. Also additional cultural sensitivity and responsiveness training should be required and monitored through random patient surveys.

- According to the CDC, full access to Pre Exposure Prophylaxis (PrEP) information and prescriptions as a biomedical tool that can be combined with condom use for high risk negatives.
- Lack of cost efficient transportation and adequate housing inventory continue as a barrier to HIV treatment and access to care in rural sections of the state according to the CDC.

Scalability of Activities

Also, keeping in alignment with CDC’s recommended activities under “Core Prevention Programs” for Category-A funded grant recipients, we will continue to:

- Prioritize HIV testing among identified priority populations, i.e. African American MSM 19-34, heterosexual Black Women, High risk negatives.
- Continue to identify and minimize barriers to linkages to care and treatment (high impact prevention with positives by increasing effectiveness of services and minimizing long term cost)
- Utilize a Data to Care strategy to increase outcomes of those either lost to or not retained in care.
- Increase social marketing, media, and community mobilization efforts as core funded initiatives.
- Continue to recognize the importance of condom distribution as a core component in decreasing new infections. Condoms are currently distributed at HIV testing events, via the Community Connectors program and other non-clinical venues and events targeting prioritized populations. In our health care settings, local health units will also continue to provide condoms upon request. It is our goal to increase condom distribution access by 20% in identified key access points in all five health regions. (high impact/low cost)

Prevention Partners and Strategies

The primary mechanism for coordination of health education/risk reduction services has been through local HIV prevention contractors. The Infectious Disease Branch provides funding to 4 HIV prevention contractors for implementation of proven effective evidence-based interventions. Each Prevention Contractor works collaboratively with various and diverse agencies and organizations, including but not limited to local alcohol and drug abuse authorities, county health clinic programs, housing communities, faith-based organizations and houses of worship, youth-serving organizations, jails and corrections facilities, minority-based organizations, and homeless and domestic violence shelters. Funded prevention contractors must demonstrate community partnerships and support as well as the ability to reach priority populations with priority high impact prevention testing and counseling using qualified evidenced based interventions to

targeted populations being served. (See appendix for Prevention Partners and Care Provider Listing)

The funding for the 2017 HIV Prevention Projects will focus on three areas:

- ▶ HIV Prevention Interventions with MSM
- ▶ HIV Testing and Counseling with High Risk Populations
- ▶ Innovative Approaches for Marginalized Populations

Responsible agency/group to carry out the activity

The Infectious Disease Branch will be responsible to carry out the activities and will continue to collaborate with funded agencies, community based organizations, and community members-at-large for achieving high impact results with our prioritized populations.

Contact Information for this program plan:

Contact:	Phone:	E-mail Address:
Courtney Hampton (Primary) Contact:	501-661-2749	Courtney.Hampton@arkansas.gov
Cornelius Mabin (Secondary)	501-349-7777	Nealix101@comcast.net

Health Department Funded Categories

Please select the required core components and recommended program components implemented with the jurisdiction:

Category A: HIV Prevention Programs for Health Departments

Required core components (required for all funded grantees):

- HIV Testing
- Comprehensive Prevention with Positives
- Condom Distribution
- Policy Initiatives

Recommended program components:

- Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk
- Social Marketing, Media and Mobilization

PS12-1201 Resource Allocation

One of the goals of this FOA is to reduce HIV transmission by building capacity of health departments to focus HIV prevention efforts in communities and local areas, where HIV is most heavily concentrated, to achieve the greatest impact in decreasing the risks of acquiring HIV. Grantees should monitor the HIV/AIDS epidemic within the jurisdiction for program planning, resource allocation and monitoring and evaluation purposes. Grantees should utilize the most current epidemiological and surveillance data and other available data sources to assist in program planning and evaluation.

To ensure that resources are reaching the areas of greatest need, grantees will be required to report annually to CDC on the amount of funding allocated to the areas with 30% or greater of the HIV epidemic and how the funds were used.

Please identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas or zip codes within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease.			
MSA/CITY	Percentage of HIV Epidemic	Percentage of PS12-1201 Funds Allocated	Components and Activities Funded
Little Rock	32%	50%	HIV Testing and Counseling for High Risk Populations
Pine Bluff	6%	10%	HIV Testing and Counseling for High Risk Populations
Fayetteville	5%	12%	HIV Testing and counseling for High Risk Populations

Note: If a state with a directly-funded city funds programs within that city with PS12-1201 funds, then the state should include the directly-funded city within this reporting. If a state with a directly-funded city does not fund any programs within the directly-funded city with PS12-1201 funds, the state should exclude cases attributable to directly-funded cities and recalculate the areas that represent 30% or greater of the HIV disease burden for the remainder of the jurisdiction.

PS12-1201 Category A
HIV Prevention Programs for Health Departments (*core funding*)

Required Component: HIV Testing

The following are the National-Level Objectives and Performance Standards that will be used for HIV testing and linkage to care activities funded under Category A. Category A goals and objectives should be developed in relation to the National-Level Objectives and Performance Standards while also addressing elements of each program component as listed in the FOA.

National Goal: CDC expects approximately **two** million HIV tests will be provided annually, among all funded jurisdictions, when the program is fully implemented.

Performance Standards: CDC expects each funded jurisdiction to achieve the following performance standards, when the program is fully implemented:

- For targeted HIV testing in non-healthcare settings or venues, achieve at least a 1.0% rate of newly-identified HIV-positive tests annually.
- At least 85% of persons who test positive for HIV receive their test results.
- At least 80% of persons who receive their HIV-positive test results are linked to medical care and attend their first appointment (within 90 days of the positive HIV test).
- At least 75% of persons who receive their HIV-positive test results are referred to and interviewed for Partner Services (within 30 days of having received a positive test result).

Required Elements for HIV Testing:

- A. Implement and/or coordinate opt-out HIV testing of patients' ages 13-64 in healthcare settings.
- B. Implement and/or coordinate HIV testing in non-healthcare settings to identify undiagnosed HIV infection using multiple strategies and the most current recommendations for HIV counseling, testing and referral.
- C. Support HIV testing activities in venues that reach persons with undiagnosed HIV infections. D. Ensure the provision of test results, particularly to clients testing positive.

- D. Promote routine, early HIV screening for all pregnant women according to current CDC recommendations.
- E. Encourage and support health department and non-health department providers to increase the number of persons diagnosed with HIV through strengthening current HIV testing efforts or creating new services.
- F. Facilitate voluntary testing for other STDs (e.g., syphilis, gonorrhea, and Chlamydia infection), HBV, HCV, and TB, in conjunction with HIV testing, including referral and linkage to appropriate services, where feasible and appropriate and in accordance with current CDC guidelines and recommendations. *(This activity may be implemented in collaboration with STD, hepatitis, and/or TB programs).*
- G. Ensure that testing laboratories provide tests of adequate quality, report findings promptly, and participate in a laboratory performance evaluation program for testing. *(This activity may be done in conjunction with surveillance and/or laboratory services).*
- H. Incorporate new testing technologies, where feasible and appropriate.

HIV Testing Goals:

- Reducing new infections.
- Increase HIV Testing in non-clinical settings.
- Reduce HIV stigma through the utilization of local and national campaigns targeting diverse populations.
- Increase testing capacity and education to community stakeholders by providing testing kits and promotional resources.

HIV Testing Objectives and Annual Targets

In an effort to monitor progress toward meeting the PS12-1201 Category A national objectives, please submit your jurisdictional proposed objectives for number of HIV test events, number of newly-identified HIV-positive test results, and new HIV-positive test rate for years 1-5 of the project period. For each year, enter the projected number of HIV test events that will be conducted and the anticipated new HIV-positive test rate.

Objectives	Targets per Year					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
# of HIV testing events	10	9	9	8	8	44
# of HIV positive test results	20	20	20	20	20	100
# of newly-identified HIV-positive test results	20	20	20	20	20	100
New HIV-positive test rate (%)*	20/10	20/9	20/9	20/8	20/8	
# of newly identified HIV-positive test results returned to clients	20	20	20	20	20	100

*# of newly-identified HIV-positive test results (numerator)/# of HIV testing events (Denominator) = Target rate for new HIV positivity.

Outcome Objective(s)

1. Increase rates of linking newly identified infections into care and treatment.
2. Reduce HIV stigma through HIV education and awareness campaigns
 - **Process Objective 1:** By January 30, 2017, establish three additional testing sites in non-traditional settings
 - **Process Objective 2:** By April 1, 2017, developed strategies to distribute and promote local and national HIV Testing and Prevention Campaigns
 - **Process Objective 3:** By December 2018, provide service providers with resources and collaborative opportunities to increase HIV screenings in non-clinical settings

Capacity Building Activities Planned for HIV Testing:

- Conducting Voluntary Testing, Counseling and Referral (VCT/CTR)) Courses throughout the state
1. Provide capacity building to stakeholders and community organizations for HIV/Health events

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
How many VCT/CRT Trainings were conducted?	Number of trainings, number of participants	Training calendar, enrollment data,	January – December 2017
Was technical Assistance provided?	Hours provided to assist with stakeholders/community events,	Time sheets, telephone/conference records, minutes, social and internet communications,	January – December 2017

Required Component: Comprehensive Prevention with Positives

Required Elements for Comprehensive Prevention with Positives:

- A. Provide linkage to HIV care, treatment, and prevention services for those persons testing HIV-positive or currently living with HIV/AIDS.
- B. Promote retention or re-engagement in care for HIV-positive persons.
- C. Offer referral and linkage to other medical and social services such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and other services as needed for HIV-positive persons.
- D. Provide ongoing Partner Services (Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydia Infection, 2008 (1) for HIV-positive persons and their partners: Collaborate and coordinate with STI programs, and HIV and/or STI surveillance programs to utilize data to maximize the number of persons identified as candidates for Partner Services. (2) Partner with non-health department providers, including CBOs and private medical treatment providers, to identify more opportunities to provide Partner Services.

- E. Assure that HIV-positive pregnant women receive the necessary interventions and treatment for the prevention of prenatal transmission.
- F. Conduct sentinel event case review and community action to address local systems issues that lead to missed perinatal HIV prevention opportunities by utilizing the Fetal and Infant Mortality Review (FIMR)-HIV Prevention Methodology, including CDC’s web-based data system (see www.fimrhiv.org), where appropriate and based on local need and the availability of resources.
- G. Support behavioral and clinical risk screening followed by risk reduction interventions for HIV-positive persons and HIV-discordant couples at risk of transmitting HIV.
- H. Support implementation of behavioral, structural, and/or biomedical interventions (including interventions focused on treatment adherence) for HIV-infected persons.
- I. Support and/or coordinate integrated hepatitis, TB, and STD screening (STD Treatment Guidelines, 2010), and Partner Services for HIV-infected persons, according to existing guidelines.
- J. Support reporting of CD4 and viral load results to health departments and use of these data for estimating linkage and retention in care, community viral load, quality of care, and providing feedback of results to providers and patients, as deemed appropriate.
- K. Promote the provision of antiretroviral therapy (ART) in accordance with current treatment guidelines. (CDC funds may not be used to purchase antiretroviral therapy).

Comprehensive Prevention with Positives: Goals

1. Create an enhanced linkage to care system for individuals who are HIV positive
2. Increase the STD Testing of infected HIV Positive persons

Comprehensive Prevention with Positive Objectives and Annual Targets 2017-2021						
Objectives	Targets					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Newly-identified HIV-positives						
# HIV-diagnosed clients (new and previous positives) linked to HIV medical care	1136	1151	1166	1181	1196	5830
# of newly identified HIV positive clients who were referred and linked to prevention services	200	250	300	350	400	1150
# of clients with a newly identified HIV positive test result referred to and interviewed for Partner Services	1136	1151	1166	1181	1196	5830

Outcome Objective(s)	Responsible for implementation
<p>Process Objective 1: By June 2017, the Arkansas Department of Health will institute a strategy to promote and increase efforts for Program Collaboration and Service Integration in care and prevention programs including mental health, sexual assault and substance use.</p> <p>Process Objective 2: By November 30, 2017, 85% (70 of approximately 82) of HIV case Managers will attend training with an emphasis on Pre-Exposure Prophylaxis.</p> <p>Process Objective 3: By January 30, 2018, the Arkansas Department of Health will require its DIS employees to complete required ASTDI competencies including Passport for Partner Services.</p> <p>Process Objective 4: By December 1, 2019, the Arkansas Department of Health will collect more behavioral risk data, needs assessment information involving members of priority populations to better guide decisions for planning and implementing intervention programs and targeting resources.</p>	<p>Ryan White Program, DIS, and HIV Prevention Public Health Educator and Trainer</p>

Capacity Building Activities Planned for Prevention with Positives:

1. Enhance linkage to care education for clients with a recent history of being categorized as “out of care” by conducting educational sessions on linkage to care services and regimen adherence.
2. Create at least a core support group for African Americans in selected regions in Arkansas for individuals who are living with HIV or HIV Stage 3.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
How many HIV Case Managers were trained on the importance of adherence?	Number of HIV Case Managers in Arkansas	Participant sign-in sheet from trainings	September 30, 2017-October 1, 2016
How many support groups were identified in each region?	Number of established and functional HIV support groups in each regions	Participant sign-in sheet from support group sessions	September 30, 2017-October 1, 2016

Required Component: Condom Distribution

Required Elements for Condom Distribution:

A. Conduct condom distribution to target HIV-positive persons and persons at highest risk of acquiring HIV infection.

Condom Distribution Goals:

Goal 1: Implement a social marketing campaign to promote condom usage on 3 social media sites.

Goal 2: Conduct community wide mobilization efforts to support and encourage condom usage.

Condom Distribution Objectives and Annual Targets

Objectives	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Number of condoms to be distributed identified to HIV-positive individuals	10,000	10,500	11,000	11,500	12,000	55,000
Number of condoms to be distributed targeted to high-risk negatives/HIV unknown status	10,000	10,500	11,000	11,500	12,000	55,000
Total condoms to be distributed (overall)	21,000	21,000	22,000	23,000	24,000	110,000

Outcome Objective(s)	Responsible for implementation
Process Objective 1: By January 30, 2017 Establish baseline for wide scale distribution.	HIV Prevention Staff, HPG, and DIS
Process Objective 2: By March 30, 2017, increase the number of condom distribution sites.	
Process Objective 3: By May 30, 2017 identify possible policy issues and funding allocations for condom distribution.	

Capacity Building Activities Planned for Condom Distribution:

1. Establish a condom distribution committee and chairperson on the HPG
2. Create condom distribution tracking sheet to be used by Health Department staff, funded CBOs, and condom distribution committee on the HPG.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
How Many Condoms were distributed?	Number of condoms ordered	Condom distribution tracking sheet	October 1, 2016-September 30, 2017
To what populations were condoms distributed?	Populations that condoms were distributed to	Condom Distribution tracking sheet	October 1, 2016-September 30, 2017

Required Component: Policy Initiatives

Required Elements for Policy Initiative Strategies:

A. Identify and align structures, policies, and regulations in the jurisdiction with High Impact HIV prevention, linkage to care and treatment, and create a productive environment for all sexual health efforts. Policy efforts should aim to improve efficiency of infectious disease prevention efforts where applicable, and are subject to lobbying restrictions under federal law.

Policy Initiative Goals:

Goal 1: Promote awareness of Ark. Code Ann 5-14-123, Arkansas Criminalization Statue and advocate for modernizing the statue based on current evidence based sciences. Model the approach on passed legislation in Iowa 2014/ Colorado 2016.

Goal 2: Work with Arkansas Department of Health upper management, Branch Chief, and additional policy makers to clarify any policies that are currently set on condom purchasing and distribution in Arkansas.

Note: When providing the Policy Initiatives objectives, please indicate at what stage the jurisdiction expects to be for each of their policy initiatives for each year, using the following categories: *Identification* (i.e., Identification/recognition of need, review of existing policies); *Planning* (i.e., policy formulation/preparation/development); *Implementation*; or *Evaluation*.

Outcome Objective(s) HPG recommends the following Outcome Objectives

- **Process Objective 1:** By April 31, 2017, provide educational forums to identified stakeholders to outline the tenants of the statue and strategies to present to collaborators and establish a proposed HIV Criminalization Modernization Working Group.
- **Process Objective 2:** By February 2019, offer information sessions and proposed legislation to identified key legislators on Public Health Committee.
- **Process Objective 3:** By April 2019, HPG will co- host a web based special debriefing session to detail outcomes, barriers, best practices and next steps on the outcomes of the legislative approach.
- **Process Objectives:** By February 2020, the working group will publish a “white paper,” to detail project outcomes, timelines, challenges, barriers and impact.

Responsible for Implementation:

Arkansas HIV Planning Group, Community Connectors, Proposed HIV Criminalization Modernization Working Group

Capacity Building Activities Planned for Policy Initiative:

1. Request trainings from the Center for HIV Law and Policy and other CBA providers who provide expertise in this issue.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
How many people were educated about the proposed legislation?	Number of read email responses	Email Distribution Lists	April 2017-December 2017
How many stakeholders received training and fully participated in the effort?	Number of Trainings	Sign-in sheet form Trainings	April 2017-February 2018

Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk of Acquiring HIV
Not applicable

Recommended Elements for Innovative Interventions for HIV-Negative at High Risk:
(In 2024 CDC no longer supported technical assistance, training and literature for the DEBI intervention RESPECT.)

- A. Voluntary Counseling and Testing
- B. Implement community evidence-based interventions that reduce HIV risk.
- C. Increase education outlets concerning Harm Reduction Programs, where allowable, and according to HHS and CDC guidelines. Programs that use federal funding for HRP should adhere to state and local laws, regulations, and requirements related to such programs or services. Programs must have a certification signed by an authorized official. Funded grantees must, in turn, have documentation that local law enforcement and local public health authorities have agreed upon the location for the operation of the program.

HIV Prevention Intervention Goals:

Goal 1: Provide coordinated community level high impact testing and counseling services based on the Community PROMISE strategy.

Goal 2: Ensure that high-risk individuals receive culturally appropriate information based on the Culturally Competent Care approach.

EBIs for High-Risk Negatives Objectives and Annual Targets						
Objectives	Targets Per Year					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total

# of high-risk HIV negative clients who will enroll in individual and group level evidence-based interventions (ILIs and GLIs)	0	50	75	95	105	325
# of community level high impact testing and counseling events to be conducted	2	2	2	2	2	10
# of people to be reached by community level high impact testing and counseling events	500	650	725	900	975	3750

Outcome Objective(s)	Responsible for implementation
Process Objective 1: RFA will be released in 2017.	HIV Prevention Program Manager and Branch Chief
Process Objective 2: By June 2017, identify high prevalence areas for EBIs to be considered for implementation.	HIV Prevention Program Epidemiologist

Capacity Building Activities Planned for HIV Prevention Interventions:

1. Provide up to five (5) CDC approved trainings for organizations that are selected to implement EBI interventions.

Monitoring and Evaluation question

Indicator(s)/Measure(m) Data Source(ds) Timeline(t)

(s)How many high risk clients were enrolled in EBI interventions in Arkansas?

(s)How many EBI interventions were implemented?

(ds)Number of funded organizations who implement EBIs

(ds)Names of agencies who were selected to provide services from the 2017 RFA

(m)Programmatic Reports from funded grantees

(T)Results of 2017 RFA selection process beginning November 1, 2017-November 30, 2018

Recommended Component: Social Marketing, Media, and Mobilization

Recommended Elements for Social Marketing, Media, and Mobilization:

- A. The Know Now Campaign is a branded campaign of the Infectious Disease Branch of the Arkansas Department of Health.

B. Support and promote educational and informational programs for the general population based on local needs, and link these efforts to other funded HIV prevention activities (e.g., pamphlets, hotlines, or social marketing campaigns).

C. Support and promote the use of media technology (e.g., Internet, texting, and web applications) for HIV prevention messaging to targeted populations and communities.

D. Encourage community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among family, friends, and neighbors.

Social Marketing, Media, & Mobilization Goals:

Goal 1: To create an innovative social media marketing strategy leveraged to mobilize youth 13-24 using the KNOW NOW Campaign

Goal 2: SMART: Sensible, Measurable, Attainable, Realistic and Timely.

Goal 3: To communicate culturally responsive and accurate information while addressing the integration of social determinants of health and structural interventions impacting prioritized populations.

Goal 4: Develop clear and efficacious campaigns deployed to penetrate and increase the information viral load of allies, PLWH, stakeholders and targeted audiences utilizing all HIV Awareness Day events scheduled throughout the calendar year.

Social Marketing, Media, & Mobilization Objectives and Annual Targets						
Objectives	Targets Per Year					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
# of social marketing/public information campaigns to be conducted	2	3	2	3	2	12
# of people to be reached (exposures)	100,000	100,000	100,000	100,000	100,000	500,000
# of media placements for marketing campaigns	1000	1,500	2,000	5,000	10,000	19,500
Outcome Objective(s)				Responsible for implementation		
Process Objective 1: Increase the number of clients who get tested in high risk populations by 10% by encouraging High Risk Populations to get tested by using the Arkansas branded Know Now campaign Process Objective 2: Provide HIV education to 25 local community partners in Arkansas.				HIV Prevention Staff		

Capacity Building Activities Planned for Social Marketing, Media, & Mobilization:

1. Presence of Know Now campaign at heavily populated events targeting the High Risk population (i.e. Blues on the River, Riverfest, Gay Pride events, faith based organizations, universities, State Fair).
2. Partnering with Tobacco Cessation Programs at major events targeting the high risk population to reach larger audiences.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
What was the percent increase of people who were tested after upgraded Know Now campaign was implemented?	Number of people tested for HIV	HIV Test Forms	March 2017-July 2019
How many community partners were trained on HIV 101?	Number of participating community partners	Sign-in sheets from community partner trainings.	March 2017- March 2018

How do individuals perceive the quality of the Know Now campaign in comparison to other health related campaign?

Recommended Component: Pre-Exposure Prophylaxis and Non-Occupational Post-Exposure Prophylaxis Services: Applicable

Recommend Elements for Pre-Exposure Prophylaxis and Non-Occupational Post-Exposure Prophylaxis:

- A. Support Pre-Exposure Prophylaxis (PrEP) services to MSM at high-risk for HIV consistent with CDC guidelines (“Pre-exposure Prophylaxis (PrEP) for the Prevention of HIV Infection in Men Who Have Sex with Men” guidelines in the *Morbidity and Mortality Weekly Report (MMWR)*. Programs that use federal funding for PrEP related activities should adhere to state and local laws, regulations, and requirements related to such programs or services. PrEP-related activities must be implemented as part of a comprehensive HIV prevention program that includes, as appropriate, linkage and referral to prevention and treatment services for STD, viral hepatitis, substance abuse, and mental health, and other prevention support services. Funds may **not** be used for PrEP medications (antiretroviral therapy).
- B. Offer Non-Occupational Post-Exposure Prophylaxis (nPEP) to populations at greatest risk.

PrEP and n-PEP Goals:

PrEP and n-PEP Objectives and Annual Targets						
Objectives	Targets Per Year					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
# of PrEP general trainings	2	4	6	8	10	30
# of PrEP capacity building session for organizations seeking to implement access to PrEP	2	3	4	5	6	20

Outcome Objective(s)	Responsible for implementation
Process Objective 1: To specifically pursue specified funding within the 2017 RFA.	Arkansas Dept of Health (IDB)
Process Objective 2: Support the development of a statewide awareness campaign	

Capacity Building Activities Planned for PrEP and n-PEP

Utilize the AIDS Education and Training Center Program and Associated Capacity Building Entities

Coordination and Linkages

Collaboration and linkages between state and local agencies and organizations are essential to successfully plan, implement, and evaluate effective and comprehensive HIV prevention and care services. Coordination of resources (programmatic, skills, fiscal, and personnel) strengthens prevention and care efforts in local areas and across the state, especially in times of increasing demand and decreasing dollars. The governmental and non-governmental programs, agencies and organizations noted in this section work together to deliver comprehensive HIV prevention services and/or link to prevention activities that reduce the risk of transmission of HIV and delay onset of illness in persons with HIV.

Partnerships between programs facilitate the sharing of information, materials, or client referrals. Coordination is an active process to enhance efforts toward a common goal or purpose, and in doing so:

- Integrates and maximizes resources;
- Facilitates complementary and supplementary programs; and leads to a system in which the whole is greater than the sum of its parts.

The benefits of coordination are compelling and beneficial to the public and include, but are not limited to:

- Standardized and consistent prevention and early intervention messages;
- Minimized duplication of effort;
- Maximized use of available resources;
- Increased access to funding opportunities and other resources;
- Increased capacity and improved quality of services to individuals and communities because of shared knowledge and improved planning; and
- Expanded communication and technical assistance opportunities through interaction with others who provide complementary skills, knowledge, or other resources.

Some providers experience or perceive disadvantages or threats related to participation, despite the benefits coordination offers. The strongest disincentives to coordination include, but are not limited to:

- Increased competition for limited dollars or resources;
- Concern by individuals or agencies that a coordinated process might result in their loss of control over programs or resources;
- A perceived change in equity or standing within the power structure; and
- Time constraints of participants.

ADH and its partners work diligently to strengthen and increase linkages and coordination through their work to decrease gaps in and barriers to effective Program Coordination and Services Integration, as well as increase the benefits to participation.

ARKANSAS DEPARTMENT OF HEALTH INFECTIOUS DISEASE BRANCH

The Infectious Disease Branch (IDB) administers the CDC HIV and STD prevention programs, Ryan White Treatment Modernization Act Parts B (including ADAP) and D, and the primary portion of the statewide HOPWA program. This organizational structure ensures collaboration of state and local staff and coordination of planning and funding mechanisms.

Prevention programs are delivered primarily in six health regions (covering 110 county health units) and community organizations such as local alcohol and drug abuse commissions, AIDS service organizations, and minority community-based organizations. A complete listing of Health Department-based HIV Prevention Program Models by Region for

The Infectious Disease Branch has developed a comprehensive approach to STD/HIV prevention, which includes:

Active surveillance to track the STD/HIV epidemics; Cost-effective routine screening and treatment of at-risk populations; Consistent messages emphasizing the availability of a continuum of services from prevention to care; Partner services; Targeted health education/risk reduction

interventions; Routine screening for HIV within funded hospital emergency departments; On-going training and capacity-building assistance as well as, on-going evaluation and quality management.

HIV and STD programs are fully integrated. HIV tests are routinely offered via qualified grantees, community based groups, QHFC and Community Connectors Initiative. Educational messages, monitoring of data for trends, and staff training are conducted jointly. Mobile van screenings for HIV and STDs (syphilis, Chlamydia, and gonorrhea) were discontinued as of 12/31/15 due to a resource reassignment by a Ryan White grantee.

The toll-free Arkansas AIDS/STD Hotline, operated by ADH staff, facilitates linkages, including information about accessing counseling and testing services, and other prevention services, as well as Ryan White, HOPWA and other care services.

The Infectious Disease Branch also maintains a website which is accessible to the public www.healthyarkansas.gov. Information contained on the website includes:

- Surveillance report data for HIV/AIDS and other STDs;
- The Arkansas Bureau of Public Health Laboratories also has a long-standing relationship with the STI/HIV Division. The labs process and report confirmatory HIV, Viral Load, CD4, and STD test results.

Additional coordination and linkages activities include:

- HIV Care and Support Information for Communities, including an overview of ADAP, and HOPWA;
- HIV Counseling, Testing, and Referral Services (CTRS);
- Public Information Programs; and
- Information for Health Care Providers, including information on Prenatal Screening; and Additional Resources and Links.
- The primary linkages to HIV counseling and testing services re made through:
 - Partner services;
 - AIDS hotline referrals; **(800-462-0599 / 800-661-2169)**
 - HIV prevention contractors and CBOs providing health education/risk reduction;
 - Outreach strategies by community organizations, Ryan White Part C and D providers,
 - Routine opt-out HIV screening in STD, TB, and Family Planning clinics;
 - Routine HIV screening for pregnant women;
 - Hospital Emergency Departments participating in the Expanded Testing initiative;
 - HIV testing in several alcohol and drug abuse facilities;
 - Physicians/primary care providers; and
 - Public information/media awareness activities and events.

HIV counseling, testing and referral services are available in each county health department. The Infectious Disease Branch HIV tests and numbers of new cases detected are leveling, except for increases among gay African American's 15-34. It's the branch's ongoing goal to increase access to effective HIV treatments as well as intense prevention services delivered by community organizations, local health departments and HIV service providers who have contributed to slowing the annual rate of new HIV cases. Expanding testing services in other clinical settings such as hospital emergency departments is recommended to diagnose more HIV infected persons earlier, allowing for improved health. A growing number of persons with HIV are living longer, requiring on-going care, treatment and prevention services. At the end of 2015, more than **5,579** persons were known to be living with HIV/AIDS in the state.

All newly diagnosed persons with HIV infection in counseling and testing sites are referred to existing care services. Depending on insurance status or personal situations, clients are referred either to private providers or Ryan White Parts B, C, and/or D providers. In order to facilitate referrals, county health department counseling and testing sites offer an initial HIV Screening test on a sliding scale to clients seeking services. Screening for syphilis and tuberculosis is provided for all newly identified HIV-infected clients and referrals are made for treatment within the health department if necessary. Screening for Hepatitis C is also routinely provided. Staff also makes referrals for drug treatment services, counseling, support groups, AIDS service organization services, Medicaid, and other services as appropriate.

RYAN WHITE SERVICES

The Arkansas Ryan White Part B CARE Program is funded by an annual federal grant. Its goal is to assist low-income, HIV infected individuals with the cost of specific health care needs. Benefits of the program are determined by federal guidelines and a state advisory council made up of representatives from health care, those with HIV disease, support groups, and state agencies. The Arkansas Department of Health, Infectious Disease Branch administers the program which currently serves **1804** clients statewide in all health care districts

Arkansas receives funding from Part B of the Ryan White CARE Act. Funds are utilized to provide economic assistance for HOPWA rent, utilities, transportation, health insurance, food, and nutritional supplements to individuals infected with HIV disease. These services allow individuals who do not qualify for Medicaid, Medicare, or private insurance to access needed services.

The annual federal grant also funds AIDS Drug Assistance Program (ADAP). ADAP provides medications to low-income individuals who are infected with HIV disease. Qualified individuals have limited or no coverage under Medicaid, Medicare, or private insurance that may provide access to medications for the treatment of HIV disease. As of August 1, 2016, Arkansas' ADAP Formulary included 116 medications: ARV=36; Opportunistic Infections (OI) =20; other=56; Hepatitis C=4, this includes all medications currently approved by the FDA for the treatment of HIV disease. In addition to federal funding, HIV Services acts as the ADAP provider for the state. Qualified individuals statewide receive medications through an ADAP-approved pharmacy, which offers walk-ins and mail orders.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 is the defining federal legislation impacting the program. It provides Arkansas with additional funding and flexibility to respond effectively to the changing epidemic. In Arkansas, Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS. A significant impact affecting Arkansas' Ryan White Program is that at least 75% of the grant funds must be spent on "core medical services," across our provider network in Figure 8. Core medical services include:

- HIV-related medications through the Arkansas Drug Assistance Program (ADAP)
- Laboratory Services
- Oral Health Care
- Primary Medical Care

Figure 8: The Ryan White Service Providers Network

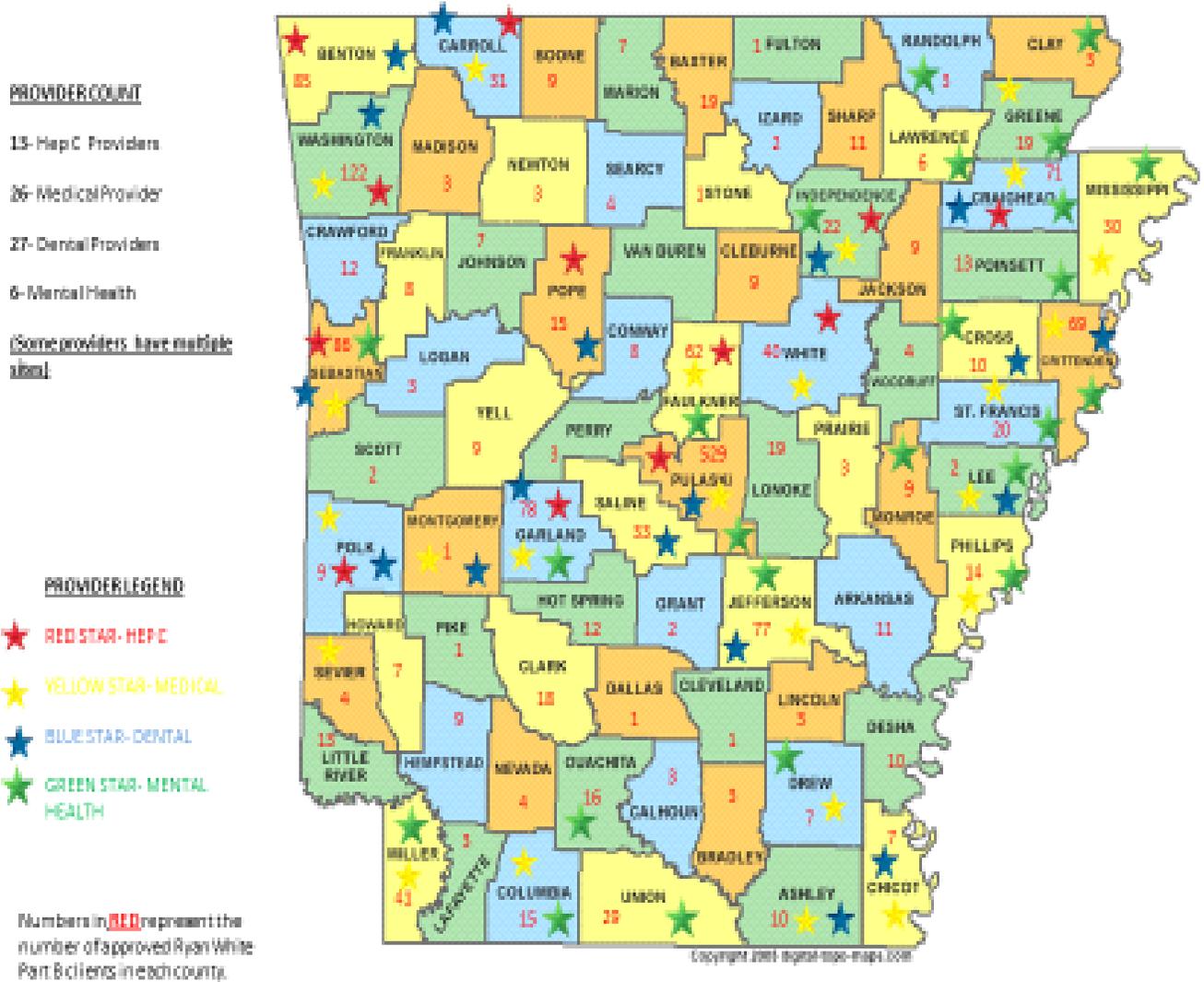


Figure 9: Ryan White Active Client Count By Month

RYAN WHITE ACTIVE CLIENT COUNT BY MONTH							
Date	Dist 1	Dist 2	Dist 3	Dist 4	Dist 5	Dist 6	Total
07/02/14	310	105	246	227	597	118	1,603
08/28/14	309	100	252	231	617	119	1,628
10/02/14	314	101	254	231	612	118	1,630
10/30/14	312	102	252	228	602	103	1,599
11/26/14	316	103	258	231	580	112	1,600
12/31/14	310	106	258	239	582	106	1,601
01/29/15	313	108	260	238	582	106	1,607
02/27/15	317	107	263	243	591	106	1,627
03/30/15	333	100	257	244	602	111	1,647
04/30/15	343	100	257	243	598	110	1,651
05/28/15	349	100	250	242	615	106	1,662
06/30/15	349	105	255	248	615	106	1,678
07/30/15	357	101	260	245	628	106	1,697
08/31/15	360	102	261	250	642	105	1,720
10/01/15	359	108	265	249	637	110	1,728
10/30/15	356	111	263	247	651	110	1,738
12/02/15	366	111	262	252	649	111	1,751
12/31/15	369	111	268	248	659	112	1,767
01/28/16	370	109	264	257	656	112	1,768
02/29/16	367	110	266	259	658	112	1,772
03/31/16	368	115	265	259	670	118	1,795
04/28/16	370	118	271	269	695	124	1,847
05/31/16	366	123	273	261	694	126	1,843
06/30/16	374	121	270	264	685	119	1,833
07/18/16	369	120	268	254	704	89	1,804

Service Access Centers

Service Access Centers (SAC) are a part of the program funded by Ryan White Part B in the State of Arkansas. Service Access Centers are non-clinical locations throughout the state where HIV positive Arkansans can apply for and obtain Ryan White Part B services. The Arkansas Department of Health provided a total of \$2,209,000 for funding a 12-month sub grant(s) beginning April 1, 2016 and ending March 31, 2017.

The network's mission is to offer a coordinated system to deliver HIV-related health care services where a comprehensive continuum of care is sound, practical, and applicable across all regions in the state, and which maximizes limited resources while continuing the goal of assisting low-income HIV-infected individuals with the cost of specific health care needs.

Six districts have been formed to ensure accessibility to HIV-related services and collaborative efforts within communities throughout the state. Currently there are twelve (12) Service Access Centers (SAC) and four satellites within the six (6) districts across the state. AR Care, Incorporated is the primary contractor/ project sponsor serving clients statewide. Clients may elect to receive services from a SAC outside of the service area in which they reside. However, a client may only be enrolled in one (1) SAC at any given time. Case load projections for GY 15/16 will reach a threshold of **1542** with projections for GY16/17 reaching **1710**.

Each Service Access Centers must be physically located in a county of each district and must provide services for all the counties indicated within that district.

Using the "one stop shop" approach, the centers are required to provide comprehensive client-centered HIV Care Coordination services by a multidisciplinary team that includes, at a minimum, a non-medical case manager and a Medical Case Manager (MCM). Care coordination will include, but may not be limited to, the following duties:

A. Non-Medical Case Manager

- Intake and eligibility screening and registration into the Ryan White Part B Program
- Development of a non-Medical Case Manager Plan for each client within thirty (30) days of enrollment following standards and forms required by ADH completing an intake and screening form(s) upon admission.
- Coordination of non-medical services and activities.
- Make referrals to outside services and medical case managers to address intake screening, assessment and adherence findings as appropriate.
- Review of non-Medical Case Manager Plan every six (6) months that includes a documented Service Access Plan review interaction either face-to-face or via telephone with the client.
- Develop an outreach plan striving to achieve the goal of serving at least 40 % of the need in each district.
- Recertification of the client's income and residency eligibility every six (6) months or per ADH policy.
- Services administration, coordination and reporting.
- Conduct annual face-to-face non-medical case management screening.
- Provide referral and access to support services for HIV infected clients in the community.
- Provide/facilitate mental health support group(s) within service area on a monthly basis.
- Provide health education and risk reduction education and counselling.
- Facilitate client transfer and inactivation in compliance with ADH policies.
- Document client interaction in progress notes, on required forms and in the CAREWare database.
- Client-specific advocacy.

- Review of client utilization of services.
- Assist clients with applying for medical services payment programs, such as Medicare, Medicaid, the Health Insurance Marketplace or other third-party payers.
- Provide direct support services to assist clients to successfully remain in HIV medical care and treatment.

B. Medical Case Manager:

- Develop a Medical Services Plan, for all clients who are receiving on-going Medical Case Management, within thirty (30) days of enrollment following the standards and MCM Assessment form(s) required by ADH.
- Coordinate medical care and disease management activities
- Review Medical Services Plan for all active MCM clients based on their acuity level following the standards required by ADH.
- Conduct annual face-to-face Medical Case Management Assessment to include history taking and an appraisal of the general overall appearance, demeanor and affect of the client. (Medical Case Manager Assessment/Reassessment Form is required.)
- Participate in case conferencing with the client’s medical services provider at a minimum of every six (6) months or as required by acuity level in the standards of care.
- Facilitate health education and risk reduction education and counselling.
- Facilitate client transfer and inactivation in compliance with ADH policies.
- Document client interacting in progress notes, on required forms and in the CAREWare database
- Provide referrals for medical evaluation and treatment.
- Schedule and coordinate medical appointments and follow up.
- Facilitate clinical care and treatment plan implementation.
- Conduct home visits as deemed necessary to improve adherence to treatment plan.
- Manage case consultation with physicians, dentists, Registered Nurses, Advanced Practices Nurses, Physician Assistants and Service Access Specialists.
- Provide education about HIV, its transmission, complications, risk reduction and harm education.
- Provide education and counseling about HIV disease process management.
- Provide case management of HIV medication therapy to include education of client concerning risks and side effects, monitoring disease process to include lab values; monitoring client adherence and tolerance of medications; and collaborating with the AIDS Drug Assistance Program (ADAP) Coordinator and the ADAP contracted pharmacy to ensure accurate ordering and shipping of client medications.
- Conduct adherence assessment and interventions to include counseling, education and referral, as appropriate.

- Provide nutritional assessment and interventions to include counseling, education and referral, as appropriate.
- Provide interventions and education about a variety of issues, as appropriate to both client assessed need for intervention and the MCM's trained skills.

Interventions may include (but are not limited to):

1. Healthful living habits
2. Holistic approach to wellness o Safer sex practices
3. Partner notification and testing
4. Prevention of exposure to opportunistic pathogens
5. Teaching women to perform breast self-exam o Needed immunizations

The ultimate goal is to create a well-defined network of community resources to provide a continuum of care ranging from core medical services to wrap round support services for persons living with HIV in Arkansas.

Linkage to Care Services

As of July 2014, a Linkage to Care Coordinator (LTCC) position was established and a candidate hired to perform Linkage to Care activities to address identified individuals who were seen as fallen from care or needing retention in care services. Utilizing State epidemiological and surveillance data the coordinator was to focus within populations such as African American and Hispanic citizens because of group characteristics which have been observed in more than half of all newly diagnosed cases in Arkansas in 2015.

The scaling of the program seeks to embrace the HIV Continuum of Care Cascade to optimize opportunities for those living with HIV to remain or re-engage in care, as well as, the National HIV AIDS Strategy goal of linking 85% of newly diagnosed HIV patients to clinical care within 3 month of diagnosis. After individuals are diagnosed with HIV, positive health outcomes are achievable when individuals are both immediately linked into medical care and remain adherent to medical treatment. Arkansas currently stands at the 74.9% level of the linkage to care goal, 55% of the HIV Viral Suppression level and 20.3% decrease in HIV death rate.

Using the program's CAREWare system, the coordinator documents case notes detailing both communication(s) and additional tracking information with individuals, including type of encounter: face to face or non-face to face, the clients status of: newly diagnosed, unmet needs, 30 Day to Discharge Ryan White Part B Program, 30 Day to Discharge Aids Drug Assistance Program, or Follow up on Discharge Client(s). The 30 Day to Discharge report which is generated the 15th of each month clearly identifies clients who have been classified as possibly facing future termination from the program. Once the client has been discharged from the Ryan White Program the client runs the risk of not receiving their medications on time or not being able to access the

additional services that are provided through the Ryan White. It is a distinct goal of the LTCC to avoid such consequences or service interruptions to care.

Subsequent outcome reports demonstrate the success rate of how outreach activities such as phone calls and letters reached the contacts within targeted groups who were identified as non-compliant based on agency parameters. The program delineates that an individuals whom hasn't received either laboratory results or completed a scheduled physician's visit within a 3- 12 month period as "out of care," with the latter benchmark generating a Unmet Need report which requires additional investigation. After such a report has been cited, the coordinator uses a variety of databases and cross reference networks such as Patient Reporting Investigating Surveillance Manager (PRISM), Greenway, Arkansas Integrated Revenue System (DMV), Arkansas Department of Correction, search engines like *Spokeo* and Facebook to either compare, contrast, or update personal identifying contact data.

In certain circumstances, the Linkage to Care Coordinator travels into the field to assist clients with transportation to appointments or to meet clients face to face in a neutral setting and educate them on the qualities of the Ryan White Program and its network of providers. During these interactions the program has increased information on how to access RW Part B services, links to pharmacy services for those who have not secured refills within a 90 day period, regimen adherence, and the essentials of a care regimen in sustaining a quality of life for both those newly diagnosed or returning to care.

Working in tandem with the Ryan White Part B funded case management access sites, Case Managers, Medical Case Managers, ADAP Coordinator, the HIV prevention testing sites (including local health units), Outreach Specialists, ADH Epidemiologists/Surveillance, Disease Intervention Specialists, and medical providers to ensure individuals are subjected to our priority appointment "Red Carpet" approach to "treatment as prevention.

The Quality Management Coordinator and the Linkage to Care Coordinator also work closely together to develop the following measured outcomes:

- Unmet Need-the number of persons without a reported laboratory in twelve months; that are successfully linked into care with a contracted program medical provider.
- Newly Diagnosed- the number of persons linked into care thirty days after diagnosis.
- Thirty Day Pending Discharge of Ryan White and ADAP- the number of persons pending discharged that are retained into care.
- Linkage Attempts- number of encounter face to face or non-face to face.

As an integrated function of addressing HIV in Arkansas, it's paramount to correlate all our of strategies for HIV prevention involving early diagnosis and linkage to care, retention in care, and sustained antiretroviral therapy (ART) in order to decrease new infections while increasing the proportion of patients with undetectable viral load. The Linkage to Care program foresees itself continuing to encourage client centric decision making to achieve greater health outcomes.

ADAP Services

The Arkansas AIDS Drug Assistance Program (ADAP) is a state administered program that provides HIV/AIDS medications to low-income individuals living with HIV/AIDS who have little or no coverage from private or third party insurance. The program serves as a core service of the Arkansas Ryan White program and assists clients with medications to treat HIV disease, health insurance coverage for eligible clients, and services that enhance access, adherence, and monitoring of medication treatment.

The program's budget for fiscal year 2013 (FY) was \$5,304,984, a 9% reduction from FY 2012 appropriations as included in the 2014 National ADAP Monitoring Project Annual Report prepared by the National Alliance of State and Territorial AIDS Directors. (NASTAD)

The program is registered as a 340B Rebate State through the Office of Pharmacy Affairs, which allows participation in 340B drug pricing which enables the program to receive outpatient drugs at a significantly reduced price. In FY 2013 the program estimated to recover \$800,000 in rebates, which is 15% of its budget as a cost saving mechanism.

Clients are placed on ADAP through the state's Eligibility Screening Specialist in which the prospective client must provide proof of current residency, whether they are uninsured or under-insured and meets the financial eligibility threshold of 400 % of the Federal Poverty Level (FPL). All Arkansas ADAP clients must recertify every six months.

As of 3rd Quarter 2016 there are 448 individuals being served by the ADAP program. 121 on full ADAP medication service (no insurance coverage). The remaining clients have insurance coverage but are receiving assistance after insurance coverage with medications from the ADAP: 84=Medicaid; 168=Medicare Part D; 75=Private. Demographically, the program serves 35% African Americans, 52% Non-Hispanic White, 2% Hispanic and 4% as unknown. From a gender prospective the program serves 73% Males, 27% Females and 0.2% identifying as Transgendered. Clients served age range from 13-24 (12%), 25-44 (44%), and 45-64 (30%).

Through the provision of continuum of care ADAP provides wrap-around services for eligible Medicare Part D clients who are in need of assistance with co-pays and deductibles. The program is used to enhance access for all clients by utilizing a centralized pharmacy to ship all medications via postal mail.

Leveraging the capability to interface with the Arkansas Medicaid database has increased the programs efficiency to coordinate with the Ryan White asset to more easily identify those clients who are 100% covered by Medicaid. Further enhancing the programs efforts is a data sharing working agreement with the Center for Medicare and Medicaid Services for the exchange of ADAP client's enrollment information.

Sharing this data has allowed the Arkansas ADAP to identify individuals that are both eligible for Part D and have already enrolled in a Part D plan. Our pharmacy component contracted to HealthCare Pharmacy, Incorporated, located in Little Rock, Region 5 of our health care districts, is a full service contractor which has an additional Medicaid number that allows the ADAP to bill

retroactively for patients who become Medicaid eligible. Within its scope of services, HealthCare Pharmacy dispenses and delivers medications via postal mail directly to the client. Any reimbursements from Medicaid are returned to ADAP program to purchase of medications through the Department's wholesaler accessing Public Health Service (PHS) pricing. Ryan White Service Access Specialists continue to assess and assist clients during intake for private insurance under the Affordable Care Act (ACA), VA benefits, Medicare Part D benefits and Medicaid eligibility including Arkansas Works which is the state's Medicaid expansion program.

HOUSING OPPORTUNITIES FOR PEOPLE LIVING WITH AIDS

Stable housing allows persons living with HIV/AIDS to access comprehensive healthcare and adhere to complex HIV/AIDS drug therapies. The purpose of the HOPWA Program in Arkansas is to provide localities with resources and incentives to devise long-term strategies for meeting the housing needs of low-income persons living with HIV/AIDS and their families. This focus on providing housing assistance and related support services for HOPWA-eligible clients will reduce the risks of homelessness for this population and increase access to appropriate healthcare and other support. The state is aligned with the National HIV AIDS Strategies goals and approach to implement the concept of "housing as prevention," as another resource to achieve viral suppression.

Participation in the program is limited to a 3 year threshold and requires clients to participate in updated measures that included in enrolling in General Educational Development (GED) testing, accessing Workforce Services or other job training services in pursuit of gainful employment, entering into rehabilitative pathways to increase chances to either further vocational training or higher education outcomes. Through case management and supportive services, clients are assisted with developing Client Housing Plans to identify emergency, transitional and or permanent domicile goals and completion dates focused on off boarding the program.

Homelessness, HIV disease, nutritional services and access to health care can be fundamentally interconnected. Therefore, stable housing coupled with supportive services responsive to their complex needs, increases the ability of persons living with HIV/AIDS, particularly those who are low income, to access and adhere to life-sustaining HIV/AIDS treatment. Without stable housing, persons with HIV/AIDS suffer barriers and challenges to access the complex treatment and care vital to survival. Access to clean water, bathrooms, refrigeration, food, and the ability to take medications on a routine schedule can be severely impaired, resulting in declining health.

Utilizing Housing and Urban Development formula funding, Arkansas received \$554,150.00 FY2015 and \$559,011.00 FY2016. The City of Little Rock received a separate jurisdictional award of \$339,773.00 in HOPWA funds in FY2016. The program is administered across six (6) Districts in Arkansas by (3) three entities: The state of Arkansas Department of Health (ADH), the City Of Little Rock, and the Memphis, Tennessee EMSA. The ADH and City of Little Rock subgrant to project sponsor agencies that may be either non-Profit organizations or governmental housing agencies:

Northeast Arkansas Regional AIDS Network (**ADH Project Sponsor: both ADH and City of Little Rock**)

2604 East Mathews Jonesboro, AR 72401,
Debbie Biazio, Executive Director
870-931-4448

Pine Bluff Housing Authority (**ADH Project Sponsor**)

2503 Belle Meade, Pine Bluff, AR 71611
Maude Anderson, Program Manager
870-536-2074

Arkansas AIDS Foundation (**City of Little Rock Project Sponsor**)

523 Louisiana Street, Little Rock, AR 72201
Kendra Torrence, Executive Director
501-376-6299

Arkansas provides HOPWA services across 74 of 75 counties: Crittenden County in the state's north-east is serviced as part of the Memphis Eligible Metropolitan Statistical Area (EMSA). The Central Arkansas 6-county geographic region, known as HOPWA District 5 (including Faulkner, Grant, Lonoke, Perry, Pulaski and Saline Counties) are administered under the City of Little Rock Administration. On January 1, 2011 the City of Little Rock began offering HOPWA services in District 5 as part of the HOPWA Entitlement Funding award. All remaining 68 counties are administered under ADH HOPWA (see HOPWA Map: **Figure 10** below).

State programs follow national guidelines including income determination which must be calculated and verified annually. Individuals must meet the below 80% of area median income criteria to be eligible for assistance under the HOPWA program and provide documentation identifying the individuals HIV/AIDS status. Income determination covers all members of the household which is defined as a single individual or a family composed of two or more persons for which household incomes are used to determine eligibility and for calculation of the resident rent payment. Clients are offered fair housing counseling in lieu of being subjected to discrimination based on race, color, religion, sex, age, national origin, familial status or disability.

- Eligible Individuals and Families: Under the HOPWA program, non-related individuals residing with a person with HIV/AIDS will be considered "family" members if those individuals are found to be important to that person's care and well-being. As a result, providers must determine the composition of the assisted household and verify the income of all household members. See 24 CFR 574.3 for definitions of eligible individuals and families.

- **Shared Housing Arrangements:** In shared housing arrangements, where the assisted client has roommates, the amount paid by HOPWA should be pro-rated to cover the actual portion of the dwelling unit occupied by the assisted client. See 24 CFR 574.320.
- **Income Adjustments:** Adjustments to income may include deductions for dependents and for elderly and disabled family members as well as for un-reimbursed medical expenses. See 24 CFR 5.611.

The HIV Status Determination HIV is subject to confidentiality procedures and includes the following acceptable forms of documentation:

- Documentation from a health professional qualified to make such a determination.
- Documentation from an HIV test conducted by a physician, community health center, or HIV counseling center.

Each entity serving as project sponsors provide: Short-Term rent, mortgage, and utility assistance (STRMU) for some portion or all of the permitted 21-week period; Tenant-based rental assistance (TBRA); Supportive services such as case management, assessments and counseling and Housing Information and Resource Identification which includes counseling and referral services to assist with self-sustaining permanent housing. Concurrent to the essential services offered, each entity also has entered into local partnerships to refer clients for job placement/training, nutrition services, and building other transitional life skills elements.

Figure 10: HOPWA Service Map



NARAN (Districts 1-4) Households Served: 183

City of Little Rock (District 5) Clients Served: 116

Pine Bluff Housing Authority (District 6) Clients Served: 33

STD/HIV Surveillance Programs

The STD/HIV Surveillance Division collects and analyzes data on HIV and STD morbidity and mortality and prepares surveillance reports. A complete description of STD/HIV Surveillance Division activities is available on the ADH website.

The STD Prevention Program has implemented the following improvements after a need assessment was conducted in 2014:

- CDC Public Health Advisor (PHA) was requested and assigned to the STD Prevention Program July 2015. The PHA functions as a DIS/DIS Supervisor Trainer position that enhanced state/local STD prevention capacity by establishing and maintaining the expertise needed for the field staff to perform the required function of STD prevention.

- The STD Prevention Program Manager with guidance from the PHA, developed the HIV/STD Program Guideline for the DIS staff and STD Prevention Program. This guideline was to assist with the prevention and intervention efforts. It provided the STD Program with clear, standardized roles and responsibilities to help alleviate several of the inconsistencies across the state. This manual specifically addressed the standards of HIV, STD and field services.
- The job descriptions and responsibilities for the DIS and DIS supervisor were updated in October 2015 and fully implemented in January 2016. They were updated to reflect the standards outlined in the HIV/STD Program Guideline.
- A field operator manager positions was approved for the STD Program in May 2016. The position is critical to both the HIV and STD Program as it will enable the program to effectively manage the field staff and assure they are adhering to program standards. This will include: partner services activities for HIV and STD patients, meeting of programmatic goals, efficient supervision and training of DIS and additional technical assistance.

STD /Partner Services (PS)

Partner services utilizes public health resources to identify infected persons, notify their partners of their possible exposure, and provide infected persons and their partners a range of medical, prevention, and psychosocial services. During 2016, Partner Services conducted 291 HIV interviews involving 1558 number of sex partners named.

These services can have positive results including 1) positive behavior changes and reduced infectiousness; 2) decreased STD/HIV transmission; and 3) reduced STD/HIV incidence and improved public health activities.

PS activities are provided mainly by Disease Intervention Specialists (DIS) through local health departments and the activities encompass a broad array of services that are offered to persons with HIV infection, syphilis, gonorrhea and chlamydial infection and their partners, with HIV and syphilis infection being the established priority populations. It is a process in which infected persons are engaged to provide assurance of appropriate management as well as offer appropriate resources such as care, follow up therapy and/or counseling. Additionally, individuals are interviewed to elicit information about their partners and others who could benefit from risk reduction counseling, status identification or other intervention services. Each identified person is then confidentially notified of their possible exposure or potential risk. Additional critical components provided by DIS are the counseling and testing for those potentially exposed to infection as well as evaluation for other relevant STIs, including hepatitis screening and vaccination, treatment or linkage to medical care and/or other prevention services. Linkage or referral to other services (e.g., reproductive health services, prenatal care, substance abuse

treatment, social support, housing assistance and mental health services) is also provided as needed.

Adult Viral Hepatitis Prevention

The Infectious Disease Branch of the Arkansas Department of Health Hepatitis C program began its Hepatitis C Initiative in 2014. The basis of the initiative was to test the target population in Local Health Units therefore increasing testing to the target population from 0% to 90%.

The Arkansas Department of Health implemented guidelines for Local Health Units to ensure testing of the following target population/ high risk groups:

-Persons who are part of the baby boomer cohort (born between 1945 and 1965) are identified as at high-risk for Hepatitis C - past or current injection drug users - recipient of a blood transfusion or organ transplant before July 1992 -receiving clotting factor concentrates before 1987 -long-term hemodialysis - having persistent abnormal alanine aminotransferase levels - being born to an HCV-infected mother - intranasal drug use - getting an unregulated tattoo - having Human Immunodeficiency Virus (HIV) infection - other percutaneous exposures [such as health care workers or from having surgery before the implementation of universal precautions] - high- risk sexual behaviors [multiple sex partners, unprotected sex, or sex with an HCV-infected person or injection drug user]

In addition, this information has been shared with medical providers throughout the state as suggested testing/screening for patients receiving services in their private practices.

Hepatitis C laboratory testing is performed at the state's Public Health Laboratory on the blood specimens drawn at the Local Health Units. Since the last report in February 2016 for the time frame of September 2014 to December 2015 **3,544** Hepatitis C screening tests have been conducted and **325** of the test were found to be positive.

Additional follow up data is ongoing to determine if those found to be positive have received any additional care and treatment follow-up. Currently in Arkansas the medication treatment cost for Hepatitis C is very expensive. Even for those clients with insurance coverage the co-payment/ deductible cost may still be too large for their financial situations.

However, the Infectious Disease Branch does recognize and understand the connection between HIV and Hep C; and because of the cost restraints for individuals, the Arkansas Department of Health's Ryan White Part B and AIDS Drug Assistance Program (ADAP) began offering Hep C medical care and treatment as a covered program service in April of 2015 for approved Ryan White Part B co-infected clients. The program has recruited eight Hep C medical service providers; included Fibrosure, HCV PCR, and HCV Genotype testing as a part of its covered laboratory services; and added the medications Viekira Pak, Harvoni and Zepatier to the ADAP Formulary.

February 1, 2016 the Part B/ ADAP reported the following information: - 7 clients have completed Hep C treatment - 4 clients have currently started the 12 week regimen - 1 client was discharged from Hep C program services due to non-compliance to discontinue for their use of drugs and alcohol.

Collaborative training and capacity building efforts are essential to maximize limited resources and address training needs of prevention providers, care and supportive services partners, and other minority- and community-based organizations. The IDB sponsors and coordinates training on effective behavioral interventions, prevention counseling, population-specific prevention strategies, cultural competency, STI updates for clinicians and for non-clinicians, HIV 101 and 201, HIV care and treatment, and capacity building topics. The Branch conducts routine assessments on training needs and offers training workshops open to all prevention providers, minority CBOs, care providers, and community partners.

Key partners involved in planning and coordinating training include the CDC and its Capacity Building Assistance (CBA) providers, the South Central AIDS Education Training Center (the state contractor of the Southeast AIDS Training and Education Center, funded via the Ryan White Treatment Modernization Act, Part F), UAMS Public School of Health (UAMS), and others.

National and regional CBA providers are invited to present training on diverse issues identified in training needs assessments. When possible, the Branch hosts CDC-sponsored national or regional trainings to better enable the attendance and participation of health department staff, contractors, and community partners. The Branch also works closely with planners of the state's bi-annual HIV/STD Conference to ensure that up-to-date training opportunities are provided to state and regional health department staff, prevention and care contractors, CBOs, consumers, and other interested community partners and persons.

Other Health Department Program Areas

The Epidemiology division ensures Viral Hepatitis surveillance and manages electronic lab reporting. Throughout the year the epidemiology staff also consults on special collaborative projects, such as the merger of Hepatitis C case data with HIV cases for first estimates of HIV-Hepatitis C coinfection.

The branch has a long-standing close collaborative relationship with TB Control for TB testing of and services to PLWHA. Through the provision of case management and Directly Observed therapy, Region TB staff ensures that TB treatment is maximized. Routine testing for HIV is provided for persons presenting with TB. Additionally, staff is cross-trained and epidemiologic data are closely monitored for trends.

Other Coordination and Linkages

The Arkansas Office of Minority Health & Health Disparities (OMHHD) collaborative relationship with the IDB Branch has increased over the years as the HIV epidemic experienced significant growth in minority communities. OMHHD serves as principal advisor to the Branch as well as to other agencies and organizations on public health issues affecting Arkansas minority populations (African Americans, Hispanic/ Latinos, American Indians and Asian/Pacific Islanders) in the state. OMHHD conducts technical assistance for health department staff and community partners upon request. Many efforts are targeted to African Americans as a priority population as they represent the largest minority group and carry a disproportionate burden of the health disparities.

The Office focuses its efforts on eight priority goals which account for the large and disproportionate number of preventable deaths and disabilities affecting minorities in the state, including HIV/AIDS. The core philosophy of the entity is to envision a state in which health disparities are eliminated, thereby better ensuring optimal health for all Arkansans.

Mental Health Services and Substance Abuse Services

The Division of Behavioral Health Services facilitates the provision of public mental health services by operating 222 beds in the Arkansas State Hospital and 285 beds in the Arkansas Health Center (a skilled long-term nursing home facility), by contracting with thirteen local, private non-profit Community Mental Health Centers (CMHCs), and by certifying two private non-profit specialty Community Mental Health Clinics. Priority populations for DBHS mental health services are individuals found not guilty by reason of mental disease or defect; individuals assessed as potentially violent, other forensic clients, adults with a serious mental illness, and children and adolescents with a serious emotional disturbance.

The Arkansas State Hospital includes 90 adult acute care beds, 96 forensic beds, and 36 adolescent beds. Admission to acute care beds is through a referral from the state's CMHCs. Admission to forensic beds, for either evaluation and/or treatment, is by a circuit court order. The Arkansas Health Center provides skilled nursing home services for individuals with mental health problems that cannot be effectively managed in other nursing homes. The Center also provides some other specialized nursing home care.

The Division of Behavioral Health Services (DBHS), within the Department of Human Services, is responsible for ensuring the provision of public mental health and substance abuse treatment/prevention services throughout the state of Arkansas. It's the single state agency responsible for the funding of alcohol and drug prevention and treatment services, providing court ordered treatment, licensing of alcohol and drug treatment programs, overseeing the State Methadone Authority, administering the Drug and Alcohol Safety Educational Programs,

providing treatment ordered by juvenile drug court, and assisting with providing training in the field of substance abuse.

Each of the state's 13 CMHCs provides services in one of 13 designated geographic catchment areas that encompass the entire state. All CMHCs are nationally accredited by either the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). CMHCs operate out of 119 sites located in 65 of the state's 75 counties.

Services are provided in all counties of the state through off-site outreach. CMHCs provide screenings for all persons referred for publicly supported inpatient care, including at the Arkansas State Hospital and in local psychiatric hospital beds paid for through funds provided to the CMHCs.

DBHS distributes federal funds from the Substance Abuse Prevention and Treatment Block Grant to provide alcohol and drug prevention and treatment services in the state.

Prevention Services are funded through 2 grants (Block Grant and Partnership for Success (PFS)) to provide sub grants and to contract with local programs, communities and other organizations to provide an array of prevention services and data collection and analysis. Sub-grants include the 8 Regional Prevention Providers (RPR) and 37 Partnership for Success Grantee in the state that are designed to respond to the needs of a particular geographical area to support its prevention initiatives

DBHS licenses 54 alcohol and drug treatment programs in the state and approves Opioid Treatment Programs. DBHS is responsible for overseeing the provision that court-ordered persons receiving treatment meet the requirements of the Substance Abuse Commitment Law. Alcohol and drug treatment services are provided through various funding sources. DBHS funds the following treatment services:

Five secure treatment beds that provide secure treatment for court committed clients from outside of the Central Arkansas Area;

eight funded residential/outpatient treatment centers that provide alcohol and drug counseling service coupled with room and board when necessary.

Court-Ordered Referral and Treatment Program providing court ordered treatment for clients committed to treatment under the Substance Abuse Commitment Law from Central Arkansas; Alcohol and Drug Detoxification services are provided by all eight funded providers to persons needing supervised withdrawal from some type of substance abuse. DBHS also funds one medical detox program.

DBHS funds the Arkansas Prevention Certification Board which oversees the quality of persons providing alcohol and drug counseling and prevention services. DBHS also administers two major data collection efforts that include the Arkansas Prevention Needs Assessment Student Survey

conducted and published annually, and the Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas, an archival data report compiled from various state data sources.

DBHS administers and funds eight Drug and Alcohol Safety Educational Programs (DASEP). DASEP is responsible for providing the court with a Pre-sentence Screening Report on all persons adjudicated for Driving While Intoxicated/Driving under the Influence of alcohol or other drugs. Educational services are also provided by DASEP for those offenders required to take an educational course to get their driver's license reinstated.

Six Special Women's Services programs allow a parent to bring up to two children into treatment with her. Other services include alcohol and drug counseling, parenting skills, room and board, transportation, referral for medical services, job readiness and child care; Two residential adolescent treatment programs that provide residential alcohol and drug treatment; Six licensed Opioid Treatment Program (methadone maintenance treatment) providing medication and outpatient drug counseling to opiate abusing clients including one program (i.e. UAMS) funded by DBHS;

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Additionally CMHCs provide a comprehensive array of clinical and rehabilitative mental health services including: crisis intervention and stabilization; mental health, psychiatric, psychological and forensic assessment; treatment planning; individual, family, and group therapy; medication management; case management; day treatment/partial hospitalization programs; psychiatric rehabilitation day programs; specialized services for children with serious emotional disturbance, including interagency service coordination and wrap-around; prevention, consultation, and education; and other supportive services such as housing, vocational, and foster care services.

The state's two certified Community Mental Health Clinics (Birch and Gain) provide specialized services for adults with severe and persistent mental illness. Center for Youth and Families is an affiliate of Little Rock Community Mental Health Center and provides services for children and adolescents.

Looking Forward to 2017-2021

Arkansas' high impact strategy to close gaps in care is to address disparities in access and services among affected and historically underserved populations is to expand testing sites throughout the state, informing clients of their test results at the point of care and referring clients to treatment and support services as expeditiously as possible.

The state will mirror the CDC's Advancing HIV Prevention (AHP) initiative which focuses on the need to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment, and ongoing prevention services for those diagnosed with HIV. The basis for this initiative centers on advances in HIV treatment which have significantly improved the lives of people living with HIV/HIV Stage 3 and the approaches to responding to the epidemic.

It is our ultimate goal to emphasize the importance of prevention for the number one priority population, African American Men who have Sex with Men, as identified by our collaborators for prevention services. Secondly, we must continue to be aggressive in our pursuit to use data driven care approaches in addressing persons living with HIV/HIV3. Furthermore, we will assess our delivery systems, both the impact as well as outcomes of our mechanisms of care, medical case management, health education and risk reduction, the availability of HIV medications, housing, and linkage to care for inmates, new positives, transgender individuals and persons out of care.

Managing this disease helps both to delay the onset of HIV3, as well as, reduce the risk of HIV transmission to others by lowering viral loads and potentially decreasing the level of one's infectiousness. We acknowledge the many challenges that exist for persons living with HIV, including but not limited to:

- Denial of one's HIV status;
- Stigma of HIV, particularly in rural areas;
- Awareness of and access to HIV and primary care;
- Factors related to continuation of and retention in care and support services; • Adherence to medication and treatment regimens;
- Side effects of medications;
- Managing the high costs of care and medications;
- Diagnosis and management of co-morbidities;
- Competing life events; transgender health issues and
- Depression and other psychosocial issues.

The Branch will continue to adopt best practices and innovative concepts over the first three years of this plan which highlights ongoing medical management and prevention support services being made available to help persons living with HIV disease to be successful with medication adherence to prevent or delay illness, and to help them adopt and maintain healthy behaviors including steps to prevent infecting others.

In subsequent year 2 and 4 it's our goal to increase supportive services that link persons to stable, long-term housing, substance use treatment, or mental health counseling may also enable persons to reduce risk behaviors associated with HIV transmission and to improve our states viral suppression level set forth in the National HIV AIDS Strategy and improve our internal evaluations of the health outcomes of our grantees.

The state's care system has expanded and evolved over the past three decades to meet the needs of the changing epidemic through an array of biomedical breakthroughs, developments of care continuums, and updated guidelines. We are dedicated to monitor specific client demographics, clinical and service utilizations and expenditures to manage duplication of services and billings as well as make service and funding priority decisions each grant year.

Arkansas's Department of Health and the Infectious Disease Branch is committed to reviewing the effectiveness of our integrated delivery system while instituting critical evaluation measures of success, progress and over sight of our overall ability to decrease new infections and provide capacity building assistance and agency support to all partners in pursuit of having the greatest impact on individuals groups, institutional systems or communities across the state.

Appendix

Glossary

ADAP	AIDS Drug Assistance Program
ADH	Arkansas Department of Health
AETC	AIDS Education and Training Center
HPG	Arkansas HIV Planning Group
AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CLI	Community Level Interventions
CTR	Counseling, Testing and Referrals
DIS	Disease Intervention Specialist
EHARS	Enhanced HIV/AIDS Reporting System
GLI	Group Level Intervention
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IDB	Infectious Disease Branch
IDU	Injection Drug User
LTCC	Linkage To Care Coordinator
MSM	Men Who Have Sex with Men
PLWH	Person Living With HIV
PLWHA	Person Living with HIV/AIDS
RFA	Request For Application
SAMSHA	Substance Abuse and Mental Health Services Administration

SCSN Statewide Coordinated Statement of Need
SMART Sensible, Measurable, Attainable, Realistic, Timely
STD (STI) Sexually Transmitted Disease / Infection

Prevention Partners and Care Provider Listing

ARcare

Project Contact Information

Program Coordinator Name: Danny Harris

Address: 11219 Financial Centre Parkway Suite 200, Little Rock, AR 72211

Email: danny.harris@arcare.net

Phone: 501-455-2712

Funded to provide HIV testing and counseling state wide in Service Access Center sites

Funding amount: **\$65,000.00**

Arkansas Human Development Corporation

Project Contact Information

Program Coordinator Name: Sue Espinoza

Address: 300 South Spring Street Little Rock

Email: smespinoza@gmail.com

Phone: 501-374-1103 Ext 15

Funded to provide HIV testing and counseling targeting Hispanic Arkansans in Pulaski, Faulkner, and Saline Counties

Funding amount: **\$60,000**

Greater Delta Alliance

Project Contact Information

Program Coordinator Name: Shaluanda Jones

Address: Dumas, AR

Email: sjones@delta-tech-edu.org

Phone: 870-377-4738

Funded to provide HIV testing and counseling and education state wide

Funding amount: **\$ 70,000.00**

Jefferson Comprehensive Care System, Incorporated

Project Contact Information

Program Coordinator Name: Sybil Ward

Address: 2020 West 3rd Street Little Rock, AR 71613

Email: sward@jccsi.org

Phone: 501-372-3715

Funded to provide HIV testing and counseling in Pulaski and Jefferson counties

Funding amount: **\$65,000**

Arkansas Ryan White Part B Contracted Service Providers

MEDICAL PROVIDERS

<p>ARCare, Inc. (Case M'gt Services Only) Corporate Office 623 N. 9th St. Augusta, AR 72006 Phone: (870) 347-2534 (888) 845-8884 Toll Free Fax: (870) 347-5556 <i>Additional Ryan White Parts: C&D</i></p>	<p>ARCare-Batesville (Clinic) 1175 Vine Street Batesville, AR 72501 Phone: (870) 793-4607 Fax: (870) 793-4608 <i>Additional Ryan White Parts: C&D</i></p>	<p>ARCare- Bentonville (Case M'gt Services Only) 900 B South Walton Blvd, Ste 21 Bentonville, AR 72712 Phone: (479) 715-4745 Fax: (478) 254-6868 <i>Additional Ryan White Parts: D</i></p>
<p>ARCare-Conway (Clinic) 1500 Museum Road Conway, AR 72034 Phone: (501) 499-6308 Fax: (501) 764-1010 <i>Additional Ryan White Parts: C&D</i></p>	<p>ARCare- El Dorado (Case M'gt Services Only) 526 W Faulkner St (D Plaza) El Dorado, AR 71730 Phone: (870) 216-1223 Fax: (870) 216-1236 <i>Additional Ryan White Parts: D</i></p>	<p>ARCare-Fayetteville (Case M'gt Services Only) 2894 Mckee Circle Office 101 Fayetteville, AR 72703 Phone: (479) 571-2100 Fax: (479) 571-2102 <i>Additional Ryan White Parts: D</i></p>
<p>ARCare-Fort Smith (Case M'gt Services Only) 3800 Rogers Ave Suite 6 Fort Smith, AR 72903 Phone: (479) 782-2500 Fax: (479) 782-8557 <i>Additional Ryan White Parts: D</i></p>	<p>ARCare- Hot Springs (Case M'gt Services Only) 312 Ouachita Ave Hot Springs, AR 71901 Phone: (501) 627-1933 Fax: (501) 627-1922 <i>Additional Ryan White Parts: D</i></p>	<p>ARCare-Jonesboro North (Clinic) 1530 North Church St Jonesboro, AR 72401 Phone: (870) 932-0021 Fax: (870) 932-2601 <i>Additional Ryan White Parts: C&D</i></p>
<p>ARCare-Kensett/Searcy (Clinic) 606 Wilbur D. Mills North Kensett, AR 72802 Phone: (501) 742-1216 Fax: (501) 742- 3031 <i>Additional Ryan White Parts: C&D</i></p>	<p>ARCare – Magnolia (Case M'gt Services Only) 1617 N. Washington Magnolia, AR 71753 Phone: (870) 216-1223 Fax: (870) 216-1236 <i>Additional Ryan White Parts: D</i></p>	<p>ARCare-Melbourne (Case M'gt Services Only) Tate Springs Rd. Melbourne, AR 72653 Phone: (870) 793-4607 Fax: (870) 793-4608</p>
<p>ARCare – Little Rock (Case M'gt Services & Clinic) 11219 Financial Centre Parkway Suite 200 Little Rock, AR 72211 Phone: 501-455-2712 Fax: 501-455-2781</p>	<p>ARCare – Brinkley (Case M'gt Services Only) 306 W. Martin Luther King Brinkley, AR 72012 Phone: 870-400-0263 Fax: 870-400-0293</p>	<p>ARCare – Berryville (Case M'gt Services Only) 353 Carter St. Berryville, AR 72616 479-715-4745 Phone 479-254-6868 Fax <i>Additional Ryan White Parts: D</i></p>

<p>ARCare-Texarkana (Case M'gt Services Only) 300 East 6th St Texarkana, AR 71854 Phone: (870) 216-1223 Fax: (870) 216-1236 <i>Additional Ryan White Parts: D</i></p>	<p>ARCare-West Memphis (Case M'gt Services Only) 1028 N. Missouri Suite 6 West Memphis, AR 72301 Phone: (870) 400-0263 Fax: (870) 400-0293</p>	<p>ARCare-Whitehall (Case M'gt Services Only) 7300 Dollarway Rd., Suite 116 White Hall, AR 71602 870-247-7088</p>
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<p>East Arkansas Family Health Clinic 900 North 7th Street. West Memphis, AR 72301 Phone: (870) 735-3842 Fax: (870) 735-4379 <i>Additional Ryan White Parts: A,C, & D</i></p>	<p>Eureka Springs Family Clinic-Washington Regional 146 Passion Play Road Suite-A Eureka Springs, AR 72632 Tel: 479-253-9746 Fax: 479-253-2464 Ms. Kim Howerton (<i>Clinic Manager</i>)</p>	<p>George, David MD. 5050 Poplar, Ste 1528 Memphis, TN 38157 Phone: (901) 767-7829 Fax: (901) 767-0844</p>
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<p>Healthy Connections-De Queen 183 College Drive De Queen, AR 71832 Phone: (870) 642-5925 Fax: (870) 642-2239 Hours: Tuesday-Friday 8 am to 6 pm</p>	<p>Healthy Connections-Hot Springs 102 Chippewa Court Hot Springs, AR 71901 Phone: (501) 620-4600 Fax: (501) 620-4610</p>	<p>Hennigan, Stephen MD. 4038 N. Remington Dr Fayetteville, AR 72703 Phone: (479) 444-6522 Fax: (479) 444-9426</p>
<p>Infectious Disease & Control Consultants Abraham, Carl J. Jr., MD. 311 South Church St Jonesboro, AR 72401 Phone: (870) 932-7500 Fax: (870) 932-5043</p>	<p>Infectious Disease Resource Group, PLLC Lindley, D.A., MD. 1 St. Vincent Cir. Ste. 160 Little Rock, AR 72205 Phone: (501) 661-0037 Fax: (501) 661-0038</p>	<p>Jefferson Comprehensive Care Systems, Inc. (Main Office) 1101 Tennessee St. Pine Bluff, AR 71601 Phone: (870) 543-2300/(870) 543-2380 Fax: (870) 535-4716 <i>Additional Ryan White Parts: C&D</i></p>

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<p>Lee County Cooperative Clinic <i>Lakeview Area Clinic</i> 14066 Highway 44 Wabash, AR 72389 Phone: 870-827-3201 Fax: 870-827-3202</p>	<p>Mainline Health Systems-Dermott 300 South School St Dermott, AR 71638 Phone: (870) 538-3355 Fax: (870) 538-3701</p>	<p>Mainline Health Systems-Eudora 579 E. Beouff St Eudora, Arkansas 71638 Phone: (870) 355-2512 Fax: (870) 355-2520</p>
<p>Mainline Health Systems-Monticello Community Health Center 766 HL Ross Dr Monticello, AR 71655 Phone: (870) 367-6246 Fax: (870) 367-5857</p>	<p>Mainline Health Systems-Portland 223 North Main St Portland, AR 71663 Phone: (870) 737-2221 Fax: (870) 737-4337</p>	<p>Mainline Health Systems- Wilmot 203 McComb St Wilmot, Arkansas 71676 Phone: (870) 473-2274 Fax: (807) 473-5392</p>
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<p>Steven Dean Stroud, M.D. (NEA Baptist Clinic) 4802 E. Johnson Avenue Jonesboro, AR 72401 Phone: 870-936-7812 Fax: 870-934-3669 Amanda Wyatt, Office Manager</p>	<p>University of Arkansas-Medical Sciences-AHEC Fort Smith Family Medical Center 612 South 12th St Fort Smith, AR 72901 Phone: (479) 785-2431 Fax: (479) 494-7787</p>	<p>University of Arkansas-Medical Sciences-AHEC Magnolia South Arkansas Family Medicine Clinic 1617 N Washington Magnolia, AR 71753 Phone: (870) 234-7676 Fax: (870) 562-2560</p>
<p>University of Arkansas-Medical Sciences-AHEC Texarkana Southwest Family Clinic 300 E. 6th St Texarkana, AR 72854 Phone: (870) 779-6000 Fax: (870) 779-6100</p>	<p>UAMS Telemedicine College of Medicine, Dept. of Internal Medicine 4301 W. Markham Street, Ste. # 610 Little Rock, AR 72205 Phone: (501)-686-5585</p>	<p>UAMS College of Medicine-Infectious Disease Clinic 4301 W. Markham Street, Ste. # 610 Little Rock, AR 72205 Tel. 501-686-5585 Fax. 501-603-1538 Contact: Elaine Accord</p>

<p>Washington County HIV Clinic McGhee, Linda MD. 3270 North Wimberly Dr Fayetteville, AR 72703 Phone: (479) 973-8450 Fax: (479) 973-8452</p>	<p>Webber Medical Complex Dr. David Lee Webber, DO <i>Main Office:</i> 328 Kittle Rd Forrest City, AR 72335 Tel: (870) 494-2427 Fax: (870) 633-1410 Email: webbermedical@sbcglobal.net</p>	<p><i>Helena Office:</i> (Webber Family Practice) Dr. David Lee Webber, DO 504 Pecan St. Helena, AR 72342-3214 Tel. (870) 338-9244</p>
<p><i>Marianna Office:</i> Webber Family Practice Dr. David Lee Webber, DO 207 W Chestnut St. Marianna, AR 72360 Tel. (870) 295-2367</p>	<p>Willis Clinic Willis, Sherita D., MD. Osceola, AR 72370 Tel. 870-563-2545 (Cell) Fax. 8705632482 Email: twwillis@gmail.com Note: Office Closed on Fridays</p>	<p>Smallmon Family Medical Clinic 11998 Highway 49 N Marmaduke, AR 72443 Phone: 870-597-1231 Fax : 870-597-1226 Vanessa Ellis Clinic Administrator</p>
<p>Lynn M. Frazier, APN Arkansas Diagnostic Center 8908 Kanis Road Little Rock, AR 72215-5130 Tel: 501-227-7688 Fax: 501-687-9247</p>	<p>Lonnie Joseph Parker, MD. (HOPE URGENT CLINIC) dba Primary Care Specialist 502 E 24th St Texarkana, AR 71854 Tel. 870-773-0280; 777-8733; 779-0408 Fax. 870-495-2181 Email: primarycare2016@outlook.com</p>	
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<p>ARCare-Kensett/Searcy (Clinic) 606 Wilbur D. Mills North Kensett, AR 72802 Phone: (501) 742-1216 Fax: (501) 742- 3031</p>	<p>ARcare – Little Rock (Clinic) 11219 Financial Centre Parkway Suite 200 Little Rock, AR 72211 Phone: 501-455-2712 Fax: 501-455-2781</p>	<p>Eureka Springs Family Clinic- Washington Regional <i>John House, MD.</i> 146 Passion Play RD., Ste. A Eureka Springs, AR 72632 Tel: 479-253-9746 Fax: 479-253-2464 Contact: Ms. Lola Bunch</p>
<p>Arkansas Liver and Gastroenterology Dr. Ihab Herraka, MD 3416 Old Greenwood RD Fort Smith, AR 72903 Tel. 479-242-2888 Fax. 479-242-2889 Email: herrakaihab@yahoo.com Contact: Kelly Young</p>	<p>Dr. Ihab Herraka, MD 3127 West 2nd Russellville, AR 72801 Tel. 1-855-819-1870 Fax: 1-855-819-1871</p>	<p>Dr. Ihab Herraka, MD 312 West St. Louis Street Hot Springs, AR 71901 Tel. 1-855-819-1870 Fax: 1-855-819-1871</p>
<p>Dr. Ihab Herraka, MD 901 SE 28th Street Bentonville, AR 72712 Tel. 1-855-819-1870 Fax: 1-855-819-1871</p>	<p>Dr. Ihab Herraka, MD Mena Medical Associates 1103 College Drive Mena, AR 71953 Tel. 1-855-819-1870 Fax: 1-855-819-1871</p>	<p>Dr. Lonnie Parker <i>Primary Care Specialists</i> 502 E. 24th St. Texarkana, AR P: 870-777-8733 F: 870-495-2181 Email: parkerclinicfax@gmail.com</p>
MENTAL HEALTH PROVIDERS		
<p>Back to Basics Counseling Services, LLC 4943 Old Greenwood Rd, Ste. 2 Fort Smith, AR 72903 Phone: (479) 719-7051 Fax: (479) 242-2653 Ila DeBose (backtobasics7@gmail.com)</p>	<p>Delta Counseling Associates 790 Roberts St Monticello, AR 71655 Phone: (870) 347-6293 Fax: (870) 460-6133</p>	<p>Life Strategies Counseling- Batesville 70 Batesville Blvd, Ste C Batesville, AR 72501 Phone: (870) 793-3199 Fax: (870) 793-3151</p>
<p>Life Strategies Counseling- Conway 915 Oak St, Ste 117 Conway, AR 72032 Phone: (501) 663-2199 Fax: (501) 663-2234</p>	<p>Life Strategies Counseling- Jonesboro 1217 Stone St Jonesboro, AR 72401 Phone: (866) 972-1268 Fax: (870) 934-0847</p>	<p>Life Strategies Counseling- Little Rock 5918 Lee Ave Little Rock, AR 72401 Phone: (501) 663-2199 Fax: (501) 663-2234</p>

<p>Life Strategies Counseling- Osceola 1487 West Keiser Ave, Ste I Osceola, AR 72370 Phone: (870) 563-4500 Fax: (870) 563-4501</p>	<p>Life Strategies Counseling- Paragould 2420 Linwood Dr. Paragould, AR 72450 Phone: (870) 236-5880 Fax: (870) 236-5757</p>	<p>Life Strategies Counseling- Piggott 318 E. Poplar Piggott, AR 72454 Phone: (870) 598-1122 Fax: (870) 598-1123</p>
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<p>Mid-South Health Systems -Lee Co. 444 Atkins <u>Marianna</u>, AR 72360 Phone: 807-295-4050 Fax: 870-295-4054</p>	<p>Mid-South Health Systems -Greene Co. # 28 Southpointe Drive <u>Paragould</u>, AR 72450 Phone: 807-239-2244 Fax: 870-236-1616</p>	<p>Mid-South Health Systems -Monroe Co. 490 Broadmoor <u>Brinkley</u>, AR 72021 Phone: 807-734-3202 Fax: 870-734-3299</p>
<p>Mid-South Health Systems - Randolph Co. 2560 Old Country Rd. <u>Pocahontas</u>, AR 72455 Phone: 807-892-7111 Fax: 870-892-7101</p>	<p>Mid-South Health Systems -St. Francis Co. 4451 N. Washington <u>Forrest City</u>, AR 72335 Phone: 807-630-3880 Fax: 870-630-3892</p>	<p>Mid-South Health Systems -Lawrence Co. 102 S. Larkspur <u>Walnut Ridge</u>, AR 72476 Phone: (870) 886-7924 Fax: (870) 886-7968</p>

<p>Mid-South Health Systems-Philips Co. 801 Newman Drive <u>Helena, AR 72342</u> Phone: 807-388-3900 Fax: 870-388-7798</p>	<p>Mid-South Health Systems - Crittenden Co. 905 North 7th St. <u>West Memphis, AR 72301</u> Phone: (870) 735-5118 Fax: (870) 735-5260</p>	<p>Mid-South Health Systems - Craighead & Poinsett: 2720 Browns Lane <u>Jonesboro, AR 72401</u> Phone: 807-972-4000 Fax: 870-972-4968</p>
<p>Mid-South Health Systems-Cross Co. 661 Addison <u>Wynne, AR 72396</u> (870) 238-1135 (870) 238-1139</p>		
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<p>Abernathy, John S. DDS – Endodontics 2919 Browns Ln Jonesboro, AR 72401 Phone: 870-932-2644 Fax: 870-932-5243</p>	<p>Stephen A. Modelevsky, DDS, PA 906 Osler Drive Jonesboro, AR 72401 P: 870-972-8570</p>	<p>Arkansas Family Dental Tina Nichols, DDS Samaria Mascagni, DDS 13600 David O. Dodd Rd Little Rock, AR 72210 Phone: 501-312-7576 Fax: 501-687-0669</p>
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<p>Dentist 4 You <i>Patricia Morales, DDS</i> <i>Rachel Sauser, DDS</i> 200 N 24th St Rogers, AR 72756-3591 Phone: 479-636-2100 Fax: 479-636-2110</p>	<p>Dentures and Dental Services – Bryant <i>Rickey Perry, DDS</i> <i>Thomas M. Robbins, DDS</i> 2372 Spring Hill Rd Bryant, AR 72022 Phone: 501-847-9901 Fax: 501-847-9904</p>	<p>Dentures and Dental Services – Ft Smith <i>Heath Coleman, DDS</i> <i>Jim Curlin, DDS</i> 2501 Market Trace, Ste. A Fort Smith, AR 72908 Phone: 479-434-6966 Fax: 479-434-6964</p>
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<p>Healthy Smiles – LR Office <i>Jose E. Turcios, DDS</i> <i>Patricia F. Zarruk, DDS</i> <i>James A. Summitt, DDS</i> <i>Brandon M. Mann, DDS</i> <i>Keith Smith, DDS</i> 215 N. Bowman Rd Little Rock, AR 72211 Phone: 501-246-5186 Fax: 501-246-5234</p>	<p>Healthy Smiles – NLR Satellite Office <i>Liza Lundy, DMD</i> 2925 Lakewood Village Dr North Little Rock, AR 72116 Phone: 501-246-5145 Fax: 501-246-5147</p>	<p>Interdisciplinary Dental Therapy <i>Montgomery D. Heathman, DDS</i> <i>John N. Clark, DDS</i> 9200 Chicot Rd Little Rock, AR 72209 Phone: 501-562-3029 Fax: 501-568-1823</p>
<p>Jefferson Comprehensive Care, Inc. (Dental) – College Station <i>Austin Hoang, DDS</i> 4206 Frazier Pike P.O. Box 668 College Station, AR 72053 Phone: 501-490-2440 Fax: 501-490-0156</p>	<p>Jefferson Comprehensive Care, Inc. (Dental) – Pine Bluff <i>Tom McCall, DDS</i> 1101 Tennessee Street Pine Bluff, AR 71601 Phone: 870-543-2341 / 543-2380 Fax: 870-535-4716</p>	<p>Lee County Cooperative Clinic – Dental Svcs <i>Valentine C. Emechete, DDS</i> 530 W. Atkins Blvd Marianna, AR 72360 Phone: 870-295-5225, ext. 130 Fax: 870-295-4073</p>
<p>Rebecca F. Lucke, DDS <i>Rebecca Lucke, DDS</i> <i>Erin S. Brady, DDS</i> <i>Brandi Roach, DDS</i> <i>Swati L. Sharma, DDS</i> 615 E Appleby Rd Fayetteville, AR 72703-3914 Phone: 479-582-1312 Fax: 479-582-1355</p>	<p>Mainline Health Systems, Dental - Dermott <i>Terri Ubanks, DDS</i> 300 S School St Dermott, AR 71638 Phone: 870-538-9720 Fax: 870-538-9710</p>	<p>Mainline Health Systems, Dental - Wilmot <i>Michael McDaniels, DDS</i> 223 McComb St Wilmot, AR 71676 Phone: 870-473-2274 Fax: 870-473-5392</p>
<p>Mounts, Jason R., DMD <i>Accepting no new RW clients</i> 2501 Crestwood Road, Suite 202 North Little Rock, AR 72116 Phone: 501-753-0166 Fax: 501-753-1071</p>	<p>Phillips, James B., DDS – Oral Surgeon 2609 Browns Ln Jonesboro, AR 72401 Phone: 870-931-3000 Fax: 870-931-0190</p>	<p>Pierce Family Dentistry <i>Kevin S. Pierce, DDS</i> 1724 Executive Square Jonesboro, AR 72401 Phone: 870-268-8600 Fax: 870-268-0044</p>
<p>Pinnacle Periodontics & Dental Implants <i>Matthew D. Carlisle, DDS, MS</i> 1225 Breckenridge Dr, Ste 110 Little Rock, AR 72205 Phone: 501-225-4644 Fax: 501-225-4102</p>	<p>River Valley Oral and Maxillofacial Surgery <i>James A. Remerscheid, DDS</i> <i>John Brandebura, Jr, DDS</i> 2407 S Waldron Rd Fort Smith, AR 72903 Phone: 479-484-1011 Fax: 479-484-1205</p>	<p>Shelton Family Dentistry <i>William E. Shelton, DDS</i> 1985 Harrison St Batesville, AR 72501 Phone: 870-793-7529 Fax: 870-793-7867</p>

<p>St. Francis House NWA, Inc. Community Clinic at Rogers (Dental) <i>Monica Williams, DDS</i> 3710 Southern Hills Blvd Rogers, AR 72758 Phone: 479-936-8600 Fax: 479-636-1755</p>	<p>Summit Dental Group, Inc. <i>John Grammer, DDS</i> <i>Larry Eddy, DDS</i> <i>Rosetta Shelby-Calvin, DMD</i> 1421 Central Ave Hot Springs, AR 71901 Phone: 501-623-8333 Fax: 501-547-8212</p>	<p>Summit Dental Group, Inc. – LR Satellite <i>Lori Weaver, DDS</i> 23239 I-30 South Little Rock, AR 72022 Phone: 501-227-0500 Fax: 501-213-0394</p>
<p>Sutton Puryear Family Dentistry <i>Scott Puryear, DDS</i> <i>Jacob A. Sutton, DDS</i> 715 E Eldridge Ave Wynne, AR 72396 Phone: 870-238-3628 Fax: 870-238-0757</p>	<p>Eldon C. (Tommy) Thompson, DDS PO Box 407 208 N Main St Berryville, AR 72616-0407 Phone: 870-423-2102 Fax: 870-423-5737</p>	<p>UAMS Dental Hygiene Clinic (Shorey Bldg, 1st Floor, Room S-123) 4301 W Markham St, Slot 609 Little Rock, AR 72205 Appointments: 501-686-5733, ext. 1 Clinic Fax: 501-686-8519</p>
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Unmet Need Framework Estimate

Population Sizes	Value	Percent	Data Source
A. Number/Percent of persons living with AIDS (PLWA) as of Dec. 31, 2014	2562	46.6%	ADH eHARS Data
B. Number/Percent of persons living with HIV non-AIDS (PLWHNA), as of December 31, 2014	2932	53.4%	ADH eHARS Data
C. Total Number/Percent of persons living with HIV/AIDS (PLWHA), as of December 31, 2014	5494	100%	ADH eHARS Data
Met Need (“In Care”)	Value	Percent	Data Source Calculation
D. Number/Percent of PLWA who received the specified HIV primary medical care services in 12-month period (January-December 2015)	1494	58.3%	ADH eHARS Data & CAREWare & NEDSS Percent = D/A
E. Number/Percent of PLWHNA who received the specified HIV primary medical care services in 12-month period (January – December 2015)	1174	40.0%	ADH eHARS Data & CAREWare & NEDSS Percent = E/B
F. Total Number/Percent of PLWHA who received the specified HIV primary medical care services in 12-month period (January – December 2015)	2668	48.6%	ADH eHARS Data & CAREWare & NEDSS Percent = F/C
Unmet Need (“Out of Care”)	Value	Percent	Calculation
G. Number/Percent of PLWA who did not receive the specified HIV primary medical care services	1068	41.7%	Value = $A - D$ Percent = G/A
H. Number/Percent of PLWHNA who did not receive the specified HIV primary medical care services	1758	60.0%	Value = $B - E$ Percent = H/B
I. Total Number/Percent of PLWHA who did not receive specified HIV primary medical care services	2826	51.4%	Value = $G + H$ Percent = I/C

Table-Current Methodology: Unmet Need Estimate

Arkansas Department of Health, HIV/STD Surveillance, eHARS database, accessed January 28, 2016

Arkansas Department of Health, HIV Services, CAREWare database, received October 24, 2016

Arkansas Department of Health, Epidemiology Branch, NEDSS Database, received October 17, 2016

Please refer to the above ‘Current Methodology’ computation Table above. As of December 31, 2014, there were 5,494 persons living with HIV/AIDS (PLWHA) in the State of Arkansas; 46.6% (n=2,562) were persons living with AIDS (PLWA) and 53.4% (n=2,932) were persons living with HIV-non AIDS (PLWHNA). In calendar year (CY) 2015, 48.6% (n=2668) of PLWHA were considered “in care”. Stratified, 58.3% (n=1,494) of PLWA were ‘in-care’ and 40.0% (n=1,174) of PLWHNA were ‘in-care’. By contrast 51.4% (n=2,826) of PLWHA were considered ‘out of care’ in CY 2015; 41.7% (n=1,068) being PLWA and 60.0% being PLWHNA (n=1,758).

Unmet Need Narrative

Estimation Methods¹

The process for updating the unmet need estimate began with the HIV surveillance epidemiologist determining the number of PLWHA as of December 31, 2014 from the enhanced HIV/AIDS Reporting System (eHARS). Once that information was established, the epidemiologist looked in eHARS to see if those individuals had a viral load test or CD4 test performed in CY 2015; this information had been entered into the eHARS database by the STI/HIV surveillance staff. Persons with at least one viral load or CD4 test were considered to be preliminarily “in care,” and those without either a viral load or CD4 test in 2015 were considered to be preliminarily “out of care,” according to eHARS.

To retrieve any potentially missed lab records, the epidemiologist then matched the preliminary “out of care” list to the electronic laboratory records (ELR) of all CD4 and HIV viral load tests received in Arkansas in 2015 by the National Electronic Disease Surveillance System (NEDSS). The CDC Cancer Registry program, LinkPlus, was used to perform a “fuzzy” match between data sets using last name, first name, date of birth, and gender, with the results reviewed manually. This resulted in more PLWHA to being in care in 2015, according to NEDSS. These individuals were added to the ‘in care’ list and removed from the ‘not in care’ list.

Lastly, the remaining list of ‘not in care’ PLWHA was matched with all clients receiving at least one AIDS Drug Assistance Program (ADAP) service in CY 2015. As before, LinkPlus was used to perform a “fuzzy” match between data sets using last name, first name, date of birth, and gender, with the results reviewed manually. There were more individuals found to be in care, according to ADAP. These PLWHA were removed from the ‘out of care’ list and added to the ‘in care’ list to create a final ‘out of care’ population of 2,826, which was then described by demographics, exposure category, and location.

Several data sources were utilized to create the unmet need estimate. In eHARS, the Person View table, the document table, and the lab table were used to match patients to their CD4 and viral load tests. In the Ryan White Part B program’s CAREWare database, a table of ADAP clients that

¹ Source: enhanced HIV/AIDS Reporting System (eHARS), Arkansas

received at least one service in CY 2015 was created. In NEDSS, a SQL query generated an Excel spreadsheet with all CD4 and viral load tests reported electronically in 2015. The table below depicts how many individual people were included in each data source.

Source	Observations	In Care (additional)	Not in Care
a) eHARS: Person View	5,494	n/a	n/a
b) eHARS: Lab Table	3,524	2,641	2,853
c) NEDSS: CD4 & Viral Load Tests	2,429	(23)	2,830
d) CAREWare: ADAP Clients	840	(4)	2,826

This method was chosen because it best utilized the information currently available to the Arkansas Department of Health. The person-based table from eHARS gave information regarding the individuals that were living with HIV/AIDS at the end of the time period, while the lab table gave information regarding the use of viral load testing or CD4 counts of those persons in the person-based table. The ADAP client table created from CAREWare provided information regarding the individuals that had received at least one service through ADAP, including but not limited to receiving anti-retroviral therapy (ART). The data from NEDSS provided additional CD4 and viral load testing information that was potentially missing in the eHARS lab database.

Revisions to the unmet need estimation for CY 2015 include the use of the fuzzy matching capability of LinkPlus to match patients in external databases to PLWHA from eHARS, potentially increasing the number of PLWHA who are considered ‘in care.’

One limitation to the current unmet need estimation methods is that the information regarding antiretroviral therapy (ART) only captured those enrolled in ADAP (and thus, qualifying for Ryan White Part B services). Consequently, any individuals that received ART from a private physician but did not have any reported HIV lab tests were not captured in this estimation method.

Currently, the major labs conducting tests for Arkansas providers automatically report ELRs to NEDSS, but a few smaller labs do not report electronically. Thus, the completeness of lab test data from these smaller labs relies on results being reported directly to the STI/HIV surveillance staff and being manually entered in eHARS. Thus, the lab results in eHARS and in NEDSS are not expected to completely overlap, and both sources of data are needed to ascertain where gaps in data collection may exist.

UNMET NEED: HIV Status of PLWHA Who Were “Out of Care” in Calendar Year 2015

by Demographics, Location, & Exposure Category as of December 31, 2014

Demographic Group	AIDS		HIV-NA		Total HIV/AIDS	
	Out of Care		Out of Care		Out of Care	
Race/Ethnicity	Number	Percent	Number	Percent	Number	Percent
White, Non-Hispanic	547	51.2%	816	46.4%	1363	48.2%
Black, Non-Hispanic	417	39.0%	799	45.4%	1216	43.0%
Am Ind/Alaskan Native	5	0.5%	1	0.1%	6	0.2%
Asian/HI/Pacific Islander	5	0.5%	10	0.6%	15	0.5%
Hispanic	66	6.2%	90	5.1%	156	5.6%
Multi-Race	27	2.5%	27	1.5%	54	1.9%
Other/Unk/Not Specified	1	0.1%	15	0.9%	16	0.6%
Total	1068	100%	1758	100%	2826	100%
Gender	Number	Percent	Number	Percent	Number	Percent
Female	208	19.5%	446	25.4%	654	23.1%
Male	860	80.5%	1312	74.6%	2172	76.9%
Total	1068	100%	1758	100%	2826	100%

Age at HIV Diagnosis	Number	Percent	Number	Percent	Number	Percent
< 13	6	0.6%	17	0.9%	23	0.8%
13-19	31	2.9%	117	6.7%	148	5.2%
20-44	854	79.9%	1360	77.4%	2214	78.3%
45+	170	15.9%	217	12.3%	387	13.7%
Unknown	7	0.7%	47	2.7%	54	2.0%
Total	1068	100%	1758	100%	2826	100%

Exposure Category	Number	Percent	Number	Percent	Number	Percent
Male Sex w/ Male (MSM)	547	51.2%	824	46.9%	1371	48.5%
Injection Drug Use (IDU)	138	12.9%	182	10.3%	320	11.3%
MSM & IDU	79	7.4%	73	4.1%	152	5.4%
High Risk Heterosexual	207	19.4%	372	21.2%	579	20.5%
Transfusion	0	0%	5	0.3%	5	0.2%
Hemophiliac	6	0.6%	3	0.2%	9	0.3%
Perinatal Exposure	13	1.2%	11	0.6%	24	0.8%
No Identified/Reported Risk	78	7.3%	288	16.4%	366	13.0%
Total	1068	100%	1758	100%	2826	100%

Ryan White District	Number	Percent	Number	Percent	Number	Percent
District 1	240	22.5%	331	18.8%	571	20.2%
District 2	53	5.0%	70	4.0%	123	4.4%
District 3	136	12.7%	263	15.0%	399	14.1%
District 4	163	15.2%	245	13.9%	408	14.4%
District 5	386	36.1%	666	37.9%	1052	37.2%
District 6	85	8.0%	174	9.9%	259	9.2%
Unknown	5	0.5%	9	0.5%	14	0.5%
Total	1068	100%	1758	100%	2826	100%

Assessment of Unmet Need:²

Demographics and location of Persons Living with HIV/AIDS (PLWHA) who are ‘out of care’:

Race/Ethnicity: The White, non-Hispanic population accounted for 48.2% (n=1,363) of the ‘out of care’ PLWHA, the Black, non-Hispanic population accounted for 43.0% (n=1,216) of the ‘out of care’ PLWHA, and the Hispanic population accounted for 5.6% (n=156) of the

² Source: enhanced HIV/AIDS Reporting System (eHARS), Arkansas

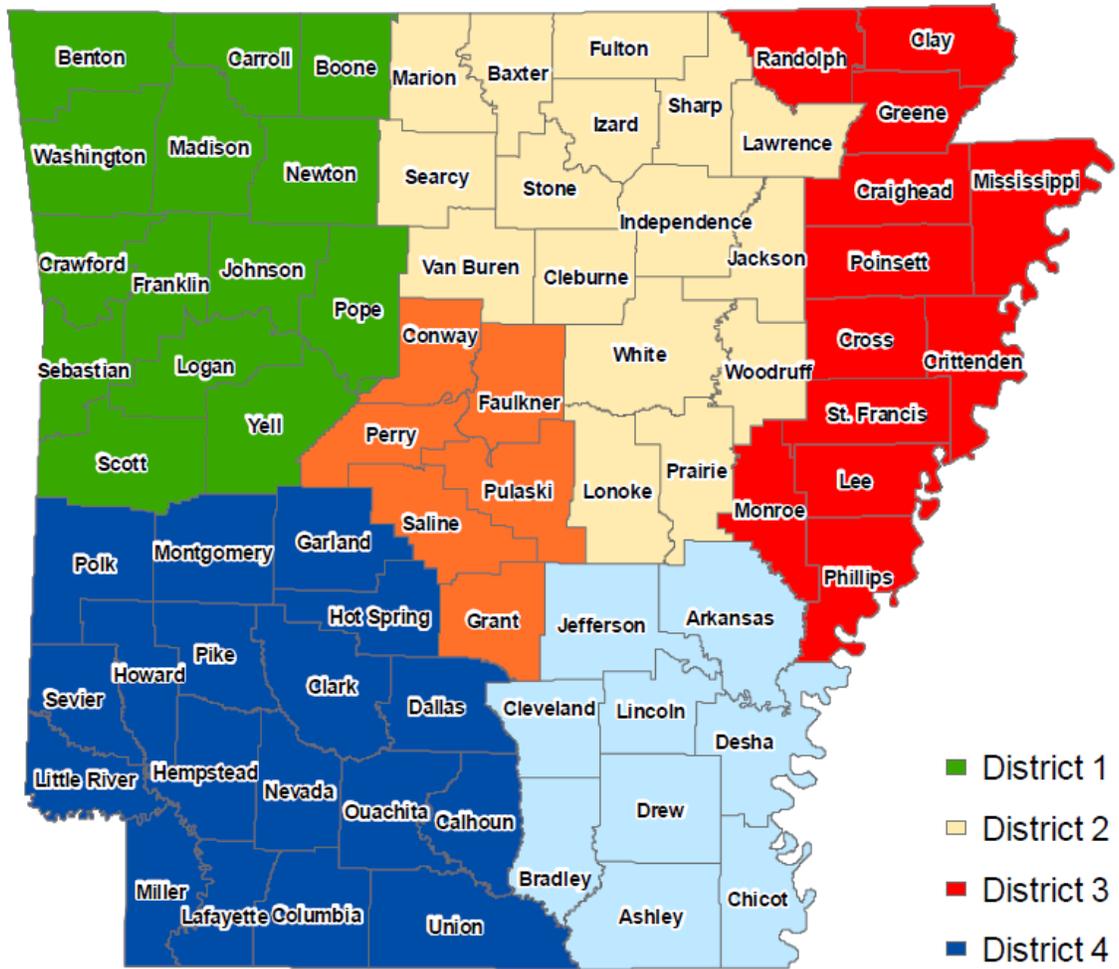
'out of care' PLWHA. About three percent of PLWHA belonged to the remaining race/ethnicity categories. Non-Hispanic Blacks and Hispanics combined account for less than 20% of the state's total population, but combined, account for the greater proportion of HIV unmet need, about 49%.

Gender: The majority of 'out of care' PLWHA were male, and this population accounted for 76.9% (n=2,172) of the state's 'out of care' PLWHA.

Age at HIV Diagnosis: One percent (0.8%; n=23) of the 'out of care' PLWHA were under the age of 13 at the time of their HIV diagnosis. Although 5.2% (n=148) were between the ages of 13 and 19 years at the time of their HIV diagnosis, the majority of the 'out of care' PLWHA in the state of Arkansas were diagnosed between the ages of 20 and 44 (78.3%, n=2,214). Individuals diagnosed with HIV at age 45 years or older comprised 13.7% (n=387) of 'out of care' PLWHA in the state of Arkansas. 54 of the 'out of care' PLWHA had an unknown age at diagnosis.

HIV Exposure Category: The majority of the state's 'out of care' PLWHA were considered to have known risk factors (87%, n=2,460). Less than one percent had a known perinatal exposure (0.8%, n=24) and 13.0% (n=366) did not have a risk factor reported or identified. Among the 2,460 'out of care' PLWHA with an identified risk factor for disease, 48.5% (n=1,371) reported male-to-male sexual contact (MSM), 11.3% (n=320) reported injection drug use (IDU), and 5.4% (n=152) reported both MSM and IDU. The second most commonly reported risk factor among 'out of care' PLWHA was high-risk heterosexual contact, which comprised 20.5% (n=579) of the risk factors reported.

Geographic Distribution: There are 75 counties within the State of Arkansas, which make up the six Ryan White Part B Districts (see map). District 5 is the most populous, and was the residence of the majority of the 'out of care' PLWHA (37.2%, n=1,052). The next highest district was District 1 at 20.2% (n=571), which was followed by Districts 4 and 3 at 14.4% and 14.1%, respectively. The two smallest reported districts were District 6 and District 2, with 9.2% and 4.4% of the 'out of care' PLWHA, respectively.



- District 1
- District 2
- District 3
- District 4
- District 5
- District 6



Source: Arkansas Department of Health
 Author: Amanda Fincher
 Date: May 18, 2010

Description of Unmet Need Trends over the past 5 years:

There has been a 1% decrease in the Unmet Need since the 2015 grant submittal, But comparing to the previous grant submittal (prior to FY 2015) there has been an increase in the Unmet Need, which may be attributed to using a 12-month timeframe (January 1 to December 31, 2013) that has been used since FY 2015 instead of the 18-month window (January 1, 2012 to June 30, 2013) previously used, to look for persons with a ‘met need’ or ‘in care’. There have been changes in the surveillance staff, extensive data cleaning within the eHARS database, and updates to the methodology of the Unmet Need analysis in recent years. As such, it is not possible to report any reliable trends at this time.

HIV Status of PLWHA Who Were “In Care” in Calendar Year 2015						
by Demographics, Location, & Exposure Category as of December 31, 2014						
Demographic Group	AIDS		HIV-NA		Total HIV/AIDS	
	In Care		In Care		In Care	
Race/Ethnicity	Number	Percent	Number	Percent	Number	Percent
White, Non-Hispanic	667	44.6%	542	46.2%	1209	45.3%
Black, Non-Hispanic	673	45.1%	516	44.0%	1189	44.6%
Am Ind/Alaskan Native	1	0.1%	0	0%	1	0.0%
Asian/HI/Pacific Islander	5	0.3%	3	0.2%	8	0.3%
Hispanic	78	5.2%	66	5.6%	144	5.4%
Multi-Race	70	4.7%	47	4.0%	117	4.4%
Total	1494	100%	1174	100%	2668	100%
Gender	Number	Percent	Number	Percent	Number	Percent
Female	353	23.6%	271	23.1%	624	23.4%
Male	1141	76.4%	903	76.9%	2044	76.6%
Total	1494	100%	1174	100%	2668	100%
Age at HIV Diagnosis	Number	Percent	Number	Percent	Number	Percent
< 13	7	0.5%	8	0.7%	15	0.6%
13-19	64	4.3%	76	6.5%	140	5.2%

20-44	1169	78.2%	915	77.9%	2084	78.1%
45+	254	17.0%	174	14.8%	428	16.0%
Unknown	0	0%	1	0.1%	1	0.0%
Total	1494	100%	1174	100%	2668	100%
Exposure Category	Number	Percent	Number	Percent	Number	Percent
Male Sex w/ Male (MSM)	853	57.1%	699	59.6%	1552	58.2%
Injection Drug Use (IDU)	129	8.6%	76	6.5%	205	7.7%
MSM & IDU	67	4.5%	51	4.3%	118	4.4%
High Risk Heterosexual	335	22.4%	214	18.2%	549	20.6%
Transfusion	3	0.2%	0	0%	3	0.1%
Hemophiliac	1	0.1%	1	0.1%	2	0.1%
Perinatal Exposure	7	0.5%	5	0.4%	12	0.4%
No Identified/Reported Risk	99	6.6%	128	10.9%	227	8.5%
Total	1494	100%	1174	100%	2668	100%
Ryan White District	Number	Percent	Number	Percent	Number	Percent
District 1	286	19.1%	200	17.0%	486	18.2%
District 2	81	5.4%	58	5.0%	139	5.2%
District 3	189	12.7%	159	13.5%	348	13.0%
District 4	192	12.9%	153	13.0%	345	12.9%
District 5	582	39.0%	490	41.8%	1072	40.1%
District 6	156	10.4%	107	9.1%	263	10.0%
Unknown	8	0.5%	7	0.6%	15	0.6%
Total	1494	100%	1174	100%	2668	100%

Needs, Gaps and Barriers Assessment:

In Arkansas, there is an overwhelming desire to have everyone that tests positive for HIV to be in care. This will increase outcomes on both the individual and community level. The biggest challenges in a rural state are transportation, lack of providers that are knowledgeable about HIV care, and providers that are willing to treat those who are HIV positive. Clients also indicate vision care is something that is needed but not offered.

There are no major interstate highways in areas of the state and public transportation is limited. There is an urban transportation system in eight (8) counties: Pulaski, Benton, Washington, Sebastian, Miller, Jefferson, Garland, and Craighead. There is a rural transportation system in seven (7) areas of the state which are primarily for non-emergency medication transportation for people with Medicaid and the older population living in those areas. For people that are not on Medicaid, there is a fee for transportation and the services are based on demand.

Due to the limited public transportation, many clients need others to transport them to and from appointments. This is identified as problem given the cost of gasoline and other means of conveyance. Gas cards are only available after the clients are deemed eligible and approved for the Part B program.

In the State of Arkansas, there are many individuals living with HIV who are unaware of their status, and many individuals are not provided comprehensive primary and HIV medical care due to barriers such as lack of physicians to care for them.

There are many physicians that lack HIV knowledge and up-to-date treatment guidelines and medications. Unfortunately, this is due to stigma and lack of up-to-date and ongoing training regarding HIV due to competing priorities. In rural settings, the physicians are likely to be one-stop clinics for areas that would include anything ranging from pediatrics to annual physicals to obstetrics.

Stigma is a common client-related barrier especially in rural areas where anything out of the norm is not as accepted and where there is less support for minorities. Many individuals in this population also suffer economic burdens and survival issues may rank higher on their priority list than HIV diagnosis and care. Knowledge regarding the availability of HIV-specific care and treatment resources is also limited in rural areas.

Providers are reporting an increasing number of Hispanics coming into care, but they tend to come in much later. Many are facing a language barrier and do not speak any English. Many need the assistance of an interpreter to access HIV medical care, case management, treatment, and therapies. Language, fear of deportation and the hostile immigration laws in the past few years are all significant barriers to accessing HIV medical care and therapy in Arkansas for Hispanic PLWHA. Arkansas, in particular, has seen an increase in Hispanic workers brought in by large employers in the poultry industry.

Addressing Unmet Need:

Outreach Activities

Each population presents unique challenges to the Arkansas Ryan White HIV Care Continuum. Arkansas HIV Services has a functional testing and linkage-to-care system. This system implements activities that rely on collaboration and coordination between Voluntary Counseling and Testing, prevention programs, outreach programs, CBOs and other Ryan White Parts. Issues regarding ensuring that individuals aware of their status are not only linked to care but also retained in care, as well as training culturally and linguistically competent staff at all levels of care, prevention and referral services still demand additional work and financial resources. Activities that are currently being carried out include conducting testing in high-priority population areas of the state every three (3) months, continually educating the public and all medical providers about available care and support services for PLWH/A through outreach and in-services. Also, Arkansas will continually increase targeted testing, early intervention, and outreach using nontraditional method through HIV Prevention, Consumers, and the Community-Based partner agencies.

Continuum of Care Activities

The ADH contracts with a single community-based organization with FQHC status as a subrecipient to provide statewide coverage through multiple Service Access Centers (SAC). Part B services provided through those SAC include primary medical care, HIV related medications (ADAP), health insurance premium and cost sharing assistance, medical case management, mental health, medical nutrition therapy, oral health, and outpatient substance abuse services, all of which are core services. Support services include food bank, linguistics, medical transportation, non-medical case management, outreach, and psychosocial support services. Non-medical case managers at the Service Access Centers also make appropriate referrals to other non-Ryan White funded programs and resources.

Collaboration with other Entities

HIV Services collaborate with other Ryan White grantees, prevention staff, service providers and community stakeholders to reduce barriers to HIV screening and reduce HIV-related health disparities. Arkansas' EIIHA strategy is centered on increasing coordination among stakeholders to maximize available resources for outreach and testing, improve follow-up and linkage to medical care and reduce duplication of services and gaps in the HIV continuum of services. Evidence-based and targeted activities will continue to be implemented to identify high-priority populations disproportionately impacted by HIV. Increased targeted outreach and testing activities to identify individuals that are unaware of their status and make such individuals aware of their status. The program will continue ongoing efforts to remove or eliminate barriers to routine testing, condom distribution, and linkage to care.

Challenges Encountered In Linking Unmet Need to Care

Challenges the Arkansas HIV program has encountered throughout the process and implementation phase of linking unmet need individuals into care include: the development of clear and specific goals and objectives for testing, linking to care, and maintaining in care a variety of populations, including populations aware of their status but not in care (unmet need) and populations unaware of their status; developing solutions for closing gaps in care and addressing overlaps in care; and coordinating with other programs to achieve these goals and, more broadly, to achieve the goals of the National HIV/AIDS Strategy. Since 2014 the program has made progress with eliminating some of these challenges and continues to design innovative models that would allow for successful linkage of individuals not in care.

Unmet Need Outcomes through linkage to care

In July 2014, the Ryan White Part B program implemented a Linkage to Care (LTC) model for the state of Arkansas. This model has proven to be very beneficial for consistency of tracking and reaching out to those persons not in care. Over the past year, linkage to care efforts has reached out to 726 people and of these individuals 215 have been linked to care.

Table 1-New Methodology: Unmet Need Estimate Based on the HIV Care Continuum Framework

Arkansas Unmet Need Framework as of December 31, 2014 Using New Methodology			
Population Sizes	Value	Percent	Data Source
A. Number/Percent of persons living with AIDS (PLWA), as of December 31, 2014	2562	46.60%	ADH eHARS Data
B. Number/Percent of persons living with HIV non-AIDS (PLWHNA), as of December 31, 2014	2932	53.40%	ADH eHARS Data
C. Total Number/Percent of persons living with HIV/AIDS (PLWHA), as of December 31, 2014	5494	100%	ADH eHARS Data
Met Need (“In Care”)	Value	Percent	Data Source Calculation
D. Number/Percent of PLWA who received two or more specified HIV primary medical care services at least three months apart in 12-month period (January-December 2015)	585	22.83%	ADH eHARS Data Percent = D/A
E. Number/Percent of PLWHNA who received two or more specified HIV primary medical care services at least three months apart in 12-month period (January-December 2015)	440	15.00%	ADH eHARS Data Percent = E/B
F. Total Number/Percent of PLWHA who received two or more specified HIV primary medical care services at least three months apart in 12-month period (January-December 2015)	1025	18.66%	ADH eHARS Data Percent = F/C
Unmet Need (“Out of Care”)	Value	Percent	Calculation
G. Number/Percent of PLWA who did not received two or more specified HIV primary medical care services at least three months apart in 12-month period (January-December 2015)	1977	77.17%	Value = $A - D$ Percent = G/A
H. Number/Percent of PLWHNA who did not received two or more specified HIV primary medical care services at least three months apart in 12-month period (January-December 2015)	2492	84.99%	Value = $B - E$ Percent = H/B
I. Total Number/Percent of PLWHA who did	4469	81.34%	Value = $G + H$

not received two or more specified HIV primary medical care services at least three months apart in 12-month period (January-December 2015)

Percent = I/C

Arkansas Department of Health, HIV/STD Surveillance, eHARS database, accessed

Table 2A Summary Comparisons- Current and New Methodologies for Estimation of Unmet Need ('Out of Care')

HIV Care Continuum Methodology			Current Methodology		
Pop. size	Value	(%)	Pop. size	Value	(%)
Number/Percent of PLWA who did not receive 2 or more specified HIV primary medical care services at least 3 months apart in 12-month period (Jan. - Dec. 2015)	1,977	77.2%	Number/Percent of PLWA who did not receive specified HIV primary medical care services in the 12-month period (Jan. - Dec. 2015)	1,068	41.7%
Number/Percent of PLWHNA who did not receive 2 or more specified HIV primary medical care services at least 3 months apart in 12-month period (Jan. - Dec. 2015)	2,492	84.9%	Number/Percent of PLWHNA who did not receive specified HIV primary medical care services in the 12-month period (Jan. - Dec. 2015)	1,758	60.0%
Total Number/Percent of PLWHA who did not receive 2 or more specified HIV primary medical care services at least 3 months apart in 12-month period (Jan. - Dec. 2015)	4,469	81.3%	Total Number/Percent of PLWHA who did not receive specified HIV primary medical care services in the 12-month period (Jan. - Dec. 2015)	2,826	51.4%

Table 2B Summary Comparisons- Current and New Methodologies: 'In Care' Estimations

HIV Care Continuum Methodology			Current Methodology		
Pop. size	Value	(%)	Pop. size	Value	(%)
Number/Percent of PLWA who received 2 or more specified HIV primary medical care services at least 3 months apart in 12-month period (Jan. - Dec. 2015)	585	22.8%	Number/Percent of PLWA who received specified HIV primary medical care services in the 12-month period (Jan. - Dec. 2015)	1,494	58.3%
Number/Percent of PLWHNA who received 2 or more specified HIV primary medical care services at least 3 months apart in 12-month period (Jan. - Dec. 2015)	440	15.0%	Number/Percent of PLWA who received specified HIV primary medical care services in the 12-month period (Jan. - Dec. 2015)	1,174	40.0%
Total Number/Percent of PLWHA who received 2 or more specified HIV primary medical care services at least 3 months apart in 12-month period (Jan. - Dec. 2015)	1,025	18.7%	Number/Percent of PLWA who received specified HIV primary medical care services in the 12-month period (Jan. - Dec. 2015)	2,668	48.6%

Variances in Unmet Need estimates for CY 2017 resulting from the HIV Care Continuum Framework Methodology:

There is a significantly wide variance between estimates derived by the HIV Care Continuum Framework Method compared to the current/traditional method: 81% compared to 51%, respectively. [See Table 2A above]

Based on the estimates above (Table 2A) there is no point of alignment.

Were the estimates of Unmet Need determined by the HIV Care Continuum Framework to serve as a basis for the state's planning for care services it would require a radical and wholesale modification (if not total scrapping) of strategies for identifying, informing, referring and linking clients to care and treatment. The need for skilled human as well as material resources for surveillance, prevention and treatment would most likely double in order to match the scale of the Unmet Need, while viral suppression attainment goals may be beyond the NHAS 2020 timeline.

Primary challenges may be summed as follows:

- i. Lack of reporting from care providers (physicians, clinics, hospitals and laboratories) to ADH surveillance database
- ii. Underreporting/partial of variables for calculating HAB or CDC measures from providers into CAREWare and eHARS (ART prescription, VL, CD4, clinic visits, etc.).
- iii. Arkansas is a *dual reporting state* by law (both clinics and labs must submit reports on VL and CD4 to state surveillance), but the current laws are weak in terms of having enforcement powers.
- iv. Some care providers seem to be unaware that reporting is required of them.
- v. Inadequate documentation of visits and progress notes in patient's medical records.
- vi. Use of electronic record systems is inadequate and not uniform across the state.
- vii. Inadequate training of primary care physicians on current HIV treatment guidelines.
- viii. Individuals not on ADAP that received ART from private physicians may not have any reported HIV lab tests reported to or captured in CAREWare.

Strengthening and enforcement of reporting laws, as well as provider education on reporting requirements all across the state and increase in adapting to use of standardized and user-friendly electronic reporting formats may help reflect true Unmet Need estimates in Arkansas in the future.

Evaluating Impact of Unmet Need Efforts: The Arkansas Ryan White Part B program's plan, as is for EIIHA, is an integrated design of the HIV programs in the Infectious Disease (ID) Branch. It combines resources of all ID Branch programs to achieve the goal of ensuring priority populations including Unmet Need are identified, tested, referred and linked into care. ID Branch programs have dedicated data systems for data capture, storage and analysis (see #7 below). These systems generate reports that allow the Infectious Disease Branch, as well as the Part B, to have a well-defined illustration of where the state stands in relation to HIV gaps

including Unmet Need. The Part B program realizes the importance of the roles of all ID Branch Programs in meeting the Unmet Need burden in order to have an effective plan that results in positive outcomes in reducing Unmet need estimates.

Each of these program's components implemented in the EIIHA plan is monitored and tracked based upon the database systems used. The system reports generated allow the Infectious Disease Branch generally, as well as the Part B specifically, to have a clear picture of where the state stands in relation to HIV needs and for determining any imperatives for changes to the current plan and efforts.

Data capabilities in Arkansas: Data management information systems used in Arkansas for data collection, reporting operations including estimation of Unmet Need are eHARS and CAREWare. eHARS is a browser-based application provided by the Centers for Disease Control and Prevention (CDC). eHARS is used to collect, manage, and report Arkansas HIV/AIDS case surveillance data to CDC. CAREWare is an electronic health and social support services information system for Ryan White HIV/AIDS Program grant recipients and their subrecipients. HIV Prevention Program captures HIV testing and counseling data into Evaluation Web. Reporting generated from this system allows for the program to assess the amount of individuals of the priority population being identified and tested. HIV Surveillance and the STD Program utilizes PRISM for tracking, monitoring and reporting of progress towards locating individuals, performing partner services functions, and obtain data (demographics, risk factors, etc.).

Limitations include the fact that not all providers across the state have access to or can report data directly to eHARS or CAREWare, Prism, or Evaluation Web. Broadband availability is also a challenge. Another significant challenge is inadequate access to and use of electronic health record systems particularly by small private providers. All of this impact calculation of Unmet Need estimates.

Data Sources

HIV/AIDS Surveillance Data

The source for the HIV and AIDS information is the Arkansas Department of Health, HIV/STD Surveillance Section, *Enhanced HIV/AIDS Reporting System (eHARS)*, accessed January 26, 2016.

STD Case Reporting

The ADH STD division conducts statewide surveillance to determine the number of reported cases of STD's and to monitor trends. Services provided by the division include partner services counseling and notification to help reduce the spread of STD's, referral services for examination, treatment and social services. STD surveillance data can serve as a surrogate marker for unsafe sexual practices and demonstrates the prevalence of changes in a specific behavior.

Consolidated Annual Performance and Evaluation Report (CAPER)

The Consolidated Annual Performance and Evaluation Report provides annual performance reporting on client outputs and outcomes that enables an assessment of a grantee performance in achieving the housing stability outcome measures of the Housing Opportunity for People With AIDS.

State Healthcare Access Research Project (SHARP)

The project details the successes, challenges, and opportunities for healthcare access in Arkansas. The Health Care Law Clinic of Harvard Law School and the Treatment Access Expansion Project (TAEP) with support and collaboration from Bristol-Myers Squibb conducted the project. The purpose of the project was to provide a snapshot of healthcare impacting those living with HIV/AIDS.

Arkansas Minority Health Commission 2011 Interim Study

The Arkansas HIV/AIDS Minority Task Force and Minority Health Commission undertook research in 2012 among both patients and health care providers to gain more information as well as reviewing Arkansas law related to HIV testing. This report summarized the research conducted and sought out to offer recommendations for reducing barriers to voluntary HIV screening in the state.

US Census Bureau

The Census Bureau collects and provides information about the people and economy of the United States. The Census Bureau's website (www.census.gov) includes data on demographic characteristics (e.g. race, ethnicity, gender, age) of the population, family structure and poverty levels. State and county specific data are easily accessible with hyperlinks to other web portals with census information included.

The Socio-Demographic Characteristics of Arkansas's General Population

Population

The U.S. Census Bureau estimates of the population of Arkansas for 2015 was 2,978,204. Arkansas is composed of 75 counties. County population range from a low of 5,368 persons (Calhoun) to the most populated county, Pulaski, with 382,748 persons. The state is considered largely rural with two primary metropolitan statistical areas (MSAs): Little Rock-North Little Rock-Conway, and Fayetteville-Springdale-Rogers, Arkansas.

Demographic Composition

The 2015 U.S. Census Bureau count reflects that the racial and ethnic composition of Arkansas was 79.5% White, 15.7% Black, 7.2% Hispanic and 1.0% Native American.

Age and Sex

In 2015 the median age of Arkansan was 37.0 years. More than 24.4% of the population was younger than 24 years old and 16% was 65 or older. 50.9 percent of the population of the state are female.

Income, Poverty and Health Disparities

The median house income in the state of Arkansas for 2014 was \$41,264 compared to \$53,657 nationally with the state ranking 45th in the nation. According to the American Health Rankings 2015 data people with lower income tend to experience higher incidence of illness and death. Arkansas also has serious concerns of high prevalence of obesity, low immunization among adolescent females for HPV and limited availability of dentists.

Since 1990, 24.7% of people in Arkansas smoke compared with 18.1% nationally in contrast to the Healthy People 2020 goal of 12.0%. The report cited strengths as high per capita public health funding and small disparity in health status by educational level.

Education

2014 Census data reports that 84.3% of individuals 25 and older have High School diplomas and 20.6% individuals have completed a Bachelor's Degree or advanced degree education.