

2010



Kentucky HIV Comprehensive Prevention Plan

Prepared and Compiled by the
Kentucky HIV/AIDS Planning and Advisory Council
in collaboration with the
Kentucky Department for Public Health
HIV/AIDS Branch



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KEY TO ABBREVIATIONS

	African Americans
AAMSM	African American Men who have Sex with Men
ADD	Area Development Districts
AED	Academy for Educational Development
AHEC/HETC	Area Health Education Center/Health Education Training Center
ASO	AIDS Service Organization
BFHC	Bluegrass Farmworker Health Center
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CLI	Community-Level Interventions
CRCS	Comprehensive Risk Counseling and Services
CTRPN	Counseling, Testing, Referral, and Partner Notification
DEBI	Diffusion of Effective Behavioral Interventions
DHAP-IRS	Division of HIV/AIDS Prevention-Intervention Research and Support
DIS	Disease Intervention Specialist
DL	Down-low
DPH	Department for Public Health
EW	Empowerment Workshop
FTE	Full Time Employee
HC/PI	Health Communications/Public Information
GLI	Group-level Interventions
GMOC	Gay Men of Color
HAR	Hispanics at Risk
HRH	High Risk Heterosexual
IDU	Injecting Drug User
ILI	Individual-level Interventions
KDE	Kentucky Department of Education
KHCIP	Kentucky Health Continuation Insurance Program
KHPAC	Kentucky HIV/AIDS Planning and Advisory Council
KIPWAC	Kentuckiana People With AIDS Coalition
KPOL	Key Peer Opinion Leader (MSM intervention)
LWA	Living With AIDS
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men/Injecting Drug User
MSMOC	Men who have Sex with Men of Color
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PLWHIV	Persons Living With HIV
PMI	Prevention Marketing Initiative
PS	Prevention Specialist
PSE	Public Sex Environment
PSI	Postponing Sexual Involvement
PWA	People With AIDS
RRW	Risk Reduction Workshop
RTR	Reducing the Risk
SISTA	Sisters Informing Sisters about Topics on AIDS
TA	Technical Assistance
WAR	Women at Risk
YAR	Youth at Risk



INTRODUCTION

The Kentucky HIV/AIDS Planning and Advisory Council, (KHPAC) proudly presents the 2010 Comprehensive Prevention Plan. The Plan informs the Centers for Disease Control and Prevention and the Cabinet for Health and Family Services, and other stakeholders involved in HIV prevention efforts of the Council's recommendations for HIV prevention services across the state of Kentucky.

Members of the Council, advisors, state staff and other stakeholders participated in part to the production of this comprehensive plan. At the state-level the Prevention, Ryan White and Surveillance sections worked collaboratively with community based organizations, AIDS service organizations, clinics and pertinent care, policy and prevention stakeholders to produce comprehensive assessments that aided in the completion of the 2010 Comprehensive Prevention Plan. A list of individuals and documents contributing to the Plan are listed below:

Kentucky HIV/AIDS Planning and Advisory Council

Members of KHPAC – 2009

Robert Stone – Community Co-Chair	Courtney Wheeler
David Clark – State Co-Chair	Tim McAdoo
Deonna Williams	Bruce Mullan
Theresa Mayfield	Michael Wagner
Maria Montgomery	Beth Harrison Prado
Carmen Telon	Michael Logsdon
Charlie Kessinger	Mary Lynn Philbeck
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Tommy Collins – HIV Branch MSM Coordinator	Karan Todigala – HIV Branch/Epi
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Maria Chaparro - USMBHA	Shanti Bisland – USMBHA
Patrick Parker – Southern AIDS Coalition	Amanda Beck – Northern KY Hlth Dep



Contributing Documents to the 2010 Prevention Plan

- 2008 Kentucky Statewide Coordinated Statement of Need (SCSN)
- 2008 HIV Prevention Plan
- Southern States Manifesto: Update 2008
- 2007 Kentucky HIV Prevention & Care Needs Assessment
- Kentucky Department of Education HIV Project Narrative
- 2007 Kentucky African American Needs Assessment
- 2008 Kentucky Comprehensive Care Plan

OVERVIEW OF THE COMMUNITY PLANNING PROCESS

The Kentucky Department for Public Health (DPH) initiated the community planning process in 1994 in response to the Centers for Disease Control and Prevention (CDC) Announcement #300. The state was divided into three regions for the purpose of Human Immunodeficiency Virus (HIV) prevention planning for the 1994 application for funding. The designation of regions was based on HIV and Acquired Immune Deficiency Syndrome (AIDS) case data in Kentucky, existing Area Development Districts (ADD), and HIV Ryan White Care consortia boundaries. In 1998 a single statewide HIV Prevention Community Planning Group was formed with representation from the existing regions. In 2005 the HIV Prevention Community Planning Group began the process of merging with the existing Governor's HIV/AIDS Advisory Council, with the addition of a care component to the planning process. This integrated group was named the Kentucky HIV/AIDS Planning and Advisory Council, (KHPAC) indicating the primary roles of planning and advising. In March of 2006, KHPAC had its inaugural meeting. KHPAC is administered by the Kentucky Department for Public Health, HIV/AIDS Branch. DPH and KHPAC work closely to ensure that HIV prevention, care planning and policy effectively identify the needs of the people of the Commonwealth of Kentucky.

The mission of KHPAC is to identify issues and develop public health policy recommendations to prevent further HIV/AIDS infections in Kentucky, and to serve populations currently infected.

KHPAC advises the Kentucky Cabinet for Health and Family Services (CHFS) on the formulation of HIV and AIDS policy. KHPAC monitors the responsiveness of CHFS, and ensures that recommendations are being considered and followed, as prescribed by the CDC's guidelines for HIV/AIDS Prevention community planning. KHPAC offers programmatic recommendations regarding Health Resources and Services Administration (HRSA) activities. Specifically, KHPAC advises regarding Ryan White Part B Services.

KHPAC JURISDICTION AND COMPOSITION

Kentucky is comprised of 120 counties. For HIV/AIDS planning the state is divided into three regions: North Central, Eastern and Western. The North Central region includes Jefferson and the six surrounding (mostly rural) counties. All seven counties in this region make up the North Central Area for Development District (ADD). According to the December 31, 2008 cumulative statistics, this region has 2337 (approximately 47%) of the State's total 5015 reported AIDS cases. Jefferson County is the most populated county in Kentucky and is the only urban county in the North Central region. The majority of the region's cases (2131 or 91%) are reported for Jefferson County (Louisville).

The Eastern Region includes the easternmost nine ADDs with a total of seventy-one counties. The two major urban centers of the Eastern Region are Lexington and the Northern Kentucky Area immediately south of Cincinnati, Ohio. The remaining counties are mostly rural. The Eastern region has 1,804



(36%) of the State's December 31, 2008 cumulative AIDS cases reported. The majority of the regional cases are reported for the Bluegrass ADD (955 or 19% of the state's cases) and the Northern Kentucky ADD (419 or 8% of the states cases). Fayette County (Lexington) accounts for 671 (37%) of the Bluegrass ADD's cases. The remaining ADDs reported AIDS cases ranging in number from 36 to 99.

The Western Region represents the western most five ADDs with a total of forty-two counties. Most of the Western Region is rural with small cities, with no major urban areas. The Western Region accounts for 869 (17%) of the state's December 31, 2008 cumulative AIDS cases reported. The five ADDs reported AIDS cases ranging in number from 141-198.

Current KHPAC membership consists of 28 members. KHPAC's full membership is up to 30 members. The Executive Committee which functions as the Membership Committee is in the process of reviewing applications to KHPAC. According to the mandates of KRS 214.640, KHPAC consists of 2 standing members, the Commissioner for Public Health and the Commissioner for Medicaid Services. In accordance with CDC, HRSA and KRS 214.640, KHPAC also consists of representatives from other state agencies that provide HIV/AIDS health care and/or education, physicians, representatives of community based organizations (CBO), experts in epidemiology, behavioral and social sciences, program evaluation and health planning; individuals living with HIV, and individuals who reflect the characteristics of the current and projected epidemic in Kentucky. Membership on KHPAC also ensures geographic representation to the extent possible.

The following is a regional list of agencies represented on KHPAC.

EASTERN REGION

Cumberland Valley District Health Department

BLUEGRASS

AIDS Volunteers of Lexington

NORTHERN

Northern Kentucky Independent Health District

NORTH CENTRAL REGION

Sisters and Brothers Surviving AIDS (SABSA)

WINGS Clinic

Volunteers of America

Louisville-Metro Health Department

WESTERN REGION

Kentuckiana People With AIDS Coalition (KIPWAC)

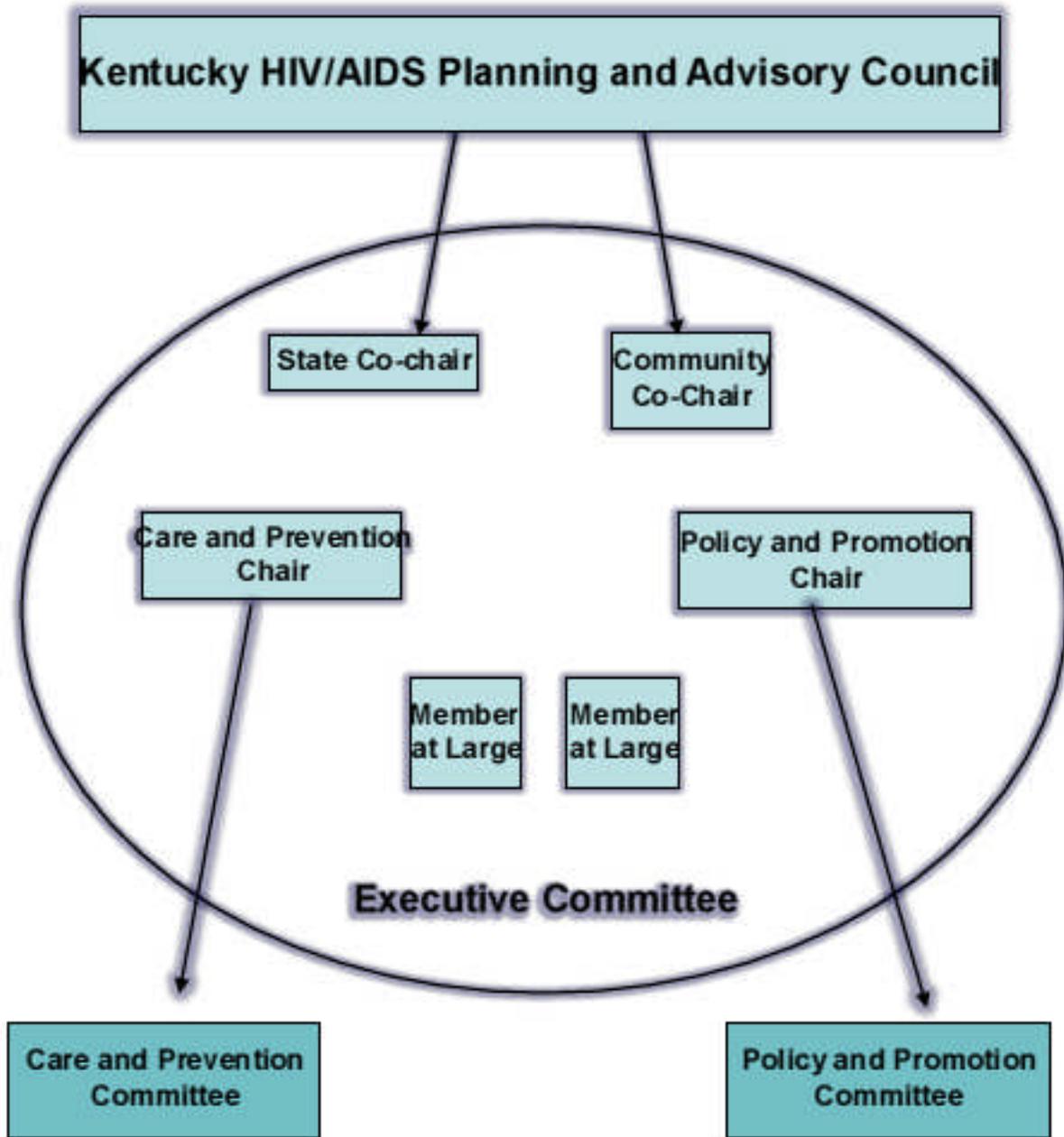
Heartland CARES, Inc.

Kentucky HIV/AIDS Advocacy and Action Group

Matthew 25

Infectious Disease Associates





General Membership



Table 1							
Kentucky HIV/AIDS Planning and Advisory Council Characteristics (as defined in the CDC Evaluation Guidance)							
Age							
< 19	19-24	25-34	34-44	45+	Total		
0	Pending (0)	2	7	19	28		
Gender							
Male	Female	Transgender	Other	Total			
16	11	1	0	28			
Sexual Orientation							
Heterosexual	Bisexual	Gay	Lesbian	Other	Unknown	No response	Total
13	0	11	1	1	2	0	28
Ethnicity							
Hispanic/Latino				Non-Hispanic/Non-Latino			Total
1				27			28
Race							
American Indian/Alaska Native	Black of African American	Native Hawaiian/Pacific Islander	Asian	White	No response	Total	
0	7	0	0	20	0	27	
Geographic Distribution							
Urban Metropolitan	Urban Non-Metro	Rural	Suburban	Other			Total
18	7	2	1	0			28
Expertise							
Community Rep.	PLWHA or affected	Community Org.	Intervention Specialist/Service Provider	HIV Care Provider	Medical Provider	Total	
15	11	2	2	4	1	29 ¹	
Expertise Cont.							
Behavioral or Social Scientist	Evaluation	Health Planner	Epidemiologist	Mental Health	Other	Total	
2	2	1	1	1	2	10 ¹	
Representation of HIV Exposure category							
MSM	MSM/IDU	IDU	HRH	Sex with transgender	Sex with transgender/IDU	No specific risk	Total
11	4	1	1	1	0	10	28 ¹
Representation of other populations through personal life experience							
Substance Use	Sex trade	STDs	Homelessness	Partners or family members of PLWHA	Corrections system	Total	
13	2	1	1	2	4	18 ¹	
Agency representation							
Faith Community	Non-minority CBO	Mental Health Services	Academic institution	Corrections	State/ Local Education Agencies	Total	
2	8	1	0	1	1	13 ¹	
Agency representation Cont.							
Community Rep.	Minority CBO	Health Department HIV/AIDS	Substance Abuse Services	Homeless Services	Research Center	Total	
7	1	3	1	0	0	12 ¹	
Agency representation							
HIV Care and Social Services	Business and Labor	Health Department: STD	Other Non-Profit	Other			Total
11	0	1	0	0			13 ¹
HIV Status							
Living with HIV/AIDS		Not living with HIV/AIDS		Unknown	No response		Total
11		17		0			28

1 – Total is unduplicated, but members may be counted in several categories

N.B. KHPAC Characteristics does not take into account the two standing members of KHPAC.



KHPAC MEMBERSHIP RECRUITMENT & ORIENTATION

KHPAC members are primarily recruited through personal referrals. The Executive Committee is responsible for reviewing applications, interviewing applicants and making membership recommendations to the full KHPAC body or directly to the Governor's Office/designee for appointment. Once KHPAC approves individuals for membership, the applications are sent to the Governor's Office/designee for appointment.

KHPAC members underwent an orientation and Technical Assistance at The Clifton Center in Louisville, Kentucky on March 5, 2009. New KHPAC members are provided with a Kentucky HIV/AIDS Planning and Advisory Council Handbook which includes KRS 214.640, the CDC HIV Prevention Community Planning Guidance, the HRSA Planning Body Duties, KHPAC by-laws and membership structures, a copy of the current HIV Prevention Plan and grant, a copy of the previous Year-End Report, an orientation guide to community planning, and other pertinent information necessary for the participation on KHPAC. Each new member is asked to attend an orientation conducted by the DPH HIV Health Policy Specialist and the Executive Committee, where they are also briefed on the current activities of KHPAC.

New KHPAC members are paired with an experienced member to provide a form of mentorship to the members during this first year of membership.

Each KHPAC Member is required to participate on one of the standing committees: Care and Prevention or Policy and Promotion.

COLLABORATIONS AND AFFILIATIONS

INSTITUTIONAL AFFILIATIONS OF CO-CHAIRS

The 2009 State Co-chair for KHPAC is David Clark, Ryan White Grant Administrator for the Department for Public Health HIV/AIDS Branch. The Community Co-chair is Robert Stone. Robert is from Owensboro.

PROCESS FOR OBTAINING COMMUNITY INPUT BEYOND KHPAC MEMBERSHIP

If a particular demographic of HIV/AIDS community is not represented on KHPAC, input is obtained from individual interviews, invited representatives of organizations, focus groups, surveys, HIV Prevention Specialists (PSs) working with the affected communities, and input from the State MSM Initiatives, IDU Initiatives and Minority/High-Risk Heterosexual Initiatives Coordinators.

PROCESS FOR CONDUCTING BUSINESS & MEETINGS

KHPAC meets at least nine times per year. The length of meetings is dependant upon the agenda. Most KHPAC meetings are held between 9:30 a.m. and 4 p.m. Regularly scheduled KHPAC meetings occur either in person or via tele/video-conferencing.

The assigned HIV Health Policy Specialist is the KHPAC Administrator and coordinates the activities of KHPAC to ensure that the mandates of KHPAC are carried out. The meetings are facilitated by the Administrator, as well as members of the Executive Committee. KHPAC members receive a summary meeting report of every meeting held, the results of evaluations which are completed by members after each meeting and any other information needed to prepare for the following meeting. These evaluations are used to improve the planning and advising process, as well as to facilitate an annual



evaluation. If a problem occurs that the group cannot rectify or if clarification of an issue is needed, technical assistance is sought from or through the DPH personnel.

All KHPAC members sign a Disclosure of Conflict of Interest form, a letter of commitment to KHPAC, and a statement of confidentiality.

Major tasks are accomplished at each KHPAC meeting. The products of the committees and reports are submitted to KHPAC where discussion, clarifications, questions and answers, and input are encouraged. Decisions are made by consensus, but if this is not possible a majority vote is taken. In Kentucky, all meetings by government or government supported groups are open to the public. Additionally, there are occasions when a group, organization, or individual are asked to attend the meeting to provide pertinent information to KHPAC.

KHPAC ACCESS TO INFORMATION & UPDATES

To ensure that KHPAC has access to any pertinent information or updates that pertain to HIV/AIDS in the Commonwealth of Kentucky or nationally, DPH provides KHPAC with updates on HIV prevention and community planning in the form of National Alliance of State and Territorial AIDS Directors (NASTAD) bulletins and newsletters, journal publications, CDC updates, and other publications.

HIV/AIDS Branch staff attend meeting KHPAC meetings (on a rotational basis) to ensure KHPAC members have access to their expertise, and to ensure the collaboration between KHPAC and DPH. HIV/AIDS Branch staff also participate in monitoring and evaluating the planning and advising process. The supplemental guidance for CDC Community Planning Groups dictates that "HIV Prevention Community Planning Group(s) should have access to current information related to HIV prevention from evaluation of programs and the behavioral and social sciences, especially as it relates to the at-risk population groups within a given community. Planning group members should also be routinely updated about relevant new findings of behavioral and social scientists." ("Supplemental Guidance on HIV Prevention Community Planning for Non-competing Continuation of Cooperative Agreements for HIV Prevention Projects", CDC, page 9)



SECTION
2
Epi Profile

Epidemiologic Profile

The Surveillance Program of the HIV/AIDS Branch, Kentucky Department for Public Health provides an overview of data on HIV and AIDS for the state of Kentucky. The Surveillance Program collected data on individuals diagnosed with AIDS since 1982. Between 1989 and July 2004, HIV cases were reported by code. In July 2004, name-based HIV reporting legislation was passed in Kentucky. HIV cases reported during the code-based period are currently under evaluation for completeness and accuracy. Therefore at this time, HIV data is only available on cases diagnosed and reported since 2005, the first full year of name-based HIV reporting. No estimates of the number of persons living with HIV in Kentucky are available at this time. The Centers for Disease Control and Prevention (CDC) will not release HIV estimates for Kentucky until four full years after name-based reporting was implemented. The majority of this report will focus on trends in AIDS cases; information at the end of the profile is dedicated to more recent data on HIV diagnoses.

AIDS Data

Nationally, Kentucky ranked 32nd among the states for the number of reported AIDS cases, with 203 AIDS cases reported in 2008 according to the CDC. Kentucky comprised less than one percent of AIDS cases reported in the United States in 2008. Among AIDS cases reported in the metropolitan statistical areas (MSA) in the United States, 96 were reported in the Louisville, Kentucky MSA in 2008, with a rate of 7.9 per 100,000 in the population.

Current Local and state epidemic

As of December 31, 2008, there have been a total of 5,015 AIDS cases reported in Kentucky to the Department for Public Health's HIV/AIDS Surveillance Program since 1982. Of these reported cases, 2,707 are still presumed to be living. In 2008, there were 216 new AIDS cases diagnosed. The annual AIDS diagnosis rate among persons in Kentucky shows a trend by year of diagnosis (Figure 1). The annual AIDS diagnosis rate has remained fairly steady from 2000 to 2006, with slight fluctuations in 2002 and 2005.



*Data are current as of December 31, 2008. The data for 2008 are considered provisional due to reporting delays and are not presented in trend analysis.

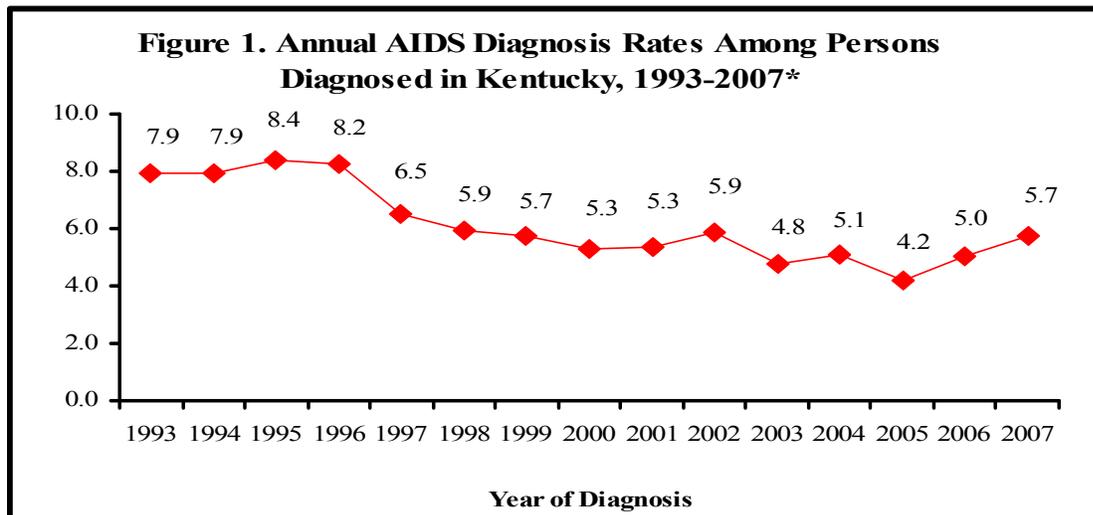
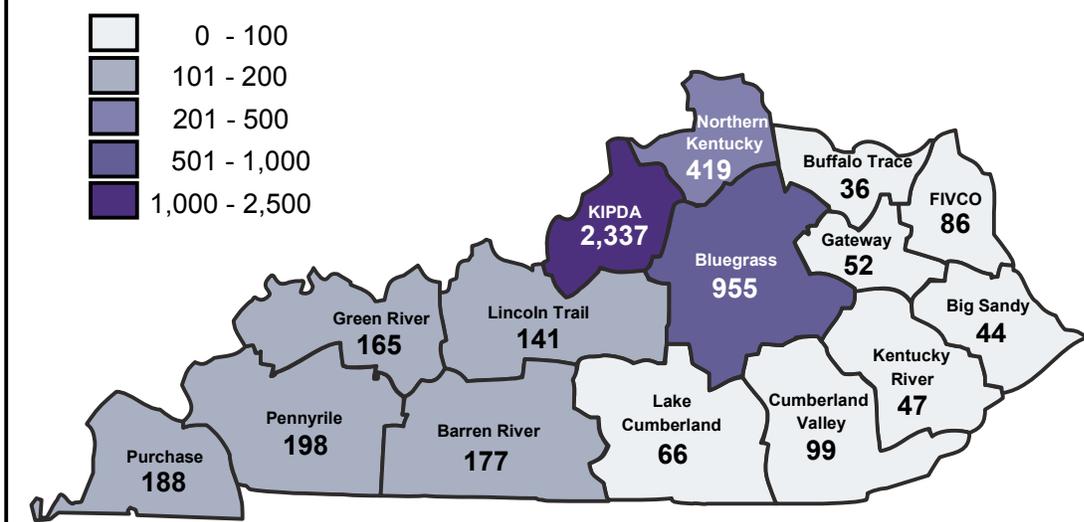


Figure 2. Cumulative AIDS Cases by Area Development District (ADD) of Residence at Time of Diagnosis through December 31, 2008

Cumulative AIDS Diagnoses by ADD



The rate of living AIDS cases is highest in the KIPDA area development district (ADD), which includes the city of Louisville. The rate of living AIDS cases is second highest in the Bluegrass ADD, which includes the city of Lexington. The rate of living AIDS cases is lowest in eastern Kentucky.



Figure 3. Percent of Reported Living AIDS Cases and Populations by Area Development District in Kentucky, 2008

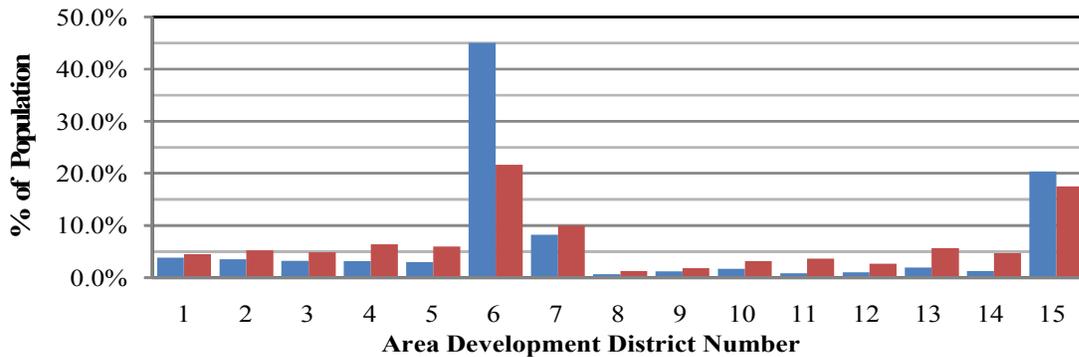
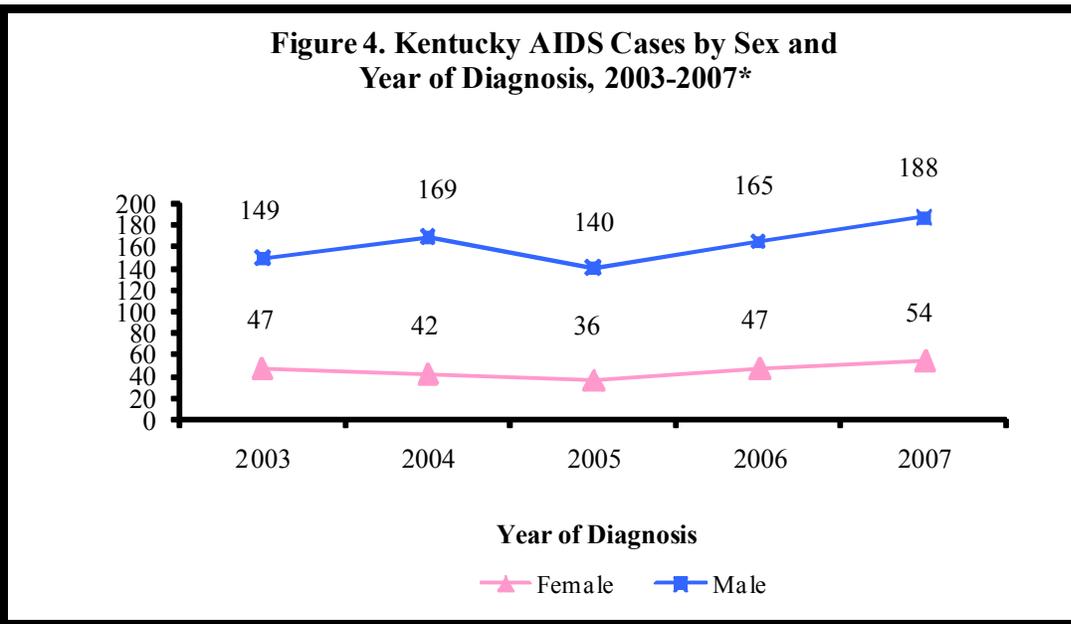


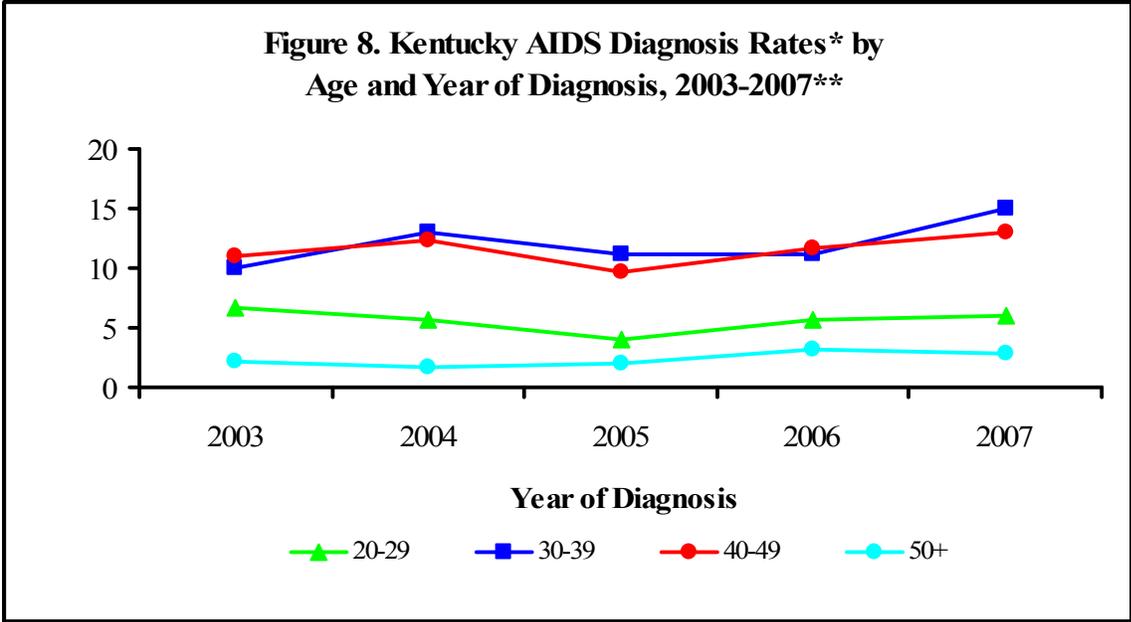
Figure 3 illustrates the disproportionate impact of AIDS on the Bluegrass ADD (15) and the KIPDA ADD (6), compared to the percent of people in the population. Although the KIPDA ADD comprises only 22% of Kentucky’s residents, this area represents 45% of living AIDS cases diagnosed in Kentucky. The two ADDs with the disproportionate impact represent the largest population centers in the state.

Figure 4. Kentucky AIDS Cases by Sex and Year of Diagnosis, 2003-2007*



*Data for 2008 are not included in trend analyses since they are considered provisional due to reporting delays; all data are subject to change due to reporting delays. Males represent the majority (84%) of total AIDS cases reported in Kentucky. On average from 2003 to 2007, the AIDS diagnosis rate among males was almost four times higher than for females (not graphed). The number of male AIDS cases diagnosed and the yearly diagnosis rate has fluctuated from 2003 to 2007. The female AIDS diagnosis rate (not graphed) has remained fairly steady 2003 to 2007, with a slight decrease seen in 2004 and 2005. These trends will continue to be monitored as data become available.

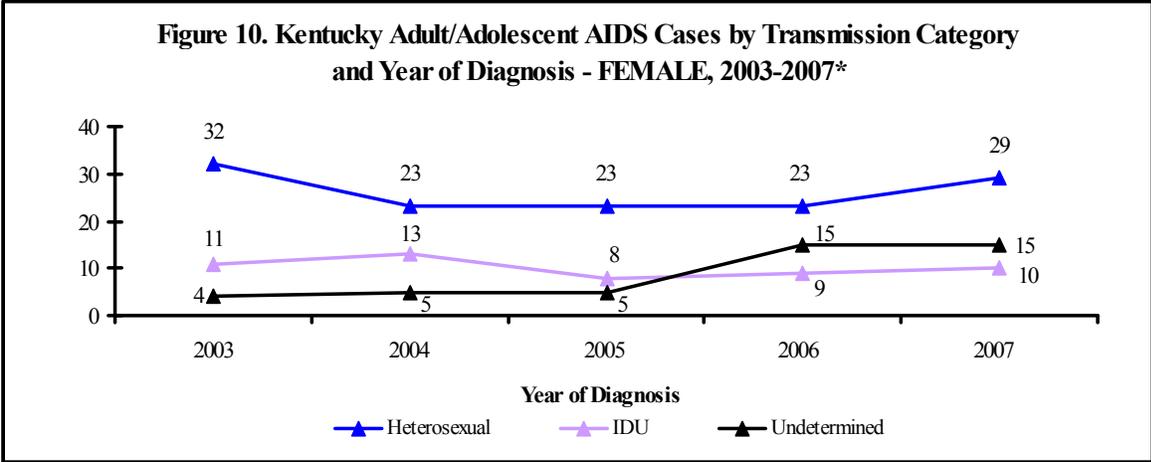


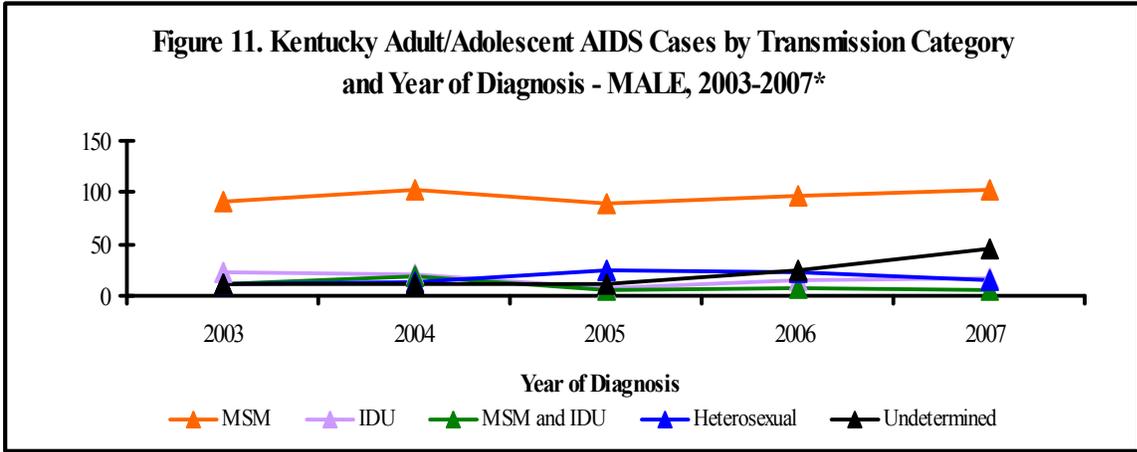


*Due to the small numbers of AIDS cases reported, rates are not presented for age groups 0-12 and 13-19 years old.

**Data for 2008 are not included in trend analyses since they are considered provisional due to reporting delays; all data are subject to change due to reporting delays.

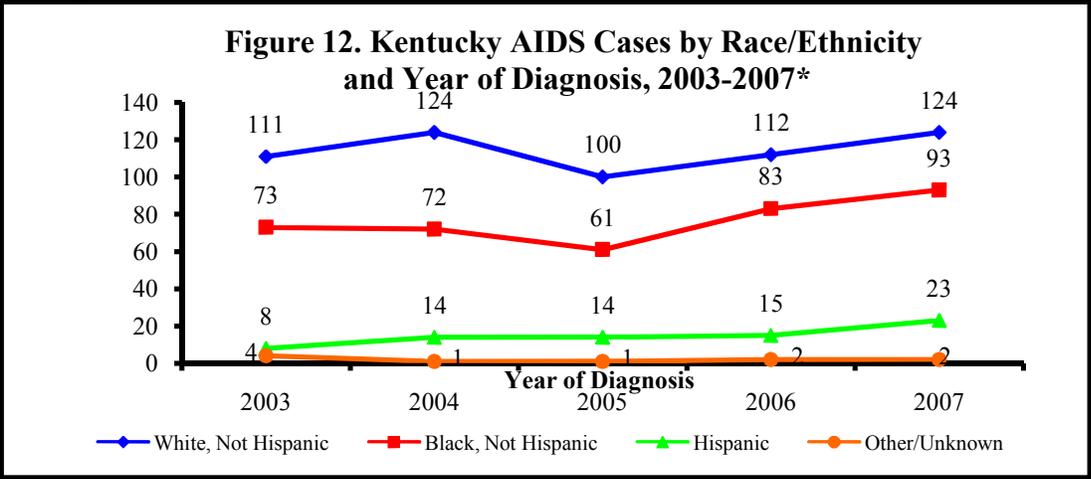
Cumulatively through December 31, 2008, the largest percentage of AIDS cases were diagnosed in their 30's (42%), followed by those in their 40's (27%). The AIDS diagnosis rate has been highest among those in their 30's and 40's from 2003 to 2007 (Figure 5). There was a slight increase in the diagnosis rates for all age categories from 2005 to 2006, except among those 30 to 39 years of age.





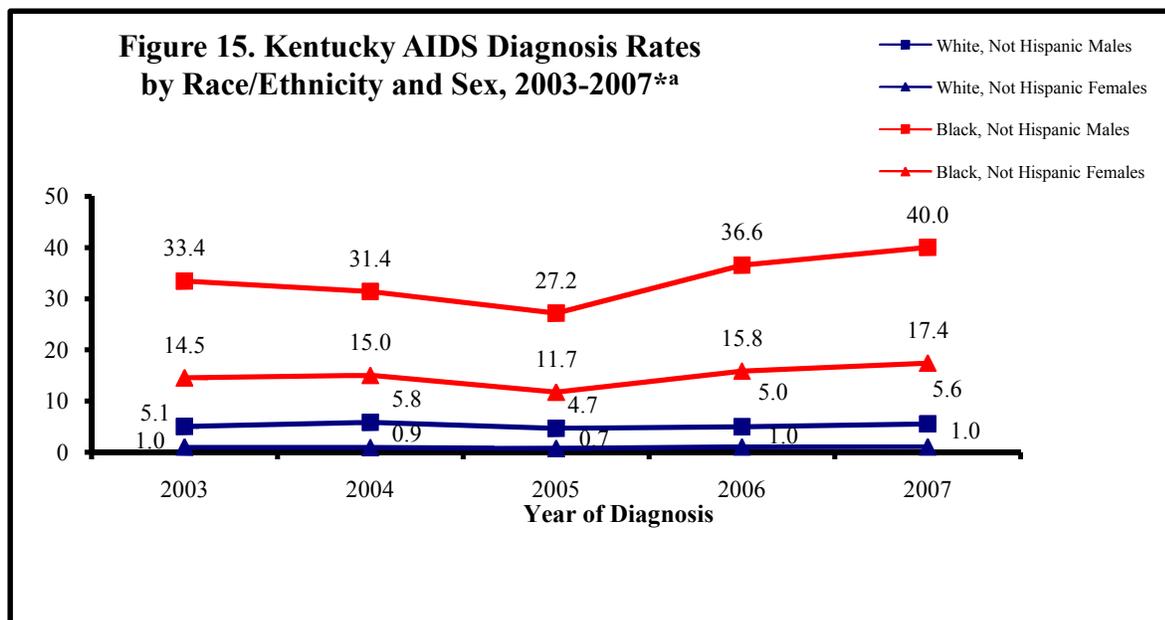
*Data for 2008 are not included in trend analyses since they are considered provisional due to reporting delays; all data are subject to change due to reporting delays.

Figure 10 and Figure 11 show female and male Kentucky adult/adolescent AIDS cases by transmission category and year of diagnosis. The number of cases among females reporting heterosexual contact as the mode of transmission decreased from 2003 to 2004, with an increase in 2007 (Figure 10). Also, the number of female cases reporting IDU as their primary mode of transmission decreased from 2004 to 2005. In Figure 11 for adult/adolescent males, please note the break in the y-axis for the number of cases diagnosed. Among males, MSM's account for the largest number of cases diagnosed each year from 2003 to 2007. The number of males reporting IDU as their primary mode of transmission decreased from 2003 to 2005, and then increased in 2006 and 2007 but has since decreased. For both sexes, the number of cases with an undetermined transmission category increased in 2006, but remained stable among females while it increased for males in 2007.



*Data for 2008 are not included in trend analyses since they are considered provisional due to reporting delays; all data are subject to change due to reporting delays.





^aData for 2008 are not included in trend analyses since they are considered provisional due to reporting delays; all data are subject to change due to reporting delays. ^aRates for Hispanic cases by sex are not presented due to the small number of cases reported.

On average from 2003-2007, the AIDS diagnosis rate for blacks was approximately eight times higher than for whites, and five times higher for Hispanics than for whites in Kentucky (Figure 14). The diagnosis rate among black males has steadily decreased between 2003 and 2005 (Figure 15). The diagnosis rate among both black males and females increased from 2005 to 2007. This trend will continue to be monitored. The diagnosis rates among white males and females have remained fairly steady from 2003 to 2007 (Figure 15).

HIV Diagnoses

Between 2005 and December 31, 2008 there have been a total of 1,415 HIV infections reported in Kentucky (Table 18). Of these cases, 24% were concurrently diagnosed with AIDS during the same calendar month as the initial HIV diagnosis. While the number of new HIV infections spiked in calendar year 2007, the proportion of concurrent diagnoses has remained fairly steady from 2005 through 2008.

Table 18. Kentucky HIV Diagnoses, 2005-2008*

Year of Diagnosis	Total HIV Diagnoses N	Without AIDS		Concurrent with AIDS Diagnosis	
		N	%	N	%
2005	334	251	75%	83	25%
2006	345	265	77%	80	23%
2007	404	307	76%	97	24%
2008*	332	249	75%	83	25%
Total	1415	1072	76%	343	24%

*Data reported January 1, 2005 through December 31, 2008.



Figure 16. HIV Diagnoses by Area Development District (ADD) of Residence at Time of Diagnosis

Total HIV Diagnoses by ADD, January 1, 2005 – December 2008

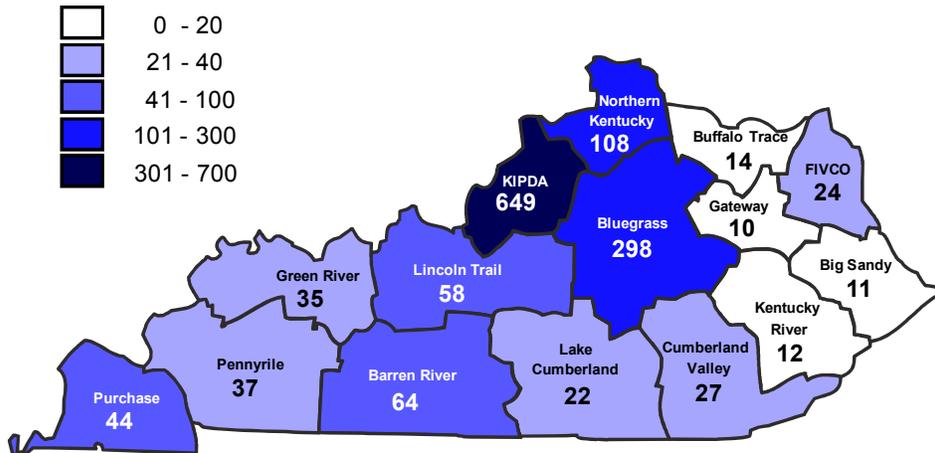


Figure 16 examines the total number of HIV infections diagnosed between 2005 and 2008 by ADD. The labels on the map represent the total number of HIV infections, regardless of disease progression status in each ADD. The largest number of cases (n=649, 46%) diagnosed in this period were residing in the KIPDA ADD, which includes the city of Louisville. The second largest number of cases (n=298, 21%) were residents of the Bluegrass ADD at the time of diagnosis. The smallest number of HIV infections diagnosed and reported during this period occurred in the ADD's located in eastern Kentucky.

Figure 17. Percent of HIV Infections Reporting Concurrent Diagnoses with AIDS by Area Development District (ADD) of Residence at Time of Diagnosis, 2005- 2008

% Concurrent Diagnoses by ADD, January 1, 2005 – December 2008

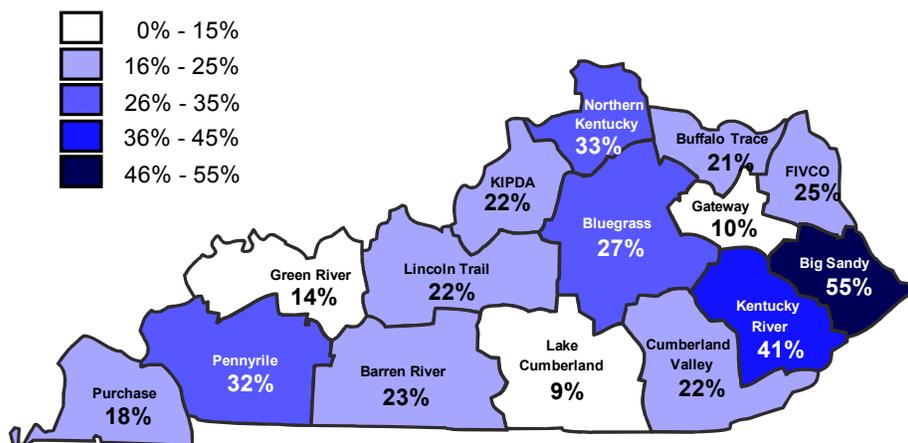
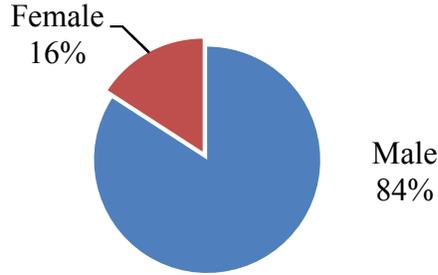


Figure 17 examines the variation by ADD in the proportion of cases within each ADD diagnosed concurrently with HIV and AIDS from 2005 to 2008. The proportion of HIV infections diagnosed concurrently with AIDS ranged from 0% to 55% among the ADDs. The ADDs with the top 2 highest proportion of HIV infections diagnosed concurrently with AIDS were in the eastern Kentucky region: the Big Sandy (55%) and Kentucky River (41%) ADDs. However, there were only a total of 11 and 12 HIV infections diagnosed in these ADDs respectively. The Northern Kentucky and Pennyriple ADDs also had comparatively higher percentages of concurrent diagnoses; 33% and 32% respectively.

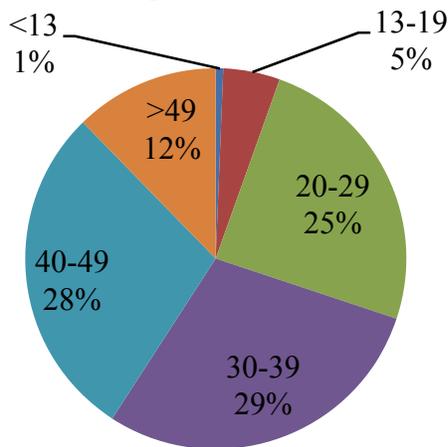


Figure 12. Percentage of Kentucky HIV Diagnoses by Sex, 2005-2008



Between 2005 and 2008, 84% of all HIV diagnoses were reported among males. There were no differences in the distribution by sex between HIV cases diagnosed without AIDS, and cases concurrently diagnosed with HIV and AIDS in the same calendar month.

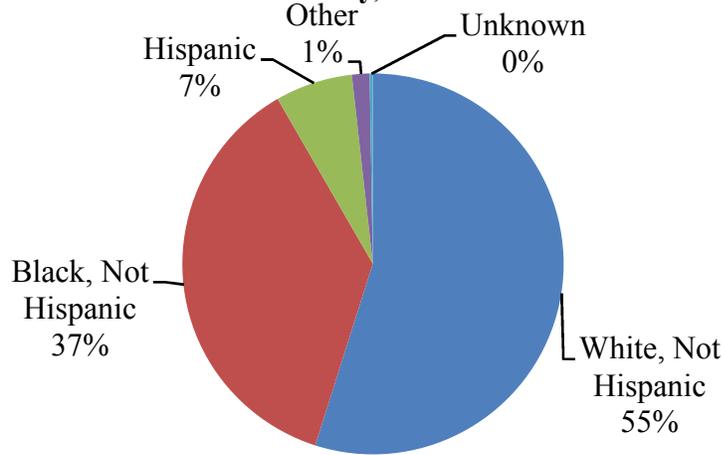
Figure 13. Percentage of Kentucky HIV Diagnoses by Age at Diagnosis, 2005-2008



Between 2005 and 2008, 29% of new HIV diagnoses were reported among those 30-39 years of age (Figure 13). Eight-two percent of all HIV infections diagnosed in this time period were among individuals 20-49 years of age. There were differences in the distribution of age at diagnosis between HIV cases diagnosed without AIDS and cases concurrently diagnosed with HIV and AIDS in the same calendar month. Among individuals diagnosed with HIV without AIDS, 25% of all cases were diagnosed among those 40-49 years of age. In comparison, individuals diagnosed between 40-49 years of age represented 39% of all HIV cases concurrently diagnosed with AIDS. In contrast, individuals diagnosed between 20-29 years of age represented 28% of HIV without AIDS diagnoses, but only represented 14% of all cases concurrently diagnosed with AIDS.



Figure 14. Percentage of Kentucky HIV Diagnoses by Race/Ethnicity, 2005-2008



Whites represented 55% of all diagnosed HIV infections from 2005 to 2008 (Figure 14). Blacks and Hispanics are disproportionately impacted by HIV. Although Blacks and Hispanics comprise only 7% and 1% of Kentucky’s general population, respectively, based on 2000 U.S. Census data, they represent 37% and 7% of all new HIV diagnoses from 2005-2008. Hispanics made up a larger proportion (11%) of concurrently diagnosed cases than their proportion (5%) among individuals diagnosed with HIV without AIDS. This data suggests that Hispanics are being diagnosed and reported at a later stage than other race/ethnicity categories.

Figure 15. Percentage of Kentucky HIV Diagnoses by Transmission Category-Adult/Adolescent Males, 2005-June 2008

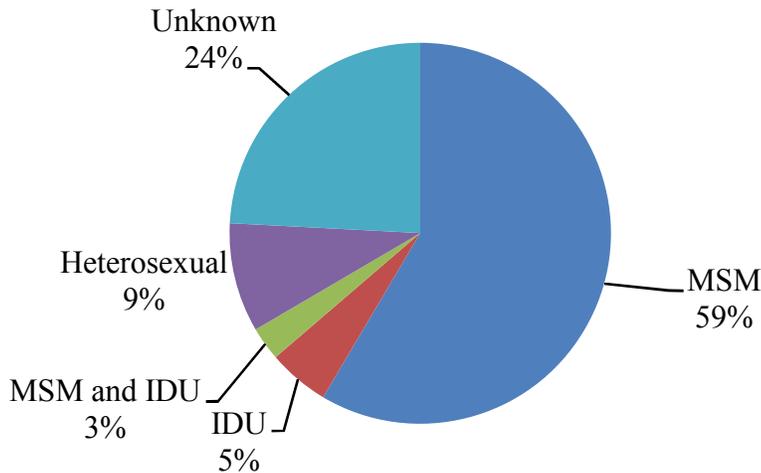


Figure 15 illustrates the distribution of HIV diagnoses from 2005 to June 2008 by transmission category among adult/adolescent males. The majority of HIV diagnoses within this time period have been attributed to men who have sex with men (59%). There are a large percentage of cases where the transmission category is unknown (24%). Cases with unknown transmission category information have not been proportionately re-distributed. The large percentage of missing cases makes it difficult to interpret this data.



**Figure 16. Percentage of Kentucky HIV Diagnoses by Transmission Category-
Adult/Adolescent Females,
2005-June 2008**

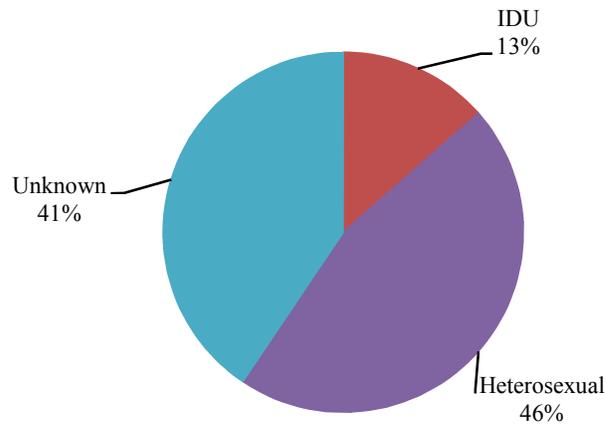


Figure 16 illustrates the distribution of HIV diagnoses from 2005 to June 2008 by transmission category among adult/adolescent females. The majority of HIV diagnoses within this time period have been attributed to heterosexual contact (46%). There are a large percentage of cases where the transmission category is unknown (41%). Cases with unknown transmission category information have not been proportionately re-distributed. second highest proportion of living AIDS cases as of December 31, 2006 (21.1%) and new AIDS cases diagnosed between January 1, 2005 and December 31, 2006 (21.0%). There has been little change in the distribution of living AIDS cases and new AIDS cases by residence at diagnosis between 2004 and 2006. See the map below for the distribution of 2006 prevalence rates by ADD.



Needs Assessment

1. Introduction: Prevention

The U.S. Centers for Disease Control and Prevention periodically require funded HIV prevention services providers to conduct a community services assessment. This report outlines the 2007 community services assessment for Kentucky. The needs assessment section draws upon a survey of 1,206 HIV- and HIV+ Kentuckians conducted in the summer of 2007. The resource inventory lists the current agencies providing prevention services in Kentucky. Finally, the gaps analysis examines where prevention services may be enhanced.

2. Needs Assessment

Survey

The 2007 Kentucky Needs Assessment Survey consists of 86 questions. HIV- individuals answer only the first 51 questions.

Principal Investigator

Jeff A. Jones, Ph.D., devised and analyzed the 2007 Kentucky Needs Assessment Survey in conjunction with the HIV Branch and participating service agencies. Dr. Jones conducted several prior HIV care assessments in Kentucky as well as administering several statewide adolescent health surveys for the CDC (Centers for Disease Control and Prevention). He is an Assistant Professor in the Department of Health Behavior at the University of Kentucky's College of Public Health.

Survey Methodology

Of the thirteen agencies participating in the joint survey of care and prevention clients, nine have prevention services. Because care clients at the four other sites also completed the prevention questions, their responses are included with the prevention sample responses. The sampling frame consists of the prevention clients at the nine participating care and prevention agencies. These sites were selected because they receive Federal funds for conducting care and prevention activities. Based on the client loads reported by each agency, Dr. Jones assigned a target sample of 1,000 prevention clients distributed between the nine agencies based on each agency's percentage of total prevention clients in the state. The agencies administered the survey to clients coming to the agency during late June and July 2007. The 86 question survey was anonymous and no names or identifying information were gathered on the survey. The participating agencies are:

- AVOL (AIDS Volunteers), Lexington*
- Barren River District Health Department, Bowling Green*
- Bluegrass Care Clinic, University of Kentucky, Lexington
- Cumberland Valley District Health Department, London



- Heartland CARES, Paducah*
- Lexington-Fayette County Health Department, Lexington*
- Louisville Metro Health Department, Louisville*
- Matthew 25, Henderson*
- Matthew 25, Bowling Green
- Northern Kentucky District Health Department, Fort Mitchell*
- Purchase District Health Department, Paducah*
- Volunteers of America, Louisville*
- WINGS Clinic, University of Louisville, Louisville

*Site had prevention services.

Sample, Responses, and Margins of Error

Site	Sample	Respondents	Response Rate	Margin of Error (+ or - at 95% confidence)
Cumberland Valley District HD	0	27	n/a	19
Bluegrass Care Clinic	0	125	n/a	9
Northern Kentucky District HD	22	65	298	12
WINGS Clinic	0	106	n/a	10
VOA	148	160	108	8
Matthew 25 Henderson	73	116	160	9
Matthew 25 Bowling Green	0	25	n/a	20
Heartland Cares	72	112	155	9
AVOL	73	16	22	25
Purchase District HD	55	47	86	14
Barren River District HD	13	10	75	31
Lexington-Fayette County HD	107	31	29	18
Louisville Metro HD	437	366	84	5
	1000	1206	121	3

The survey has an overall margin of error of +/- 3% at a 95% confidence interval and derives from the number of responses received on the survey. The margins of error for individual sites are also given. While the table above shows the margin of error for the entire survey or for individual sites, it would also be possible to compute this figure for each individual question based on the number of respondents answering the question.

Limitations

This survey has a number of limitations. Survey collection took place during a short one month period in mid-summer at various HIV care and prevention sites around the state. Some individuals who normally visit a site regularly may have been absent due to summer vacations and other summer activities. Furthermore, only individuals currently participating in prevention programs or care coordination completed the survey. As such, the prevention needs are not reflective of the state as a whole and have a bias towards urban, female, and African-American respondents.



Demographics

The following demographics compare HIV- and HIV+ respondents. These two groups are strikingly dissimilar in a number of ways.

The positive respondents are disproportionately non-Hispanic white males over the age of 40 living in urban areas. The HIV- respondents are still a male majority but with greater representation of women. The majority of negative respondents are also under the age of 40 and racial minorities. While almost half of the positive respondents are gay, four-fifths of the negative respondents are heterosexuals.

In terms of perception of residence, both groups feel they live in urban places, but the negative group is even more urban than the positive group. In another similarity, both groups have similar patterns of education attainment with about half of the individuals in both groups having a high school diploma or less.

Sex	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Male	397	54	308	71
Female	325	44	111	26
Male to female transsexual	7	1	13	3
Female to male transsexual	4	1	2	0
	733	100	434	100

Age	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Less than 18 years old	33	5	2	0
18 to 21	118	16	12	3
22 to 29	269	37	49	11
30 to 39	169	23	121	28
40 to 49	94	13	166	38
50 to 59	32	4	72	17
60 to 64	8	1	8	2
65 years or older	10	1	5	1
	733	100	435	100



Hispanic Ethnicity	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Yes	45	6	16	4
No	676	94	403	96
	721	100	419	100

Race	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
American Indian or Alaska Native	21	3	8	2
Asian	11	1	9	2
Black or African-American	315	43	114	26
Native Hawaiian or other Pacific Islander	6	1	4	1
White	340	47	283	66
Other	34	5	14	3
	727	100	432	100

According to the U.S. Census Bureau's current estimates, Kentucky's population consists of 89% non-Hispanic Whites and 7% African-Americans (Hispanic or non-Hispanic). The respondents are disproportionately minorities.

Sexual Orientation Identity	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Gay, lesbian, or homosexual	86	12	199	48
Bisexual	74	10	48	11
Heterosexual or straight	567	78	173	41
	727	100	420	100



Urban/Rural	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
City	528	74	277	64
Country	189	26	153	36
	717	100	430	100

Education	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Less than high school degree or GED	102	14	74	17
High school diploma or GED	258	36	126	30
Some college	201	28	145	34
College degree	117	17	50	12
Graduate or Professional degree	37	5	29	7
	715	100	424	100

Testing

All of the positive group should report on the 2007 Kentucky HIV/AIDS Needs Assessment Survey they have been tested at some point, but three percent marked they had not been. On the other hand, a quarter of HIV- respondents have not ever been tested for HIV. A fifth of the negative group has been tested but only returned for their results half the time or less. Fear of learning they are infected is the primary reason listed for not returning for test results in both groups.

Positive respondents are more likely to report they have been tested at a physician's office or hospital. This finding may reflect individuals who were first tested when they sought medical attention for an illness associated with their HIV disease.

Times Ever Tested for HIV

HIV Negative

HIV Positive



	Frequency	Percentage	Frequency	Percentage
None	184	25	13	3
1	170	23	155	37
2	120	17	74	17
3	104	14	50	12
4	50	7	26	6
5 or more	101	14	105	25
Total	729	100	423	100

Times
Tested Each
Year

	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
None	317	44	242	58
1	276	38	48	12
2	82	11	32	8
3	21	3	23	5
4	18	3	32	8
5 or more	15	2	36	9
Total	729	101	413	100



When Tested, How Often Returns for Results

	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
I have never been tested	169	23	8	2
I never returned for my results	64	9	17	4
Sometimes	55	8	25	6
Half the time	22	3	11	3
Most of the time	41	6	33	8
Always	371	51	316	77
Total	722	100	410	100



**Reasons For
Not
Returning for
Results**

	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
I have never been tested	178	29	14	4
I always returned for my results	374	60	259	82
I was scared to find out my results	44	7	20	6
I was scared people would see me and talk bad about me	10	1	11	4
I did not think my results would be kept secret	5	1	4	1
I did not trust the people or had a past negative experience where I got tested	6	1	9	3
Another reason	7	1	0	0
Total	624	100	317	100



**Why Do You Think
Some People
Don't Return for
Their Results**

	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
They are scared that they might have HIV	559	80	274	71
They are scared that other people will find out about their HIV test	83	12	88	23
They don't trust doctors/healthcare workers	34	5	13	3
In the past, they had a bad time with doctors/healthcare workers	21	3	9	3
Total	697	100	384	100

**Where
Tested**

	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
I have never been tested	178	25	5	1
Health department	206	29	131	32
Physician's office	98	14	93	23
Hospital or clinic	149	21	2	33
Bar, street, or prevention event	22	3	9	2
Some place else	52	7	38	9
Total	705	99	278	100



**Prevention
Services
Used**

	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Program on how to prevent HIV infection	341	47	237	56
Drug or alcohol abuse treatment program	247	34	134	32
Program for a specific group	118	17	83	20
Support group for partners, family, or friends of HIV+ Kentuckians	87	12	132	31
HIV testing center	301	43	269	64
HIV prevention specialist who tests for HIV outside of a clinic, office, or health department	196	28	120	29



Risks

Substance Used in Past Two Years	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Alcohol	493	70	282	68
Tobacco	430	61	294	71
Marijuana (recreational)	323	46	149	36
Pain pills not belonging to the client	177	25	102	24
Cocaine	129	18	71	17
Marijuana (health)	65	9	90	22
Ecstasy	103	15	35	8
Methamphetamines	79	11	34	8
Any illegal injected drug	43	6	28	7
Heroin	43	6	12	3

In a pattern similar to substance use among Kentucky youth and adults in general¹, alcohol, tobacco, and marijuana make up the most common substances used by respondents. Marijuana usage in the past two years for recreational purposes, however, is higher than in the general population as surveyed by the BRFSS. Prescription drug abuse is also higher.

It is interesting to note the self-reported prevalence of substance use is similar between positive and negative respondents in terms of alcohol, prescription drugs, cocaine, injectable drugs, and methamphetamines. Positive respondents, however, smoke more while negative respondents are more likely to use heroin, ecstasy, and recreational marijuana.

¹ Based on data from the Youth Risk Behavior Survey (YRBS) and Behavioral Risk Factor Surveillance Survey (BRFSS)



Sexual Behaviors in Past Two Years

	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Unsafe oral sex	488	72	163	41
Multiple sex partners	625	88	323	78
Unsafe vaginal-penile intercourse	402	60	85	22
Unsafe anal sex	217	33	109	28
Have had sex with someone who was jailed	162	23	89	22
Celibate	82	12	93	22
Sex in exchange for drugs or money	78	13	39	10
Had sex with someone while jailed	27	5	19	5

Responses to questions about sexual behaviors are surprisingly similar between positive and negative individuals in terms of prostitution, having had sex while in jail, having had sex with someone formerly jailed, and barebacking (unsafe anal sex). On the other hand, negative respondents are far more likely to practice unsafe behaviors in terms of oral sex and unsafe vaginal-penile intercourse. Part of this difference is the greater percentage of the negative group reporting they are heterosexual. The negative group's higher incidence of unsafe behaviors may also be linked to being younger as well as less likely to report being celibate.



Information Sources

Where Do You
Hear About HIV
Prevention
Services or
Events?

	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Care Coordinator	151	22	328	79
Physician/Clinic	300	43	297	75
HIV+ friend	163	24	171	43
HIV- friend	233	33	107	27
Internet	238	34	124	32
Media	359	51	160	41
Flyer or poster	291	42	174	44
Church, school, etc.	242	35	78	20
other	280	42	107	29

The negative and positive respondents have strikingly different sources in many cases for where they report getting information on HIV services and events. Negative respondents depend more on the media while positive individuals learn about services and events through their physician and care coordinator.

How To
Improve
Prevention
Services

	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Pass out more free condoms (rubbers)	174	27	57	18
Use a mobile van to get to more places in the community	158	24	56	18
Put out flyers where people can get them	51	8	40	13
Send out TV and radio messages	128	20	70	21
Go to more community events	134	21	95	30
Total	645	100	318	100



COMMUNITY BASED ORGANIZATIONS PROVIDING HIV PREVENTION

Agencies funded in part with CDC Cooperative Agreement funds are indicated with the KHPAC logo: 

American Red Cross (ARC) is located in nearly every county in Kentucky. The number of ARC employees range from one or two in the smaller communities to more than 300 in the Louisville Chapter. Budgets are also diverse, with smaller chapters having budgets of a few thousand dollars to in excess of a hundred thousand dollars in Lexington and Louisville. There is disparity in the provision of HI/AIDS services among counties, with smaller, more rural counties believing that there is "no problem" in their community (thus no reason for services) to the larger, more urban chapters offering quite a range of services. HIV/AIDS services include the distribution of brochures, AIDS 101 training, peer training for adolescents, African American AIDS 101 training, Hispanic AIDS 101 training, rural and church leader AIDS 101 training, prison personnel training, and a program specifically entitled "AIDS in the Workplace" which is designated for businesses and industries. (502) 589-4450

AIDS Services Center Coalition (ASCC) is a coalition of agencies whose primary goal is to direct the public to appropriate AIDS service agencies, literature distribution, and provide a HIV/AIDS resource directory. The agency has an extensive volunteer network. (502) 574-5490

House of Ruth provides social, emotional and financial support to people living with HIV/AIDS in the Louisville/Jefferson County area. (502) 587-5080

WINGS Clinic –The University of Louisville Research Foundation (ULRF) is a 501 (3) C private, non-profit foundation at the University of Louisville. WINGS provides quality HIV outpatient primary medical care and support services to the HIV infected population living in a 7county Kentucky region and Southern Indiana. Delivery of HIV medical care and services includes women, adolescents, and families. (502) 561-8844

 **Sisters and Brothers Surviving AIDS (SABSA)** is a support group located in Louisville for all HIV positive people and their friends and family. SABSA provides education and emotional support specific to the needs of those living with HIV and more specifically to the needs of the African-American community. However, everyone is welcome regardless of gender, race, sexual orientation, creed, religion or ethnic background. (502) 231-3871

AIDS Interfaith Ministries (AIM) of Louisville provides support services to individuals living with HIV/AIDS and their families. (502) 574-6085

Matthew 25 AIDS Services, Inc. located in Henderson is a Ryan White CARE Act Part B, Part C and CDC Prevention PA04064 Grantee. They are a provider of primary health care to PWHIV and LWA, in Daviess, Henderson, Union and Webster counties. Services include medical case management and referral, a buddy program, literature, spiritual support and referral, financial assistance and referral, a speakers' bureau, support groups (positive, family and friends), transportation and prevention education for the community and medical professionals. Matthew 25 also distributes HOPWA funds and does counseling and testing for HIV (blood and oral testing). (270) 826-0200 www.matthew25clinic.org



AIDS Volunteers, Inc. (AVOL) located in Lexington, KY is a community-based organization that provides HIV and AIDS education, prevention initiatives, service programs and financial assistance to persons infected and affected by HIV disease in all of Central and Eastern Kentucky. Some of the services provided by AVOL include: a speakers' bureau, support groups, financial assistance, case management, transitional housing for those who are homeless and HIV+, a community residence for those in the end stages of AIDS, community outreach, condom distribution, educational programs and materials, and prevention activities. Funding for AVOL comes from community donations, fund raisers and grants from private foundations, as well as local, state, and federal sources including HUD (HOPWA) and the United Way. Approximately 75-100 volunteers are consistently involved throughout the year for day to day operations, programs and services, volunteer caregivers and fundraising events. Program referrals and linkages are through the health departments, other volunteer organizations and HIV Care Coordinators.
www.AIDSVolunteers.org (859) 225-3000; Fax (859) 225-9244

AIDS Volunteers of Northern Kentucky (AVNK), located in Florence, KY was founded in 1990. AVNK seeks to understand and address the emotional, educational, social, spiritual and physical needs of the people in Northern Kentucky and surrounding communities who are living with HIV/AIDS, and the needs of their families, partners, friends and caregivers. AVNK strives to inform the general community about HIV/AIDS related issues for purposes of education, mobilization, prevention and advocacy. AVNK provides a number of services including three support groups, a monthly dinner/social, healing weekends, respite care, emergency financial assistance, memorial services, outreach to minority communities, World AIDS Day services and Healing Weekends. (859) 331-4719

AIDS Volunteers of Cincinnati (AVOC) located in Cincinnati, OH is a community-based organization that provides a wide variety of services to individuals diagnosed with HIV/AIDS and to the broader community, especially high-risk populations where HIV exposure is more likely. Although AVOC primarily serves Cincinnati and southwest Ohio, they offer many of their services to individuals and groups in Northern Kentucky. These services include community outreach, prevention and education presentations, street outreach to women in underserved communities, testing and counseling services, an informational and referral hotline and a speaker's bureau. (513) 421-AIDS (2437).

The I.N.D.Y (I'm Not Dead Yet) Project founded in 1994 serves Northern Kentucky. INDY is an organization dedicated to the enhancement of life for individuals affected by HIV and AIDS by providing social outlet in a variety of environments and frameworks with one basic goal in mind: having fun! Members and sponsors attend and host picnics, movie nights, dinners, camping trips, art events and parties. The group is dedicated to the proposition that through the joy of celebrating life there is hope and healing, and celebration is best engaged through groups of like minded individuals. (513) 343-9999.

University of Cincinnati Hospital, Holmes Clinic located in Cincinnati, Ohio is the Infectious Disease Center for the University of Cincinnati Hospital. Holmes Clinic provides medical services to individuals diagnosed with HIV/AIDS and is funded primarily through Ryan White Part C funds. Holmes Clinic provides these services to individuals from several states, and a significant percentage of individuals diagnosed with HIV/AIDS and living in Northern Kentucky use Holmes Clinic for their infectious disease care. In addition, Holmes Clinic conducts partner testing for patients of the clinic. (513) 584-6977



The University of Cincinnati Emergency Room also has a grant to conduct HIV testing and counseling services with patients who are seen through the Emergency Room. This program targets high-risk individuals who receive their primary medical care through the Emergency Room. If an individual is diagnosed, a referral is made to Holmes Clinic. (513) 584-5700

Bluegrass Care Clinic (BCC), located in Lexington is a Ryan White CARE Act Part C grantee. The BCC provides both clinical and support services for HIV/AIDS patients and their affected families in 63 counties through Central and Eastern Kentucky. The BCC staff is trained to provide harm reduction information and counseling regarding drug use, sexual activity and other high risk activities for HIV transmission and infection. In addition, the BCC also provides pre/post test counseling and testing. (859) 323-5544; Fax: (859) 257-2040; www.mc.uky.edu/bluegrasscareclinic.

Moveable Feast (MFL) is a nutritional support program, serving people living with HIV disease and their dependent children living in the Lexington/Fayette County area. Clients receive social support and a hot, freshly cooked dinner five days a week. MFL can also serve as a referral source to other Area Service Organizations (ASOs) in the region. All services are completely free of charge. (859) 252-2867 www.feastlex.org.

Episcopal Diocese AIDS Ministry, located in Lexington, provides care and support through bi-annual social dinners. All meals and additional limited supportive services are provided free of charge. The Episcopal Diocese AIDS Ministry can also serve as a referral source/linkage for other ASOs in the region. Contact: Lisa – lisainky@adelphia.net.

The Salvation Army of Central Kentucky, located in Lexington, operates a free medical clinic. The medical clinic, operated by the University Kentucky's College of Medicine, provides exams and physical therapy, and HIV pre/post test counseling and testing. (859) 252-7706

 **Owensboro Area HIV/AIDS Task Force, Inc.** is a non-profit CBO funded by donations. This agency serves its clients with emergency financial assistance, transitional housing, and acts as an advocate with property owners, utility companies, Social Security, HOPWA and other community service agencies. Volunteers also provide community outreach services with HIV prevention and risk reduction programs to targeted populations and various communities, medical professionals and local organizations. The Task Force dispenses printed risk reduction materials, condoms (male and female), dental dams, needle cleaning kits and crack pipe cleaning kits. The Task Force also goes into public sex environments (PSE) offering similar services, as well as HIV testing. Members of the Task Force are state certified pre and post-test counselors as well as certified to administer OraSure for HIV testing. Members are also certified to inspect potential housing for clients wishing to obtain HOPWA funding. The Task Force is a certified partner of the Balm in Gilead. A support group for PWHIV is in place. They act as a referral source to all the available assistance programs for clients. The Task Force has some HIV positive members who have made presentations at several high schools, a program describing the emotional, physical and financial stresses of being HIV positive. (270) 683-6018 www.owensboroaids.org

 **Heartland CARES, Inc.**, located in Paducah is a non-profit organization, serving people with HIV and AIDS in the Western Kentucky and Southern Illinois regions. The mission is to provide various components of care needed for persons living with HIV and AIDS regardless of ethnicity, gender, religious, beliefs, sexual orientation, or ability to pay, and to provide education and prevention to the general public to help stop the spread of HIV and STDs. Medical services



are primarily supported through Ryan White Part C funding. The clinic also has numerous supporting services, which includes the Ryan White Part B Care Coordinator Program, HOPWA Grant Emergency Assistance, Supportive Housing Grant Assistance, SAMHSA-CSAT Grant, HOPWA SPNS and HOME Grant. Heartland CARES houses the Western Kentucky Prevention Team that is responsible for HIV/AIDS prevention in 42 Kentucky counties.
(270) 444-8183

 **Volunteers of America, Inc. (VOA)** in Louisville provides HIV prevention education, focus groups, and risk reduction workshops to drug users, men, women, and youth at risk. The prevention services offered include pre-test and post-test counseling, factual information about reducing HIV risk factors associated with drug use and sexual behavior, alcoholism and drug abuse assessments, and referrals to HIV related and non-related resources as needed or by request. VOA also provides an AIDS Housing Integration Project, which offers technical assistance to shelters, housing providers, and housing developers to help establish and implement new housing programs for homeless and low-income persons with HIV/AIDS. VOA also holds the HIV Services' contract, and provides case management services for PWHIV. This includes intake and assessment, goal setting, conflict resolution, crisis intervention, referral to community services, emergency financial assistance, linkage to rental and utility assistance, entry into support groups, mental health and substance abuse counseling. (502) 635-1361

The AIDS Project, located in Louisville, provides HIV prevention, education and testing services. Programs include staff led volunteer outreach teams that go to local bars, community fairs and special events. Services include condom distribution, counseling and testing, and referrals while practicing harm reduction techniques. (502) 608-0586

North Central AHEC/HETC: The mission of the North Central AHEC is to promote healthy communities through innovative partnerships. This is accomplished by providing educational support services to health professions students and health care providers, community health education and programs to encourage health professions as a career choice.

In order to address HIV prevention in Kentucky's growing Hispanic community, the Kentucky DPH has identified agencies providing other services to our Hispanic population and provided capacity building assistance to help these agencies provide HIV prevention activities including HIV antibody testing.

North Central AHEC/HETC collaborates with Area Health Education Centers across the state that recruit individuals from Hispanic communities, provide training, and utilize them to conduct HIV prevention activities in their communities. AHECs in Lexington (covering 5 counties) and Covington (covering 4 counties) currently conduct outreach in Hispanic communities, provide HIV testing, and conduct two community level intervention (Juntos and Promotores de Salud). A third AHEC in Louisville conducts similar activities with African-American communities.

North Central AHEC/HETC also collaborates with the Bluegrass Farmworker Health Center to provide additional outreach to migrant farm workers as well as testing.

The Lexington and Covington AHECs as well as the Bluegrass Farmworker Health Center have been extremely helpful in providing interpreters and assisting Hispanic clients receive services from other service providers who lack Spanish speaking employees.



Bluegrass Farmworker Health Center: Located in Lexington and Richmond, KY, the Bluegrass Farmworker Health Center (BFHC) serves a primarily migrant/ seasonal farmworker population among eight counties in Central Kentucky. The migrant health center's service area includes: Fayette, Scott, Bourbon, Clark, Madison, Garrard, Jessamine and Woodford counties. Spanish is the primary language of approximately 96% of the BFHC clients.

The BFHC strives to optimize clients' health outcomes by providing affordable, culturally appropriate primary and preventive health care in settings that embrace the Hispanic culture and language.

BFHC values: Client-centered care, client advocacy, excellent health care for clients, extensive client-centered referral and tracking system, optimal client outcomes, life long learning, fiscal responsibility, high degree of respect among staff members. The clinical and outreach staff is fluent in Spanish and English.

The BFHC counselors and educators work with farm workers on the work site and in residences as well as utilize referrals to the actual clinic for medical needs including HIV/AIDS and other related health and care issues.

Hazard Perry County Community Ministries is located in Hazard. Their purpose is to meet community needs through supportive services (outreach and case management), crisis aid, homeless shelter, transitional housing and childcare. (606) 436-0051

Harlan Countians for a Health Community located in Baxter, is a coalition of healthcare providers, consumers, and other interested agencies whose purpose is to improve healthcare in Harlan County. (606) 573-6115

Westlake Primary Care, located in Columbia, provides information and educational AIDS material, prevention kits with condoms, confidential testing and pre and post-test counseling. 270-384-4764

LESBIAN/GAY/BISEXUAL ORGANIZATIONS PROVIDING HIV PREVENTION SERVICES

Lesbian/Gay organizations: Include **GLSO**, **Lambda** on the University of Kentucky campus, **Pride Alliance** on the Eastern Kentucky University campus, **Common Ground** at the University of Louisville, **Diversity Coalition** at Western Kentucky University, **T-Unity** at Transylvania University, **Alliance** at Murray State University, **ACE League** at Berea College, and **Unity** at the Northern Kentucky University. All provide educational interventions and support for at-risk populations, referrals, condom distribution and advocacy services. The service area includes primarily students, but is available for the community. The number of clients is not known at this time. Fiscal resources include institution funding and contributions. Program referrals and linkages are with local agencies, CBOs, and Care Coordinators.

FAMILY PLANNING CLINICS PROVIDING HIV PREVENTION SERVICES

Family Planning Clinics are offered through Health Departments throughout the state. These clinics provide counseling and condom distribution. Total number of clients served is not available at this time. Fiscal and personnel resources include state and local monies and paid



staff. Clients are women of childbearing age and sexually active men. Program referral and linkages include specialists as necessary, local Counseling and Testing sites, and CBOs.

Planned Parenthood has existed in Kentucky for more than 64 years. Planned Parenthood provides services in a large portion of Kentucky. The Louisville office has 16 employees and an operating budget of approximately \$600,000. More than six thousand clients are seen annually in the Louisville office by doctors, nurses, medical assistants or nurse practitioners. Services include distribution of condoms and prevention brochures, programs on AIDS 101 and Safer Sex and peer education for teens and youth. Planned Parenthood contracts with local health departments to provide free and confidential HIV testing for women by appointment. In addition, health department staff in Lexington provides onsite HIV testing at Planned Parenthood on a walk-in basis one day each week. Males have been referred to other agencies in the past, but the agency is increasing its focus on young men. Most clients served are females under age 19 through 39.

YOUTH SERVICES PROGRAMS PROVIDING HIV PREVENTION SERVICES

Department for Human Services/Juvenile Detention Louisville provides formal presentations, video-based programs and peer counseling/peer presentation programs. Approximately 75-80 programs are done annually with services provided to approximately 75-80 youths. The organization reports 136 individuals employed who are designated education providers. The population served is approximately 50% white, 50% black, under age 23, and has equal distribution between males and females.

Morehead State University's Delta Sigma Theta Sorority provides HIV/AIDS Prevention materials to students on campus through community outreach efforts and presentation. Main target are individuals who come from rural areas of Kentucky.

University of Kentucky's Multicultural Center provides HIV/AIDS Prevention materials to students through community outreach as well as collaboration with AIDS Volunteers, Inc and Lexington Fayette County Health Department to provide testing.

STATE PROGRAMS PROVIDING HIV PREVENTION SERVICES

DPH Targeted HIV Prevention Program is funded with state money and began in 1992 as a means of ensuring that those populations at highest risk of HIV infection were being served. The health departments were asked to identify areas of need and individuals not receiving prevention interventions through CDC funded programs. The following five (5) local health departments, located throughout the state are eligible to receive funding under this program: Barren River District Health Department, Lexington-Fayette County Health Department, Louisville Metro Health Department, Northern Kentucky District Health Department, and Purchase Area District Health Department.

DPH Core Health Education Program provides basic HIV/AIDS information and materials through nearly every local health department in the state. Programs are provided to the general public, health care professionals, and to public and private schools.

Kentucky DPH Review/Approval of continuing education for health professionals mandated by state law: This program reviews and approves, rejects, or approves with recommendations, all courses that any individual, health care provider, health education



provider, etc. wishes to provide Continuing Education Units to professionals. The program requires six content areas: epidemiology, transmission, medical treatment, legal, and appropriate attitudes and behaviors, to be included in each course offering.

DPH HIV Care Coordinator Program provides coordination of services for individuals living with HIV/AIDS. Prevention of transmission education, including safer sex and latex distribution is provided by the Care Coordinators.

Local Health Departments in each county provide on-site counseling and testing, condom distribution, and health care worker education. Off-site partner notification is also provided upon request or agreement from an infected person. Court ordered testing and court mandated risk reduction programs are provided. Many health departments (particularly those receiving Targeted HIV Prevention Program funds) employ health educators to provide street-outreach, one to one counseling, group and community outreach. Fiscal resources are federal, state and county funding. Counseling and testing is done by either social workers or nurses who have completed a certification program provided by the State. Program referrals and linkages include the Care Coordinator Program and local resources where available.

Maternal Child Health provides a variety of programs and services that include RTR and condom distribution, literature/brochure distribution, and prenatal 076 Protocol through local health departments. The HIV/AIDS Prevention Program Coordinator, in collaboration with the Adult and Child Health Branch participated in the Association of Maternal and Child Health Programs (AMCHP) Action learning Lab in September 2004. This program is composed of various disciplines from areas in the state which come together to address perinatal HIV transmission in Kentucky. This team will focus on eliminating perinatal transmission through enhanced education of health care providers, general public and focus groups. This program consists of meetings that will run through 2006.

KENTUCKY GOVERNMENTAL DEPARTMENTS

Kentucky Department of Education (KDE): In 1990, the Kentucky Education Reform Act (KERA) was passed. KERA requires that local schools and districts determine the curricula used. The Program of Studies mandates the content to be taught at each grade level. Communicable diseases, communication strategies, peer pressure, decision-making, and abstinence are contained in the Program of Studies. KDE provides professional development and technical assistance on evidence-based curricula. Some of these programs are “Reducing the Risk” (RTR), “Making Proud Choices”, “Making A Difference” and “Postponing Sexual Involvement” (PSI). KDE, DPH HIV/AIDS Branch, Kentucky Parent Teacher Association, State Substance Abuse Program and other prevention providers co-sponsor training programs for peers and other individuals who provide prevention education to individuals in and out of school and individuals in alternative living settings such as faith-based organizations and juvenile justice facilities. The number of individuals served is not available at present.

KDE also finances and coordinates the Kentucky AIDS Prevention Education Technical Review Committee. This committee is responsible for reviewing a variety of educational materials including curricula, reference books, magazines, and videos.

Kentucky Department of Mental Health/Mental Retardation (Division of substance Abuse): Provides drug prevention education in schools throughout Kentucky. Also provides funding to treatment facilities.



CORRECTIONS/PUBLIC SAFETY PROVIDING HIV PREVENTION SERVICES

Jefferson County Corrections includes four county facilities housing offenders who have committed crimes. Their programs also include drug rehabilitation. Services include individual or group counseling, distribution of prevention brochures, free and confidential counseling services. The annual budget and number of employees are unknown at this time; however, their staff does include licensed counselors, physicians, and nurses. Client profile is 20% white, 80% African-American, 90% male, and 10% female. Ages among this population range from 18 to over 66.

Lexington-Fayette County Detention Center includes a recently built facility to house inmates. HIV counseling and testing is made available on site weekly, in close coordination with the Lexington-Fayette County Health Department

Life Line Recovery is a drug/alcohol rehabilitation program for incarcerated men in Louisville. Services include distribution of prevention brochures, group counseling, and educational programs in safer drug use, AIDS 101, and safer sex. Clients are over 18 and are equally divided between males and females, African-Americans, and whites. Size of budget and staff are unknown, but the staff sees an average of 50 men a month.

Federal Medical Center, Lexington provides medical treatment and educational programs to staff and inmates. The size of budget and personnel levels are unavailable at this time. Funding sources include government sources and inmate fund-raising activities. Program referrals and linkages include the University of Kentucky Medical Center, CBOs, and the ARC. The Lexington-Fayette County Health Department provides counseling and testing by request at the facility.

RELIGIOUS ORGANIZATIONS PROVIDING HIV PREVENTION/SERVICES

Religious Organizations known to actively support prevention efforts and support services in the Lexington community include the **Metropolitan Community Church**, **Integrity** (Episcopal), **Dignity** (Catholic), **More Light** (Presbyterian), AIDS-friendly parishes and **HIV/AIDS Ministry Team** (Catholic diocesan effort), and **Unitarian-Universalist Church**. Number of clients served is not available at this time, but their client base is their membership. There is much variety in funding sources, personnel resources and program referrals/linkages.



RESOURCE INVENTORY

Resource Inventory- An abbreviated alphabetized list of organizations and individuals providing services accessible to people living with HIV in Kentucky, and who may assist with HIV/AIDS Services and Prevention planning.

AHEC/HETC-Covington	1030 Old State Rd	Park Hills, KY 41011
AHEC/HETC-Lexington	498 Georgetown St	Lexington, KY 40508
AHEC/HETC-Louisville	2215 Portland Ave	Louisville, KY 40212
AIDS Interfaith Ministeries (AIM)	850 Barrett Ave Ste 302	Louisville, KY 40204
AIDS Services Center Coalition (ASCC)	810 Barret Avenue Ste 305	Louisville, KY 40204
AIDS Volunteers Inc (AVOL)	263 North Limestone St	Lexington, KY 40507
AIDS Volunteers Of Northern Kentucky (AVNK)	PO Box 175743	Covington, KY 41017
American Red Cross (ARC)	520 East Chestnut St	Louisville, KY 40202
Barren River District Health Department	PO Box 1157	Bowling Green, KY 42102
Bluegrass Care Clinic	800 Rose St MN 672	Lexington, KY 40536
Bluegrass Community Health Center	1306 Versailles Road, Suite 120	Lexington, KY 40509
Chrysalis House	1589 Hill Rise Dr	Lexington, KY 40504
Council On Prevention And Education Substances (COPES)	845 Barret Ave	Louisville, KY 40204
Cumberland Valley District Health Department	301 Chera-Lyn Ln	London, KY 40743
Daviess County Health Center/Green River District Health Department	1600 Breckenridge	Owensboro, KY 42303
Episcopal Diocese AIDS Ministry	Po Box 616	Lexington, KY 40588
Family And Children First	2303 River Rd, 2nd Floor	Louisville, KY 40206
Franklin County Health Department	100 Glenss Creek Rd	Frankfort, KY 40601
Friend To Friend	850 Barret Ave Ste 305B	Louisville, KY 40204
Hazard Perry County Community Ministries	151 Miss Edna Lane	Hazard, KY 41701
Heartland Cares, Inc	3025 Clay St	Paducah, KY 42001
Hope Center	PO Box 6	Lexington, KY 40588
House Of Ruth	607 East Saint Catherine St	Louisville, KY 40203
Infectious Disease Consultants	20 Medical Village Dr	Edgewood, KY 41017
Kentucky Adult And Child Health Improvement Division	275 East Main St HS2WA	Frankfort, KY 40621
Kentucky AIDS Education And Training Center	800 Rose St Chandler Med Ctr Rm Mn 672	Lexington, KY 40536
Kentucky Association of Sexual Assault Programs, Inc	Po Box 4028	Frankfort, KY 40604
Kentucky Commission for Children with Special Health Care Needs	982 Eastern Pkwy	Louisville, KY 40217
Kentucky Department of Corrections	PO Box 2400	Frankfort, KY 40602
Kentucky Department of Education (Kde)	2545 Lawrenceburg Rd	Frankfort, KY 40601
Kentucky Department of Public Advocacy	100 Fair Oaks Ste 302	Frankfort, KY 40601
Kentucky Division of Mental Health And Substance Abuse	100 Fair Oaks Ln 4E-D	Frankfort, KY 40621
Kentucky Health Care Access Branch	275 East Main St HS2WB	Frankfort, KY 40621



Kentucky Housing Corporation	1231 Louisville Road	Frankfort, KY 40601
Kentucky Infectious/Communicable Disease Branch	275 East Main Street HS2EB	Frankfort, KY 40621
Kentucky Maternal and Child Health	275 East Main St	Frankfort, KY 40621
Kentucky State Reformatory	KSR 3001 W Highway 146	LaGrange, KY 40032
Kentucky STD Program	275 East Main St HS2CC	Frankfort, KY 40621
Kentucky Viral Hepatitis	275 East Main Street HS2EB	Frankfort, KY 40621
KHPAC	275 East Main HS2EC	Frankfort, KY 40621
Lexington - Fayette County Detention Center	600 Old Frankfort Circle	Lexington, KY 40510
Lexington Fayette County Health Department	650 Newtown Pike	Lexington, KY 40508
Louisville Department for Public Health and Wellness	850 Barret Avenue, Suite # 301	Louisville, KY 40204
Louisville Metro Secure Youth Detention Program	700 West Jefferson St	Louisville, KY 40202
Matthew 25 AIDS Services	452 Old Corydon Rd	Henderson, KY 42420
Medicaid Services	275 East Main St	Frankfort, KY 40621
Metropolitan Community Church (Episcopal)	1432 Highland Ave	Louisville, KY 40204
Morehead State University's Delta Sigma Theta Sorority	MSU Eta Omicron Chapter, Delta Sigma Theta Upo 2407	Morehead, KY 40351
Moveable Feast (MFL)	P O Box 367	Lexington, KY 40588
Northern Kentucky Independent District Health Department	2388 Grandview Drive, Building A	Fort Mitchell, KY 41047
Owensboro Area HIV/AIDS Task Force, Inc	224 South Ewing Rd	Owensboro, KY 42301
Primary Care Association	226 West Main St	Frankfort, KY 40601
Purchase District Health Department	320 North 7th Street	Mayfield, KY 42066
Sisters And Brothers Surviving AIDS (Sabsa)	Po Box 505	Louisville, KY 40201
Stop AIDS	220 Findlay St	Cincinnati, OH 45202
The Salvation Army Of Central Kentucky	736 West Main St	Lexington, KY 40508
Tri State Infectious Disease	2301 Lexington Ave Ste 125	Ashland, KY 41101
University Of Cincinnati Hospital, Holmes Clinic	234 Goodman St	Cincinnati, OH 45219
University Of Cincinnati Infectious Diseases Center	Eden And Bethesda Aves	Cincinnati, OH 45267
University Of Kentucky Center For Rural Health	750 Morton Blvd	Hazard, KY 41701
University of Kentucky Office of Multicultural Student Affairs	563 Pattern Office Tower	Lexington, KY 40506
University of Kentucky-Department for Health Behavior	121 Washington Ave Ste 111	Lexington, KY 40536
University of Louisville Dental Partnership Program	University Of Louisville School Of Dentistry Rm E-2	Louisville, KY 40292
Veterans Hospital	3200 Vine St	Cincinnati, OH 45220
Veterans Administration	1101 Veterans Drive	Lexington, KY 40502
Veterans Administration	800 Zorn Ave	Louisville, KY 40206
Volunteers Of America, Inc (Voa)	850 Barrett Ave Ste 302	Louisville, KY 40206
Wings Clinic	550 S. Jackson St 2nd Floor ACB	Louisville, KY 40202



GAP ANALYSIS

The dedication of a number of key individuals has ensured that HIV prevention takes place with much more effectiveness and frequency than it would without the consistent and positive efforts these individuals put forward. That said, there are numerous serious gaps that remain that are of concern.

More effective implementation of the contracts has brought to the forefront increasingly accurate assessments of what is being completed effectively in Kentucky, given the limited amount of available funding and that some areas are less effective in practice than on paper. This assessment highlights the continued need for documented accountability and for more specific targeting of at-risk populations than has been required in the past. Recent and long-term epidemiological data support these recommendations.

The DPH will provide KHPAC with an annual report on the summary of interventions carried out for that year. With the legislative change in 2004, making it a law for HIV reporting by name. HIV data is not currently being released due to the recent implementation of name-based HIV reporting. The CDC has projected full implementation of the Program Evaluation Monitoring System (PEMS) for Fall 2006, which will provide more accurate intervention data.

A crucial gap in prevention efforts statewide are those targeted toward transgender communities. While anecdotal evidence indicates that transgender people do not comprise a large portion of those who are HIV+ in Kentucky at this time, the number of HIV+ transpeople statewide and nationally is increasing significantly. This conclusion is supported both by anecdotal evidence from Kentucky HIV care and service providers and by research being done throughout the U.S., and makes transgender-specific prevention efforts imperative. Given the difficulty many transpeople have in obtaining legitimate employment with reasonable compensation and health insurance coverage, the incidence of sex work for money and the use of non-prescribed/non-monitored hormones and silicone injected with shared needles increases this population's HIV risk dramatically. However, there are currently no CDC-promulgated DEBIs that address transgender identity and experience, and there is very little training available to educate HIV prevention professionals and care providers about them. This failure to recognize the unique aspects of transgender life creates significant barriers for those who do prevention outreach, but could be remedied in large part through the education of providers and the development of appropriate intervention strategies.

Another crucial gap in prevention efforts, is the lack of recognition of the indirect effect of substance use on the spread of HIV infection. The risk for HIV associated with substance use involves more than the sharing of IDU paraphernalia. Substance use (i.e., methamphetamine, alcohol, ecstasy, etc.) is, in fact, a major factor for the spread of HIV infection and other sexually transmitted diseases. Substance abusers are more likely to have lowered inhibitions and, often times engage in sexual relations with multiple partners. There are also those substance abusers who trade sex for drugs, and consequently may find it hard to place limitations on what they will and will not do. Drug use can reduce a person's commitment to use condoms and practice safer sex. Currently there are no prevention programs that target substance use apart from intravenous drug users.



EASTERN AND NORTHERN REGIONS

Due to staffing limitations and funding, HIV prevention outreach for all targeted populations in the Eastern region of Kentucky is still not enough to effectively cover the 72 counties this region covers. Travel in this region and the limited funding for such makes it difficult to effectively reach all areas of the Eastern region.

The DPH has tried to identify and provide capacity building to the Eastern Kentucky region, and has made an impact through local churches and countywide fairs, but there is still a need for increased outreach in the more rural areas of the region.

General STD awareness and HIV prevention is not provided adequately in the Lexington-Fayette Urban County public schools. There is no long-term project currently targeting youth under the age of 21 with HIV prevention education and risk reduction information.

The IDU population is still not being effectively reached, particularly outside of Lexington-Fayette County, where outreach to IDU is extremely difficult. Within Lexington-Fayette County, some collaborations have been made with local drug treatment centers, but there are still many centers and agencies which choose not to participate.

The transgender population is not included in the list of prioritized populations due to lack of data, nor are there any approved DEBIs for this population. This makes it difficult to perform outreach with this high-risk population, since their needs are unique and do not fit appropriately with those of any other prioritized population.

NORTH CENTRAL REGION

Prevention efforts in the Metro Louisville area should be better coordinated. Service providers should strive to avoid duplication of services/efforts. More collaborative efforts among all HIV service providers should be facilitated.

The loss of three-quarters of the region's minority Community Based Organizations (CBOs) has resulted in a significant gap in reaching communities of color. (There were only four minority CBOs serving the region's seven counties prior to this loss, though the region's HIV+ population is disproportionately comprised of people of color).

There is a major gap in reaching transgender communities, youth 25 and under and adults 50 and older.

High Risk Heterosexual (HRH) HIV cases are increasing, in part, due to (1) the lack of HIV testing before, during, and upon release from incarceration, (2) the exchange of sex for money or drugs, and (3) bisexual activity. There is a gap in targeted prevention efforts in these areas.

Prevention monies spent on the HIV+ population, the number 1 prioritized population, need to be focused on providing strategies for HIV+ individuals to live healthy lives, protecting the general public and the long term health of HIV+ individuals.



WESTERN REGION

The rate of HIV infection in Western Kentucky has shown that prevention efforts are in place but the need continues to grow. HIV+, MSM, HRH (primarily minority populations), IDU, MSM/IDU are those populations at greatest need in Western Kentucky.

Gaps in HIV education and prevention can be seen in the lack of consistent HIV education in high schools, the lack of prevention efforts in correctional facilities or the work place and the lack of HIV education for the general population. The rural setting and the large travel region (42 counties) of Western Kentucky complicates the efforts to provide widespread education and the reduction of stigmatization of the disease.

Other gaps identified in the Western region are the lack of consistent mental health services and substance abuse programs which outline the need to target non IDU drug users.

FUNDING AND ACCOUNTABILITY

The most important factor KHPAC has taken into consideration is that sizable efforts be taken with the limited amount of funding available to reach the most individuals at risk for contracting HIV with evidence-based harm reduction interventions. In the past, we have been unable to document that such interventions are occurring with any sustained approach. The evaluation of DEBI interventions (conducted at the end of 2006) which targeted all at risk populations provides further information regarding the effectiveness of prevention interventions. The importance of the most cost-effective use of funding of the grant cannot be overemphasized.

It is crucial to prioritize interventions for HIV positive individuals. Programs utilizing HIV positive persons in the delivery of prevention services are lacking statewide. Lack of funding has seriously hampered the implementation of prevention case management for persons living with HIV. HIV + people across all risk categories are underserved. The best interventions for people living with HIV are peer education programs that use harm reduction.

An increased proportion of individuals reached through interventions have been designated to be HIV + within all target populations.

COUNSELING AND TESTING

A 2000-2001 evaluation of counseling and testing programs indicate that support staff at testing sites, at all levels, do not have adequate training in testing protocols, confidentiality, anonymity, client privacy and potentially awkward situations in a manner that promotes a successful program. Recommendations resulting from that evaluation and responses and goals to achieve those recommendations are listed below.

1. Site administrators and directors should raise HIV CTRPN to a higher priority, and should do so by hiring adequate numbers of staff, ensuring that anonymous and



confidential testing procedures are appropriately explained, and defining a clear policy which assesses client needs and protects confidentiality and anonymity.²

- This may be a reality in some areas of the state. The local health departments across Kentucky receive block grants from the State Health Department that are used to meet prioritized needs. Funds are allocated based on the highest prioritized need in that county. HIV may not rank very high in a given county and would receive less funding. David Raines will identify the health departments with the highest traffic related to STDs and the DPH will offer counseling and testing update and sensitivity training in these areas. Training can be offered but cannot be mandated.
2. Advertising and community outreach should be increased to raise awareness and utilization of HIV counseling and testing sites in Kentucky.
 - Press releases will be done four to five times a year highlighting prevention activities. The DPH has established a link on the DPH website to add prevention and CTS information. All Health Departments have access to the state training calendar (www.KY.TRAIN.org). The counseling and testing training has been approved by TRAIN for continuing education credits (CEUs). Tom Collins works very closely with Debbie Bohannon to make sure trainings are listed on the training website.
 3. Counselors' training should be modified so that counselors receive training on HIV CTRPN goals, prevention and behavior change counseling including the discussion of risk factors and development of risk-reduction plans, discussion of homosexuality and more specifics of risk behaviors, and how to counsel an HIV positive client.
 - The HIV/AIDS Branch used the CDC sponsored curriculum "Fundamental of HIV Prevention Counseling" as the foundation of the required training that all local health department nurses must complete before providing counseling and testing services. This curriculum addresses all the above mentioned subjects. Tom Collins completed the CDC course on the fundamentals of HIV counseling and testing in 2002. Beverly Mitchell completed the course in July 2005. Tom has trained numerous health department and CBO staff on counseling and testing and OraSure since he became certified. Update training will be offered to all counseling and testing sites, but the DPH cannot force staff to receive update training.
 4. Continued counselor and site coordinator training should be required on a regular basis.
 - The DPH can offer training but it is not required by law, a change in legislation would have to take place for it to be mandatory.
 5. Support staff should receive training on handling phone inquiries, the difference between anonymous and confidential testing, and ways of insuring privacy on the phone and at check-in.

² Zimmerman R. et al. Evaluation of HIV Counseling, Testing, Referral, and Partner Notification Services of the Kentucky Department for Public Health. HIV Prevention Research Program, University of Kentucky, 2001.



- The DPH will research videos that are available on sensitivity training, and if needed, develop a video to use with recommendations that staff receive updated training every five years. The DPH will also offer the two day counseling and testing training to all new counselors.
6. A site coordinator should be designated for each HIV CTRPN program.
 - All nurses working at local health departments are required to receive counseling training. HIV testing in rural areas does not occur often at the health departments, as the nurses have numerous other responsibilities. With low numbers of clients coming in for testing in these areas, it is not possible to achieve this at this time with the staffing and funding that is available.
 7. A regional coordinator should be appointed for each region.
 - As stated previously, this is not practical or possible in every region based on available resources and current responsibilities.
 8. The state should consider consolidating HIV counseling and testing services so a smaller number of sites will have truly sufficient resources and staff to be adequately trained, more experienced, and comfortable on a regular basis with protocols and sensitive issues.
 - It is state mandated that every county in Kentucky will have a counseling and testing site at each local health department. It would require a regulation change to incorporate this. The latest recommendations from CDC are that all people be tested. It is not practical to require persons to travel a long distance to be tested if testing is not available in their area. This would create a barrier for testing. Rather than consolidate sites, the DPH will offer more update training to staff in rural areas.
 9. An internal monitoring system should be developed. This would include regular feedback concerning the extent to which CDC protocol and guidelines are being met.
 - An objective listed under PCRS is to conduct regular site visits.
 10. OraSure and OraQuick testing should become available statewide. Health departments and districts need to have funding available or should be encouraged to seek outside funding to provide OraSure and OraQuick testing kits and training.

OraSure is not the appropriate testing method in local health departments. OraSure testing was intended to be used in outreach settings to reach people that may not come to their local health department. We encourage blood draws to screen for other STDs in a clinical setting. OraQuick or another form of rapid testing could be used to increase the number of people actually learning their serostatus, but it may decrease testing for other STDs requiring a blood-draw.



CONTRACTS & EFFICACY OF INTERVENTIONS

A full evaluation of the effectiveness of DEBIs was conducted in 2009. As a result of the evaluation and due to new hires; training was conducted in November and December with Prevention Specialists on DEBI implementation, recruitment and retention. Prevention Coordinators conduct periodic site visits to ensure the core elements of DEBIs are being completed.

CULTURALLY SPECIFIC INTERVENTIONS

Culturally appropriate interventions in CDC defined risk populations are inappropriate for youth, rural communities, transgendered people and injecting drug users. Meaningful prevention efforts in rural areas and among youth remain largely non-existent. State law prohibits access to sterile injection equipment. Relying on education about cleaning syringes with bleach and the distribution of syringe cleaning kits gives a false sense of security to the IDU community and inadequately addresses the very real prevention needs.

There is a need for targeted funding for culturally specific outreach in storefront facilities, that is, facilities and settings removed from health departments and other government buildings. Such storefront settings, we believe, would facilitate community building in CDC defined at-risk individuals.

REDRAWING THE REGIONAL BOUNDARIES OF HIV PREVENTION CONTRACTS

Kentucky is divided into three geographic regions: Eastern, North Central and Western. We believe the sheer enormity in size of the Eastern and Western regions is a barrier for effective prevention work. The Eastern region consists of 72 counties; the Western region consists of 42 counties. We believe it is imperative that the DPH study the possibility of dividing the state into more than three regions. Creating smaller regions would entice smaller CBOs, especially in the rural regions of the state, to vie for and be awarded prevention contracts with the state.

CAPACITY BUILDING

The lack of funding to non-governmental contracted CBOs does not allow for capacity building. Efforts have been made to identify and fund potential new CBOs in underserved areas, however they do not exist.

SYNOPSIS

1. Capacity building needs to be encouraged and funded to non-government contracted CBOs for geographic underserved areas of the state and within areas currently dependent on CBOs unable or unwilling to embrace harm reduction strategies.
2. While the epidemic continues to extend throughout all geographic areas of the state, prevention funding does not allow for consistent outreach efforts, especially in rural areas.
3. The ability to test for HIV in the general population continues to improve. Complete HIV epidemiology does not exist due to recent legislation providing for named reporting. The number of AIDS cases reported remains statistically the same.



4. New generations of GLBT populations are informed on the issues; however continued education remains a priority.
5. Partners of individuals in risk groups, transgendered people and neo-nates at risk remains underserved.
6. High risk populations including incarcerated persons, Hispanics and persons in rural settings remain underserved or highly underserved. Racial disparity persists in access to services.
7. Access to sterile injection equipment remains limited due to state law.
8. While remaining committed to harm reduction, secondary prevention efforts in most cases remain insufficient.
9. Continued support for state conferences on HIV/AIDS and the African American and Hispanic Leadership conference is indicated.
11. Volunteers are not mobilized in significant numbers and community building is extremely limited.
12. The state and the recipients of HIV prevention contracts remain pro-active in seeking to resolve the gaps.
13. Collaboration between DPH and the Department for Education would assist in the inclusion of HIV education in individual school district curriculum.

CONCLUSION

Except for in a few metropolitan areas, prevention efforts across the state are hit and miss. A consistent, sustained plan which includes collaboration with other agencies, community development, and harm reduction interventions reaching individuals in CDC defined risk categories that can be fully documented is an ongoing challenge.

There is a lack of linkages between the HIV/AIDS Branch and other agencies that have HIV prevention resources, including the KY Department of Education, mental health programs, substance abuse programs, family services, correction facilities, and the STD and TB programs.

The lack of linkages between the HIV/AIDS Program and the Sexually Transmitted Disease (STD) Program adversely impacts prevention efforts statewide. The currently used Program Evaluation and Monitoring system (PEMS) will help identify information for the HIV/AIDS and STD programs. The Kentucky Department for Public Health will document linkages with other government agencies and where prevention efforts are lacking, they will make every effort to resolve those issues.



CARE – Introduction

The Health Resources and Services Administration, HRSA administers the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act and requires funded states to periodically conduct a needs assessment to better guide the allocation of care resources. The 2007 Kentucky Needs Assessment consists of several sections outlining the current status of HIV care and needs in the Commonwealth. HRSA also requires funded states to conduct a Statewide Coordinated Statement of Need (SCSN). The state coordinated the 2008 development of the SCSN in conjunction with local health departments, Community Based Organizations, KHPAC and other pertinent stakeholders. The assessments along with the epidemiological profile were used to help set target priority populations and goals for prevention and overlapping service/care needs.



Assessment of Service Needs Among Affected Population

Responses by HIV+ Respondents on Use, Need, and Unmet Needs of Various Services

	Get This Service and Need It (Frequency)	Get This Service and Need It (%)	Get This Service But Don't Think Need It (Frequency)	Get This Service But Don't Think Need It (%)	Need But Do Not Get (Frequency)	Need But Do Not Get (%)
Help with clothing	162	35	153	33	153	33
Help paying for health insurance	283	61	60	13	125	27
Dental services	302	65	46	10	116	25
Help with health care in home	144	31	213	46	111	24
Help paying for transportation	274	59	84	18	107	23
Mental health services	223	48	139	30	97	21
Hospice services	102	22	269	58	93	20
Help with food	288	62	84	18	93	20
Help with alcohol or drug problems	153	33	232	50	84	18
HIV information, counseling, and testing	316	68	102	22	51	11
Health care in a clinic or health office (other than a hospital)	390	84	28	6	42	9
Help getting medications	394	85	37	8	32	7
HIV Care Coordination	399	86	37	8	28	6
Case manager/Care coordinator	404	87	32	7	28	6

The above table displays responses by HIV+ clients regarding services. As would be expected, healthier individuals are unlikely to need hospice care currently. Likewise, individuals who do not have or do not perceive themselves as having a substance abuse problem list these services as unneeded. On the other hand, most clients list care coordination and clinic services



as needed. In fact, eighty-two percent of respondents say they find out about new or current HIV services from their care coordinator or doctor/clinic. A third of respondents also reports seeing or calling their care coordinator monthly. A quarter says they only contact their care coordinator on an as-needed basis. Seven percent report having no care coordinator. Another seven percent says they have a care coordinator but do not contact him/her.

Three out of every four respondents feels having multiple services “under one roof” would make accessing these services easier. One in four does not believe such an arrangement would affect their usage of services. No one views such an organization of services as making services harder to access.

Clients list assistance with clothing, health insurance, and dental services as the most commonly unmet needs they face.

Barriers

Almost a third of clients responding to the survey list transportation as a barrier to accessing local HIV services. Clients at Volunteers of America and Matthew 25 (Bowling Green) are the mostly likely to report lack of transportation as a problem. Cumberland Valley clients are the least likely to report transportation as a barrier. Volunteers of America clients also most frequently list the other issues as barriers.

Responses from HIV+ Respondents Reporting the Following Areas Serve as Barriers to Accessing Local HIV Care Services

Barriers to Using Local Services	Frequency	Percentage
Lack of transportation	144	31
Afraid will be seen or lack of privacy for records	111	24
Don't feel respected or safe	84	18
Fear staff will know client is using drugs	37	8



Respondents also report a high incidence of other health conditions concurrent with their HIV infection. Forty percent of clients report problems with blood pressure and high cholesterol. One in five has diabetes, cancer, and/or heart disease. Nineteen percent report having tuberculosis with most saying they are not being treated with medications for the condition.

Concurrent Health Conditions Listed By Clients	Has Condition and Taking Medications For It (Frequency)	Has Condition and Taking Medications For It (%)	Has Condition but NOT Taking Medications for It (Frequency)	Has Condition but NOT Taking Medications for It (%)	Not Diagnosed with This Condition (Frequency)	Not Diagnose d with This Condition (%)
High or low blood pressure	125	27	70	15	269	58
High cholesterol	97	21	74	16	288	62
Diabetes	51	11	51	11	362	78
Heart disease	42	9	60	13	362	78
Cancer	19	4	79	17	367	79
Tuberculosis (TB)	23	5	65	14	380	82

Respondents report a heavy reliance on government aid programs to pay for their HIV prescriptions. Only one in ten have private insurance coverage for their HIV medications. Three percent report paying out of pocket for their medications and/or having no insurance to assist in paying for their HIV medications.

Who Pays for Clients' HIV Medications

	Frequency	Percentage
KDAP (Kentucky Drug Assistance Program)	241	52
Medicaid	65	14
Medicare Part D	46	10
private health insurance	46	10
don't know	32	7
KHICP (Kentucky Health Insurance Continuation Program)	14	3
out of pocket, no insurance	14	3
VA (Veterans Administration)	9	2



Assessment of Unmet Need and Service Gaps

This final section summarizes the unmet needs of Kentuckians living with HIV and provides recommendations for closing service gaps. All statistics quoted in this section derive from the 2007 Kentucky HIV/AIDS Needs Assessment Survey.

- **Increased Funding:** Undoubtedly the greatest challenge to expanding services to fill service gaps consists of the perennial need for increased funding for HIV programs.
- **Increased Staffing:** The Care Coordination Program currently has insufficient staff to meet the needs of HIV+ Kentuckians and remain in compliance with Kentucky law mandating a maximum caseload of 70. Staffing needs should be reassessed upon official numbers of all HIV+ Kentuckians.
- **Prescription Coverage for Co-Morbidities:** Fifty-eight percent of respondents reports being 40 or older. More than forty percent also lists having a concurrent chronic condition such as high cholesterol or blood pressure problems. As with any aging population, treatment for chronic disease must also figure into a holistic approach to keeping an HIV infected person healthy.
- **Increasing “One Stop Shopping”:** Respondents believe having more services at a single site makes it easier to use such services. HIV service agencies should attempt to expand coordination of multiple services at a central site.
- **Introduce Smoking Cessation Programs:** Respondents report tobacco use prevalence at a far greater level (71%) than both the national (20.0%) and Kentucky statewide (28.5%) prevalence. Reducing tobacco usage in this population would have clear preventative and health risk reduction benefits.
- **Continue Programming That Is Inclusive of Non-Gay-Identified MSM:** Almost one in every five men who report having sex with another man does not define himself as gay. Programming that is inclusive of bi and heterosexual identified MSM should be continued.
- **Expand Transportation, Clothing, and Dental Services:** Some sites offer dental services. Where possible, other sites should seek to extend dental services or referrals to clients. While difficult to solve, emphasis should be placed on improving transportation between clients and service sites. Similarly, the coordination of a clothing bank with local charities and retailers could help to meet this need identified by respondents.



EXECUTIVE SUMMARY – 2009 Comprehensive Care Plan

The Comprehensive Plan addresses the barriers to care needs and gaps in services of Kentucky's Part B program. Several key needs assessments, including the 2007 Client Needs Assessment, the 2008 Statewide Coordinated Statement of Need, 2007 Kentucky African American Needs Assessment and the 2008 Prevention Plan were used as guiding documents to prepare the 2009 Comprehensive Plan. Representatives from all Ryan White Programs, including Part B, C, D, and F were involved in one or more of these processes.

The Comprehensive Plan is a roadmap to guide Kentucky's Part B program with measurable goals, objectives and effective strategies to address the barriers, needs and gaps that have been identified. The priority challenges identified for the Comprehensive Plan are broken down into the following categories:

1. HIV Care Coordination/Medical Case Management
 - Develop an HIV initiative for the correctional system, including a Discharge Planning program
 - Enhance client transportation for medical and case manager appointments
 - Provide education and training for Part B case managers regarding Medical Case Management
 - Develop strategies to better address mental health and substance abuse issues with Part B clients
2. Clinical Care
 - Improve quality management issues among Kentucky Part C clinics
 - Increase resources and training of clinical care providers to manage co-morbidities
 - Increase collaboration between clinical care providers and HIV prevention specialists
3. Collaborations with other entities
 - Data sharing between the Part B program and Medicaid/Medicare
 - Increase internal collaborations between the HIV, TB, Immunization, and STD branches
4. Oral/Dental Health
 - Provide training and education on HIV/AIDS to private dentists in the state
 - Increase collaborations with the Part F program to provide HIV oral health trainings to the Part C clinical care providers
5. Disenfranchised Group
 - Provide cultural competency training statewide
 - Reduce stigma within African American churches
 - Improve linkages and retention in care for homeless HIV+ individuals, Hispanic individuals, and African American individuals
 - Provide education on HIV 101 to homeless shelters, Hispanic agencies, and other minority community based organizations
6. HIV Prevention
 - Educate and train members of various health disciplines as mandated by Kentucky statute
 - Develop and distribute press releases highlighting prevention activities
 - Partner with African-American churches and educational entities to educate, address, and foster service delivery regarding HIV

The initiatives in this plan will expand and enhance existing HIV services across the state and provide measurements for improvement.



Summary - 2009 Statewide Coordinated Statement of Need

The 2009 SCSN has drawn primarily on the review of existing needs assessment materials. To augment the process, participants in the process (all subject matter experts) did include anecdotal material. It is believed this information based in practice experience enhances the findings of unmet need and makes this document and process more consistent with current trends and need in the provision of services to Kentuckians living with HIV/AIDS.

In the 2009 Kentucky Comprehensive Plan, goals and strategies have been developed to address many of the prioritized issues identified under this section. If feasible, the ultimate goal of the Branch is to eventually address all of the major issues incorporating the solution strategies proposed within this document.

Concerns, Gaps, Unmet Needs

1. Care Coordination

- 1.1. Transportation needs of clients--especially those in rural areas--are not seen as core services. This gap affects care provision and retention to care for patients living outside urban areas or without access to personal transportation.
- 1.2. Gaps in Federal support for housing needs (e.g. first month's rent or deposits) mean grantees must use resources to address these needs.
- 1.3. Care coordinators provide a vital link to primary medical and other core services, but are burdened with growing caseloads and have difficulty maintaining contact with clients as regularly as would be good practice.
- 1.4. Limited resources of the Kentucky AIDS Drug Assistance Program (KADAP) are not keeping pace with increased demand.
- 1.5. Additional need for non-HIV medications creates further strain on drug assistance budgets.
- 1.6. A limited, loosely coordinated network of legal support for PLWHA exists. While there is one formalized program, the bulk of legal issues of PLWHA are addressed by an informal network of attorneys and legal experts.
- 1.7. Increasing challenges of clients with mental health problems. Difficulty exists in finding mental health providers who will see clients with limited financial resources, and the challenges of identifying funding for psychotropic medications are noted.
- 1.8. Many clients have existing substance abuse problems when enrolled in care, creating significant challenges. As with mental health clients, the complex challenges presented by these clients include resource constraints for treatment and medication, and resistance of substance abuse providers to provide care for clients who have limited resources for payment of services.
- 1.9. Systems of collaboration between local jails and Ryan White programs could be enhanced; HIV positive inmates are discharged with poor or no plan of follow-up for primary medical services or case management services. Need to enhance discharge planning and establish consistency when discharging patients from jails or prisons.
- 1.10. Severely limited housing for individuals with advanced HIV is concerning; and existing social service and homeless activities cannot adequately address this need. Many nursing homes and tertiary care facilities avoid providing services to individuals with HIV disease.
- 1.11. An unmet need for care coordinators exists in Part C clinics.
- 1.12. Patient medical information is often being discussed in non-private settings such as the waiting room and the front desk. Participants from rural communities also highlighted reluctance to disclose status, even in medical settings, due to the fact



that confidentiality is a big concern for clients.

1.13. Patients with poor health literacy--the ability to comprehend and apply health information--create challenges for providers and care systems.

All HIV medical clinics need medical case managers who are specifically trained on the medical aspects of case management such as procurement of medication.

1.14. Patients who "fall off the radar screen" with the KY Care Coordinator Program should NOT be prevented from reapplying for 6 months.

PRIORITY CHALLENGES

- Need to begin to develop a discharge planning program within the prison system.
- Need to enhance transportation for medical appointments and meetings with case managers.
- Need to improve access to medications and medication adherence.
- Need to increase opportunities for education, training, and professional development for Part B case managers on Medical Case Management.
- Need to address mental health and substance abuse needs of patients, particularly when specialty care is indicated.

2. Clinical Care

2.1 Access to medical care, as noted above, is challenging. Patients in rural areas often drive many hours to care sites. In addition, stigma and fear of discrimination make accessing care difficult for clients in many parts of this largely rural state.

2.2 Significant geographical gaps in care exist; limited care providers especially in rural parts of the state pose concerns about the burden to care providers. Conversely, in the most urban regions, particularly the Louisville and Lexington areas, the number of patients in busy care settings creates a similar burden for different reasons.

2.3 Co-morbid conditions create many challenges for HIV care providers. Time and resources to manage issues like sexually transmitted infections (STI)s, hepatitis, and other chronic conditions are increasingly common and demand clinician's attention and resources.

2.4 Quality Improvement activities tax existing human and financial resources. Though QI measures for clinical care are in place, the requirement to hold meetings and document initiatives places a burden on care providers.

2.5 Challenges integrating prevention into care have been identified. With limited human and financial resources, the expectation of care providers providing prevention interventions at every clinical visit creates a burden.

2.6 Burden on care provision systems is growing. Expensive labs for resistance testing and new medications mean strain on both financial and human resources.

2.7 Adherence protocols are increasingly challenging as patients with mental health and substance abuse problems present for care.

2.8 Medical providers who do not treat HIV have limited HIV knowledge and limited expectations of receiving ongoing HIV education.

2.10 Pharmacies in rural areas do not have HIV drugs available.

2.11 Small clinics in rural areas do not receive Ryan White funds for self-pay patients. There is also a lack of psychiatric support available for individuals in rural areas.

2.13 Patients presenting with advanced disease cost more to treat and burden the system.

Primary care provider must prioritize care for clients. HIV life expectancy now approximates the national average.



- 2.14 There is a need for providers to be close to clients' residence for acute and general care.
- 2.15 Unable to prescribe non-HIV medications or specialty referrals (ex. Chest X-rays, etc.)
- 2.16 There is a need to establish a sub-speciality medical support system available to all clients.
- 2.17 Non-HIV related medical assistance should be available to all clients. Funding for medical specialties should be reestablished for outpatient care.
- 2.18 Hepatitis C testing should be enhanced, with additional follow-up care.
- 2.19 There are limited home health care services available for individuals who lack private health insurance.
- 2.20 There are individuals who could benefit from hospice care who are not eligible because they wish to keep taking ARVs.

PRIORITY CHALLENGES

- There is a strong need to increase access to care.
- The resources and availability of clinical care providers to manage co-morbid conditions and lack of sub-specialists who will treat HIV patients is concerning.
- There is a need to increase collaboration between prevention and care providers.
- There is a need to establish a comprehensive network of primary care providers for HIV positive patients, with close subspecialty support.

3. Collaborations

- 3.1 Need to increase collaboration with the Department of Corrections and local jails/ correctional settings. Communication about adherence and discharge planning needs will enhance continuity of care.
- 3.2. Statewide Care standards, especially with care coordination, need to be established.
- 3.3 Identified need for smoking cessation programs targeting individuals in HIV care; rates of tobacco use are higher in Kentucky than the national average.
- 3.4 STD treatment and care is available for many diseases, but screening for HPV and herpes is not available. Particularly, not being able to diagnose herpes has very significant implications for HIV care and prevention.
- 3.5 Administration of Part B and Part C clinics is fragmented, especially in light of the availability of care coordination at all sites.
- 3.6 A number of HIV care settings do not provide prevention services in their agencies.
- 3.7 Medicaid and Medicare provide some additional support for care of PLWHA. Still, the number of uninsured/underinsured patients and lack of providers who accept Medicare and Medicaid creates a significant gap in care for PLWHA.
- 3.8 Poor internal collaboration is noted between HIV and STD, Hepatitis [no public testing or treatment programs are available], TB, immunization, and Maternal and Child Health within the Department for Public Health.

PRIORITY CHALLENGES

- STD treatment and care is available for many diseases, but screening for HPV and herpes is not available. Particularly not being able to diagnose herpes has very significant implications for HIV care and prevention.



- Medicaid and Medicare provide the largest funding sources highlighting a pertinent need for ongoing collaborations to ensure that the services being provided are responsive to the needs of PLWHA. There are too many uninsured/underinsured patients and too few providers who accept Medicare and Medicaid.
- There is a need for improved internal collaborations between the HIV, STD, Hepatitis, TB, immunization, and Maternal and Child Health programs within the Department for Public Health.

4. Dental/Oral Health

4.1 Chart review indicates more than 90% of patients have unmet dental needs. These included fillings, crowns, bridges, extractions, and oral lesion diagnosis.

4.2 Kentuckians—including those with HIV—have a higher than average rate of natural teeth extraction.

4.3 Individuals at lower socio-economic levels are less likely to visit the dentist than individuals with more resources.

4.4 Kentuckians have significantly higher rates of tobacco use and the concomitant challenge of increased risk for periodontal disease.

4.5 An uneven distribution of dentists in Kentucky creates problems of access—most notably in Eastern Kentucky.

4.6 While both University of Louisville and University of Kentucky have dental schools that provide care to indigent patients, limitations on the number of patients that can be seen and challenges of finding transportation can involve overcoming distances of two to five hours' drive.

4.7 Barriers cited in receiving oral health care included discrimination, affordability, fear of disclosing HIV status to dental care provider, lack of insurance, and lack of accessible providers.

4.8 Dental education/counseling to dentist to encourage providing care to HIV positive patients.

PRIORITY CHALLENGES

- Lack of enough slots for clients in the University of Louisville Part F program (Oral Health).
- Some Dentists lack HIV information and education.
- Clinical care providers often lack knowledge of oral health issues.
- Dental patients are lost to follow up.
- Transportation is sometimes a challenge, especially in rural areas.

5. Disenfranchised Populations

5.1 Providing effective translation for Spanish-speaking clients is challenging. In addition, an increasing number of immigrants who present linguistic and cultural challenges to care service delivery are being identified as disenfranchised.

5.2 Increasing HIV rates among heterosexuals, particularly African-Americans, is concerning.

5.3 Lower-income and less-educated PLWHA who enter care, are diagnosed later in the disease process (e.g. entering care following an opportunistic infection/OI diagnosis), and often present adherence and compliance challenges to the treatment system.

5.4 Limited resources for traditional 'outreach' activities targeting this group may be creating gaps in diagnosis and difficulty accessing care for socially disenfranchised



Kentuckians.

5.5 One in five MSM consumers do not identify as 'Gay'; need exists for culturally-sensitive care and prevention interventions to address the needs of these men.

5.6 The needs of pregnant women were identified as being a significant concern; linkages between obstetricians and HIV care providers are identified as needing improvement.

5.7 Reaching the needs of Kentuckians who are incarcerated is a challenge and has been identified in multiple resources as being a significant unmet need which calls for improved collaboration with correctional systems.

5.8. The needs of transgender individuals, although difficult to document in surveillance figures, has been noted as a concern. Bias against these individuals, as well as a documented history of risk behavior, offers concern for both prevention and access to HIV care.

5.9 Immigrants and other disenfranchised individuals coming into complex and organized systems of care may lack skills and experience to negotiate these systems.

5.10 There is a need to build a statewide network of African Americans who would advocate for PLWHA, and address issues of racial separation, apathy, distrust of community and public health systems, and the health seeking behaviors of African Americans

PRIORITY POPULATIONS

- Spanish speakers
- African-Americans
- PLWHAs (Especially those who were Diagnosed late)
- Non-Gay identifying MSM
- Pregnant women
- Incarcerated clients
- Transgendered persons
- Immigrants
- Rural clients
- Poly-substance users
- Truckers
- Sex workers
- Runaway youth
- Refugees

6. Prevention

6.1 Transportation costs for testing and outreach staff are increasing.

6.2 Many at risk persons are meeting on internet sites and chat rooms; existing prevention interventions have not been adapted to meet this need.

6.3 Need for enhanced training of test counselors, especially regarding counseling needs of persons who test positive.

6.4 Measuring effectiveness of Evidence-Based Interventions (EBIs) is challenging. In terms of implementation of EBIs in KY, the difficulty to do impact or outcome evaluations make it unclear about whether these interventions have efficacy for prevention in KY.

6.5 Need to increase the involvement of faith-based organizations to provide comprehensive prevention efforts.

6.6 Lack of information about HIV risk for non-injecting substance users identified as a problem; increased use of methamphetamine in particular poses new challenges.



6.7 Gaps in access to HIV prevention for rural Kentuckians are an ongoing problem. There are insufficient HIV testing and counseling services in many regions.

6.8 Unmet needs of transgender Kentuckians are a concern. Though the actual number of transgender clients living with HIV remains relatively low, the absence of identified effective interventions targeting this population and national trends documenting high prevalence rates in this population are concerning.

6.9 Kentucky and national data suggests individuals with HIV who know their status are more likely to use barrier protection during sex. The need to increase the number of Kentuckians with HIV who know their status should be a priority.

6.10 STD data suggests significant syphilis/HIV co-infection in 2007; this reinforces the need for ongoing HIV/STD prevention interventions with PLWHA.

6.11 While effective collaborations exist between care and prevention staff in many regions, opportunities for enhanced collaborations and cross-training have been identified.

6.12 There is a need for additional EBIs to reach additional populations or provide support for adaptation of existing interventions.

6.13 Limited resources available for community-based organizations makes community capacity-building challenging and may impede effectiveness of prevention efforts. A concurrent theme of limited staff to implement prevention activities is also noted.

6.14 Requirement of pre-test counseling can create a burden for health care workers in busy settings or settings where HIV tests should be performed.

6.15 Gaps in educational materials provided to youth that meet all the needs of youth and not just abstinence only programs. Education in high schools is inconsistent and inadequate.

6.16 Need for HIV education and prevention for inmates in KY correctional settings

6.17 Many Kentuckians-especially in rural areas-lack information and access to HIV testing and counseling. Need for HIV testing on admission to KY Correctional facilities to initiate treatment and provide prevention interventions.

PRIORITY CHALLENGES

- There is need to address the costs associated with medical transportation.
- There is a need for enhanced collaborations with Faith-based organizations.
- Outreach and prevention activities in rural areas are difficult to accomplish.
- Addressing the needs of transgender clients is challenging.
- There is a need for individuals to know their status.
- There is a need to increase efforts to achieve the requirement of pre-test counseling.
- There is a need for HIV education in schools.

Concerns, Gaps, Unmet Needs

1. Care Coordination

- Seek additional funding for transportation
- Increase funding to hire additional care coordinators, improve staffing levels, and provide prescription coverage for co-morbidities.
- Additional, housing funds should be made available to pay outstanding utility bills so that current utilities can be turned on.
- Develop model for “one stop shop” facilities.



- Expand transportation and clothing services.
- Develop ambulatory/outpatient care to include transportation, buddy system/ride sharing, and volunteer services (churches, buses, taxis)
- Use CBOs and resources from Part B award and work with clients to develop payment plans and budgets; educate clients about energy conservation.
- Hire more case managers by shifting resources from services to staff; this should follow the mandate to move to medical case management (MCM).
- Use Patient Assistant Programs (PAPs), preauthorization, caps on meds, tax rebate monies, and client co-pays to address the cost of prescription drugs.
- Collaborate with other CBOs to purchase non-HIV meds utilizing local pharmacy pricing.
- Collaborate with local legal offices and law schools to solicit help with legal protection and advocacy per FY '08 grant.
- Collaborate with comprehensive care and local mental health care to provide training on addressing the needs of severely mentally ill persons.
- Collaborate with substance abuse programs to provide outreach to substance abuse facilities that don't specialize in STD/HIV.
- Educate Part B providers on correctional systems; develop discharge planning process in prisons. Provide education in local jails regarding comprehensive care.
- Provide education in nursing homes regarding HIV care.
- Collaborate with home health and palliative care organizations.
- Provide training on confidentiality and patient health information; assure that confidentiality forms emphasize accountability for breeches of confidence.
- Continue providing education to case managers/medical case managers on HIV basics, prescriptions, and adherence.
- Expand presence of case management into all Part C clinics.
- Expand use of electronic medical records to increase portability and communication in patient medical records.

2. Clinical Care

- An education campaign for primary and Family Healthcare Providers and emergency rooms.
- State wide advocacy for HIV education of medical providers to return to a bi-annual system instead of every 10 years. This should include all disciplines, including mental health, and substance abuse providers.
- Implement a Department of Corrections (DOC) policy on lab schedule for HIV+ inmates similar to the policy in the free world clinics-every 3 months.
- Develop strategies to advocate for coordinated clinical care in county jails.
- HIV+ inmates should be seen at least quarterly to review lab results and make sure no other problems are occurring.
- All newly diagnosed HIV+ inmates should be referred to an Infectious Disease physician.
- DOC should change discharge policy to include:
 - a. Meet with inmate and review disease process.
 - b. Inmate sign Release of Medical Information form so medical records can be sent to HIV clinic or medical person inmate requests. If inmate refuses, then he gets copies of lab and any other HIV related records.
 - c. Discharge nurse will call HIV Clinic and speak to Care Coordinator to



arrange appointment date. Inmate can also speak to Care Coordinator if he or she has questions.

- Develop standards of care in all Part B programs which are integrated into Part C settings.
- Use Part B funds to employ two new specific care coordinators: one to deal with new immigrants and one to deal with corrections issues.
- Make HIV drugs available in rural area pharmacies.
- Seek Ryan White Grant Fund for HIV treatment in small clinics.
- Provide Psychiatry/Psychology hotline for referrals.
- Train internists in rural areas to provide services for HIV primary care problems to reduce travel to care sites. Establish processes and communication to train, support, and provide technical assistance to medical staff in order to accomplish this initiative.
- Consider creating medical school programs—especially in internal medicine and family medicine—to encourage engagement in HIV care.
- Partner with Community Health Centers to increase their capacity to provide primary care and have HIV providers offer testing and prevention services in CHCs.
- Consider reducing lab costs by negotiating statewide contracts with agencies.
- Enhance education and training for all health care workers. Lobby for mandatory HIV training more often, network with the Branch and Part F AIDS Training and Education Center for policy change.
- Establish a clinical care facility that can fill currently lacking services in Eastern Kentucky.
- Provide smoking cessation programs at all Part B, D, and F facilities.
- Facilitate linkage between Part B programs, Disease Intervention Specialists (DIS), and prevention programs to ensure provisions of evidence-based prevention services to PLWHAs.
- Enhance collaborations at state and local levels to increase STD and Hepatitis testing and care.
- Enhance collaborations with primary care providers by offering testing and prevention services and asking for help managing complex patients with non-HIV illnesses.
- Consider renting vans to transport multiple rural patients to appointments.

3. Collaborations

- Provide Quality Improvement workshops at the State Conference and spread the word about TA availability.
- Collaboration with the DPH, HIV/AIDS Branch on training and engaging the Prevention Specialist and Care Coordinators in providing education and develop continuum of care. Identify and tie together the mission and goals of the Department of Corrections and the Kentucky Department for Public Health.
- Develop a pilot project that integrates Public Health Services within the Kentucky Department of Corrections.
- Foster collaborative linkages between the State and the community to offer cross trainings on interagency programs and State agency policies in order to support and sustain new initiatives.
- Capacity Building needs to be encouraged and funded to non-governmental contracted CBO's for geographically underserved areas of the state.



- Integrate HOPWA staff into Part B and Part C clinics so patients in need of housing will have access.
- DPH, Medicaid, and Medicare should create a joint task force to facilitate information exchange. This task force will identify joint initiatives such as data exchange, cross check patients who are eligible, and transition them to Medicaid/ Medicare. This will also allow for cross-program input on HIV related policies.
- Look at ways to expand providers who recognize/accept Medicaid/Medicare. Identify states that have had success in expanding network of Medicaid/Medicare providers and collaborate to implement steps they took.
- Program managers for HIV, Communicable Diseases, Adult and Child Health should designate a staff member from each program to an internal DPH committee that would be charged with identifying opportunities for joint projects (e.g. implementing routine HIV testing and prevention services for adults, pregnant women, and infants in regions with high HIV/TB/STD/Hepatitis prevalence).

4. Dental/Oral Health

- Expand dental services.
- Provide case workers in dental settings to assist in finding patients lost to follow up or who need transportation.
- Provide training to dental providers on basic HIV, oral health manifestations, and routine oral health care for PLWHAs.
- Clinical care providers should receive training on dental screening.
- Expand on use of mobile dental unit to expand services and increase dental slots.
- Continue to enhance multi-disciplinary collaboration.

5. Disenfranchised Populations

- More individuals from disenfranchised groups engaged in advocacy work on state and federal levels might be helpful.
- Develop standards of care for translators and mandating HIV 101 be taken by the translators.
- There is a need to build a statewide network of Black advocates for PLWHA who will, among other things, look into issues of racism and its impacts on health-seeking behaviors of African Americans, community distrust, and lack of response from the public health system.
- Work with colleges and universities, Catholic churches and other agencies.
- Increase sub cultural sensitivity.
- Create collaborations with agencies with specific service focus, i.e. incarcerated populations, substance abuse, HIV prevention, intersecting missions.
- Expand the understanding and acceptance of definition of family and relationships as applicable to the various disenfranchised groups.
- HIV testing among pregnant women.
- Approach the trucking industry with help for their 'bottom line' for health care expense.
- Push the Kentucky Legislature for testing inmates in correctional settings and before discharge.
- Place HIV prevention and testing information in rest areas, truck stops, smoke shops to target truckers and substance users.



6. Prevention

- A statewide information campaign should be initiated...billboards, TV. and radio, etc
- Explore other funding opportunities and consider redrawing the Prevention regions
- Press releases should be done four to five times a year highlighting prevention activities. The DPH has established a link on the DPH website to add prevention and Counseling and Testing Services information.
- All Health Departments have access to the state training calendar (www.KY.TRAIN.org). The counseling and testing training has been approved by TRAIN for continuing education credits (CEUs).
- Counselors' training should be modified so that counselors receive training on HIV CTRPN goals, prevention and behavior change counseling including the discussion of risk factors and development of risk-reduction plans, discussion of homosexuality and more specifics of risk behaviors, and how to counsel an HIV positive client.
- New generations of GLBT populations need to be informed on HIV issues; continued education remains a priority
- More fully engaging HIV-positive individuals in prevention activity is an important possible enhancement.
- Continue efforts to partner with African-American churches and seek to develop relationships in additional denominations. Develop list of churches willing to address HIV issues, and establish relationships to foster service delivery.
- Schedule multiple activities in the same trip. Coordinate travel between agencies in the same region. Use agency vehicles.
- Ask host agencies to provide transportation.
- Collaborate with rural service providers.
- Use media outlets in rural areas to raise awareness.
- Work with service providers to market prevention services including testing events.
- Provide specialized services for transgender clients in STD clinics, and focus on transgender programs by building on MSM and IDU programs.
- Request for technical assistance from CDC to address identified contractor needs.
- Train additional staff in facilities to do HIV pre-test counseling.
- Examine clinic flow to see when counseling can be performed.
- Facilitate campaigns that focus on personal risk.
- Collaborate with the community planning group and the advocacy group to advocate for comprehensive sexuality education.
- Work with the Kentucky Department of Education.
- Promote efforts to reduce the stigma of being HIV-positive.



Current Efforts to Find People Not in Care

The 2009 Comprehensive Plan utilized information from the SCSN that was identified by various HIV/AIDS stakeholders across the state via the documents listed in Section II, as well as information from the unmet need framework. Many of the same barriers and gaps to care were identified in all the documents. Long and short term goals were developed to strive to assist Kentucky's Part B program to identify and provide care linkage to people who are HIV infected, but not in care. For example, Transportation continues to be a barrier to care. Therefore, Kentucky has identified a short term goal of implementing vanpools in all of the six direct service regions in order to address the lack of transportation resources.

Oral health for HIV infected individuals is critical to the overall health of the infected person. The SCSN determined that many dentists across the state need training on the linkage between oral health and HIV. The Kentucky HIV/AIDS Branch will conduct four (4) HIV 101 trainings to dentists in the rural areas of the state in order to assist dentists with identifying patients who are infected with HIV and direct them to seek medical care.

Medication adherence is a vital link to the HIV infected individual's healthcare. The Kentucky AIDS Drug Assistance Program (KADAP) will work in conjunction with adherence specialists, medical providers and the six (6) direct services supervisors to train Care Coordinators on medication adherence so that they can effectively identify and provide guidance to non adhering clients.

The SCSN identified the need to collaborate with the Kentucky Department of Corrections to provide HIV testing, education and discharge planning to inmates in order to identify and retain inmates in care. Kentucky will begin the first phase of implementing a HIV Discharge Planning, HIV education and testing at LaGrange Correctional facility (which holds the largest number of HIV+ inmates) beginning January, 2009.

The majority of HIV/AIDS cases (both in and out of care) in Kentucky are among the Men who have Sex with Men (MSM) population. To provide effective prevention case management to HIV+ MSMs, collaborations between the HIV prevention and the Part B and C programs will be conducted to facilitate prevention efforts to individuals seeking HIV related treatment. This will allow the prevention staff to identify and provide care linkage to partners of infected MSM who may be HIV infected, but not in care.

According to the unmet need framework, a greater percentage of HIV+ Blacks and Hispanics had an Unmet Need (36% and 6% respectively) in comparison to those with Met Need (at 32% and 3.4% respectively). Additionally, the 2000 U.S Census Bureau report, the total population in Kentucky as of July 1, 2007 was 4,241,474 with 8% self reporting as Black (non Hispanic) and 2% as Hispanic. While Black (non Hispanics) and Hispanics represent small proportions of Kentucky's overall population, they represented 32% and 5% respectfully, of the persons living with AIDS as of December 31, 2007, and 50% and 10% of the new AIDS cases diagnosed between January 1, 2006 and December 31, 2007. Kentucky continues to see a population increase of Hispanics as they travel to Kentucky for work on horse farms and in tobacco fields. Due to the increase in the Hispanic population, Kentucky has also seen an increase of HIV infected Hispanics. The Part B grantee staff will conduct an assessment to identify areas which have the highest and fastest growing populations of Hispanic individuals and will contact Community Based Organizations (CBO's) and social service agencies serving these populations to provide HIV education, testing and linkages to care for HIV infected Hispanics. Collaborations with Hispanic specific agencies will enhance communication efforts and allow for better provision of care and supportive services.

The largest minority population in Kentucky is the African American population. African Americans make up 31% of the total AIDS cases but only 8% of the general population, therefore, seeking those individuals who are HIV infected, but not in care is vital to healthcare. Part B staff will collaborate with



churches and various organizations within the African American community to provide HIV 101 trainings, testing and enhanced linkage to care services. This will provide cultural competency training, reduce stigma within indigenous African American churches, educate the African American community on the prevention and spread of HIV/AIDS, as well as identify HIV+ African Americans and link them to care.

Mental health and substance abuse issues plague Kentuckians, particularly those in rural regions. Those individuals who are infected with HIV and also have mental health or substance abuse issues are more at risk of not participating in HIV care and services. Many of the mental health and substance abuse centers lack knowledge about HIV. The 2009 Comprehensive Plan will address this need. The Part B grantee office will conduct an assessment to determine what areas of the state have the highest prevalence of mental health and substance abuse issues and contact service centers within these regions to provide staff with HIV “101” classes and provision of counseling, testing and linkage to care services.

The 2009 Comprehensive Plan will include an initiative to address the HIV needs of homeless populations. Therefore, the Part B staff will collaborate with the major homeless shelters in Louisville and Lexington (the regions with the highest prevalence of HIV and homeless) to begin an assessment of the HIV needs within the homeless population. The collaborative goal is to increase staff HIV knowledge, improve/establish testing programs and linkage to care. This will identify HIV unmet needs of major homeless shelters in Louisville and Lexington and assist in retention in care.

The Kentucky Part B program goals and objectives center around retention in care for those HIV infected individuals who are in care and those who are out of care. In Kentucky, three KHCCP contractors receive both Part B and Part C funding. In addition, the contractor for the Louisville region houses a Part B staff person at the WINGS Clinic. Collectively, these particular contractors serve the majority of KHCCP clients. Through these collaborations, clients who may have fallen out of care or are at risk of being lost to follow-up are more easily monitored and targeted for retention in care efforts. In Kentucky, the Part C (treatment) and Part B (direct care and support services) program staffs share many of the same clients and communicate frequently to coordinate needs of consumers.

Findings Regarding Disenfranchised Populations:

The disenfranchised populations identified in the SCSN process underscore the connection between HIV and social inequality and the concomitant issues that affect all disenfranchised populations. Among the unique needs identified in these populations are issues of HIV related stigma. In many areas and in multiple populations, the prejudice and discrimination of living with HIV is a huge barrier to engaging individuals in HIV care. In rural areas, the idea of being seen attending an HIV care clinic presents a major barrier for individuals living with HIV.

In addition, the stigma associated with risk behaviors linked to HIV is another aspect of the fear that impedes individuals from accessing both prevention and care services. As a majority of Kentuckians affected by HIV contracted the virus through MSM activity, the impact of homophobia on care-seeking and treatment compliance is noted. Moreover, for many patients affected by HIV, the issue of discomfort around sexuality presents additional obstacles. Issues of infidelity, sexuality, and sex outside the context of marriage have substantial cultural stigma; and the shame associated with these risk behaviors is a barrier to care.

The impact of racism and historical oppression must be factored into an understanding of the challenges facing those attempting to provide care to PLWHA who are racial and ethnic minorities. Clearly, national studies show poorer access to care and poorer health outcomes for those who are socially-disenfranchised because of race; this is striking even in Kentucky which has a relatively small non-White population. The linguistic and cultural issues of Hispanic Kentuckians and new, non-Hispanic



immigrants to Kentucky are substantial challenges for the health care delivery system.

Finally, the issue of health literacy and the ability of the affected individual to participate in care, has become an increasing barrier and a burden to the health sector. As the population of individuals living with HIV continues to change, the needs of individuals whose cultural and linguistic histories make participation in health care system challenging must be addressed. New models of recruitment and retention will have to be adapted to address these growing challenges.

Strategies to Increase Access to Care for Disenfranchised Populations

Disenfranchised populations have a wide array of social/economic barriers and impediments to information about HIV/AIDS and prevention and care resources. The 2009 SCSN identified several promising approaches to addressing needs in this area. First among these are cultural competence efforts which seek to create a welcoming climate for disenfranchised populations. Beyond training on the provider level, effective multicultural organizations address how systems and processes can become more culturally competent to serve the needs of unmet individuals.

Second, efforts to reach vulnerable populations must engage communities at the onset to create ownership in the process and to identify gatekeepers whose presence and support can be critical for public health interventions to succeed. Every effort must be made to make programs participatory, engaging community partners at every phase in the process.

Next, new efforts to find locations where marginalized populations are found must be identified. Having easily accessible outreach and case management staff, brochures and health marketing material is a critical aspect of bridging the gap between individuals not in care and the care system.

Finally, the success of identifying individuals living with HIV and not in care is intricately connected to counseling and testing efforts. In line with the CDC's Advancing HIV Prevention Initiatives and the 2006 Recommendations for Routine HIV Screening in Medical Settings, the HIV/AIDS Branch is committed to finding those Kentuckians living with HIV who do not yet know their status. The 2009 comprehensive plan goals of the Branch include finding those individuals who do not know they are infected, counseling their partners, and assisting them in accessing available care services.

CONCLUSION

The 2009 Statewide Coordinated Statement of Need offers an important view into the challenges and opportunities facing all providers in Kentucky who wish to address the unmet needs of PLWHA. There are, indeed, many problems which persist from previous assessments: issues of stigma, limited resources, challenges of multiply-diagnosed consumers, and the geography of Kentucky are themes which repeated themselves in this assessment. On the other hand, successful prevention efforts and innovative models of recruiting and retaining consumers in care offer hope in moving forward. Many resources exist for individuals living with HIV/AIDS, and effective coordination of these resources and creative strategies to address unmet needs offer hope for the future of the HIV/AIDS response in Kentucky.

As with other health issues, the assessment of unmet need is intricately linked to the reality of other health disparities. Like other chronic conditions, the disproportionate impact of HIV on racial and ethnic minorities must remain a primary concern. In addition, issues of class and gender and the impact of homophobia are all larger social issues which impact the lives of Kentuckians affected by HIV. With careful consideration and with focused persistence, impact on these issues can be made via implementation of the 2009 Comprehensive Plan.



Perhaps most importantly, the SCSN was a rich and successful process for the HIV/AIDS Branch and the statewide network of partners whose efforts have borne fruit in this document. The willingness of HIV providers to find time in their busy schedules to make time was significant; their thoughtful attention to the detail of this process was inspiring. Clearly, there are significant challenges, but the skills of these individuals, the determination of individuals living with HIV/AIDS, and the resource of the HIV/AIDS Branch will be channeled to address the unmet needs of Kentuckians living with HIV/AIDS.



WHAT ARE THE PRIORITY POPULATIONS FOR HIV PREVENTION?

ORDER OF PRIORITY POPULATIONS

At the April 5, 2009 Technical Assistance training was provided by the United States Mexico Border Health Association, USMBHA to KHPAC. A new prioritization tool was presented for review and approval by KHPAC. A special workgroup had been assigned to work with USMBHA to tailor the tool to Kentucky's needs.

On June 1, 2009 the epidemiologic data, Needs Assessments, the Statewide Coordinated, Statement of Need were shared with the members for review.

On July 23, 2009 KHPAC prioritized the populations using the new adopted tool. The Epidemiologists presented the Epidemiologic Profile, detailing the contents. Based on the Epidemiologic Profile and qualitative data, KHPAC members prioritized the target populations.

Per CDC's Advancing HIV Prevention Initiative, those living with HIV are prioritized as the highest target population. The major change in prioritization for 2009 was the removal of Mothers at Risk for Perinatal HIV Transmission, (MARP) due to insufficient data.

Explanation of the Prioritization Tool

Below are the current tools that Kentucky uses to prioritize populations. It is a two step process; labeled Step I and Step II respectively. In Step 1, factors chosen for prioritization are fairly self-explanatory except for "Riskiness of Population Behavior." In this category, points were assigned relative to the most typical risk behavior in each target population. For populations that practice multiple risk behaviors, the highest risk behavior in which they participate was used. For instance, while MSM/IDU participate in injecting drugs, receptive anal intercourse, and insertive anal intercourse, the highest risk behavior is regarded to be injecting drug use, which is assigned 5 points. The assigned multiplier would then be multiplied by this number in order to generate the final score for the specific factor. Scores for each factor were added together to obtain the final point totals for each risk population. The final point totals are listed within the table.

In step II the target populations are sub prioritized based on HIV incidence for 2007. The sub groups with the highest incidence (number of new cases) were assigned the highest rank within that behavior risk group.



STEP I

2009 Target Populations Prioritization

FACTOR		Mult.	MSM	MSM/IDU	IDU	Heterosexual
HIV Incidence (Number of New HIV Cases Diagnosed in 2007)		4				
5 points	>201		4	1	1	2
4 points	151-200		4x4 = 16	1x4 = 4	1x4 = 4	2x4 = 8
3 points	101-150					
2 points	51-100					
1 point	1-50					
0 points	0	(N=157)	(N=5)	(N=28)	(N=55)	
AIDS Prevalence (Number of Living AIDS Cases as of 12/31/08)		3				
5 points	>601		5	1	3	4
4 points	451-600		5x3 = 15	1x3 = 3	3x3 = 9	4x3 = 12
3 points	301-450					
2 points	151-300					
1 point	1-150					
0 points	0	(N=1399)	(N=145)	(N=356)	(N=498)	
Percent HIV Seropositivity at Counseling and Testing Sites in 2006		2				
4 points	HIV seropositivity greater than or equal to 5%		4	3	1	1
3 points	HIV seropositivity greater than or equal to 2%		4x2 = 8	3x2 = 6	2x1 = 2	1x3 = 3
2 points	HIV seropositivity greater than or equal to 1%					
1 point	HIV seropositivity greater than or equal to <1%					
		(5%)	(4%)	(<1%)	(<1%)	
Riskiness of Population Behavior (Highest Risk Factor)		1				
5 points	Injecting Drug Use		4	5	5	3
4 points	Receptive Anal Intercourse		4x1 = 4	5x1 = 5	5x1 = 5	3x1 = 3
3 points	Receptive Vaginal Intercourse					
2 points	Insertive Anal Intercourse					
1 point	Insertive Vaginal Intercourse					
TOTAL			43	18	20	26
RANK			1	4	3	2



2009 Target Population Sub –Prioritization

STEP II

1. HIV +

BRG	Race	Age	Sex
MSM	White	30 – 49	Male
MSM	Black	20 – 29	Male
MSM	Black	30 – 39	Male
MSM	White	20 – 29	Male
MSM	Black	13 – 19	Male
MSM	Hispanic	All	Male
HRH	Black	All	Female
HRH	White	All	Female
HRH	Hispanic	All	Female/Male
IDU	White	All	Female/Male
IDU	Black	All	Female/Male
MSM/IDU	Black/White/Hisp.	All	All

2. HIV -

BRG	Race	Age	Sex
MSM	White	30 – 49	Male
MSM	Black	20 – 29	Male
MSM	Black	30 – 39	Male
MSM	White	20 – 29	Male
MSM	Black	13 – 19	Male
MSM	Hispanic	All	Male
HRH	Black	All	Female
HRH	White	All	Female
HRH	Hispanic	All	Female/Male
IDU	White	All	Female/Male
IDU	Black	All	Female/Male
MSM/IDU	Black/White/Hisp.	All	All



The Interventions were Prioritized as Follows:

KHPAC opted to keep the interventions from 2008 with a few changes –

- Include Popular Opinion Leader, POL.
- State coordinators to find additional MSM interventions
- State coordinators to look for alternative intervention to Safety Counts

(1) HIV+

Health Relationships
CRCS (PCM)

(2) MSM

Many Men, Many Voices
CRCS
Outreach
Counseling and Testing
(CTS)
POL
D Up – adaptation for black
MSM

(3) HRH

SISTA
CRCS
Outreach
CTS

(4) IDU

Safety Counts
CRCS
Outreach
CTS

(5) MSM/IDU

Safety Counts
Many Men, Many Voices
CRCS
Outreach
CTS

Special Populations

KHPAC (Community Planning Group) also designated certain populations as “Special Populations”, this group consists of target populations which the available data does not support, but KHPAC recognizes a need to provide interventions as resources allow.

1. Transgender
 - Identify areas with high incidence of transgender populations
 - Adapt interventions to target transgender populations
2. Immigrants
 - Collaborate with pertinent stakeholders to explore the feasibility of expanding services to immigrant populations.
 - Set up meetings with the stakeholders
 - Identify the needs and set up plans to implement
3. Exiting Inmates – Population targeted via Discharge Planning program
 - Discharge planning program is in place at facility housing the highest number of HIV inmates in the state
4. Undetermined (mode of transmission) – Goal is to capture risk factor information
 - Targeted provider education information to improve risk factor reporting
 - Analyze data to identify providers that are not capturing risk factor information and in turn provide technical assistance on risk factor reporting



SECTION
5
 STRATEGIES

INTERVENTION TYPES USED IN CDC’S EVALUATION GUIDANCE

The CDC, National Center for HIV, STD, & TB Prevention, DHAP-IRS provided a series of training sessions for health department staff on Evaluating CDC-Funded Health Department HIV Prevention Programs (commonly referred to as the “Evaluation Guidance”) in February and March 2000. Kentucky sent three representatives to this training (the HIV/AIDS Branch Manager, the HIV Prevention Coordinator, and the former CPG State Co-Chair).

In compliance with the new Evaluation Guidance, and since the 2000 training KHPAC incorporated the use of CDC’s intervention classifications.

A.	Individual-level Interventions (ILI)	Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. Note: According to a strict categorization, outreach and prevention case management also are individual-level interventions. However, for the purposes of this reporting, ILI does not include outreach or prevention case management, which each constitute their own intervention categories.
B.	Group-level Interventions (GLI)	Health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support. Note: Many providers may consider general education activities to be group-level interventions. However, for the purposes of this reporting, GLI does <i>not</i> include “one-shot” educational presentations or lectures (that lack a skill component). Those types of activities should be included in the Health Communication/Public Information category.
C.	Outreach	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients’ neighborhoods or other areas where clients’ typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models.
D.	Comprehensive Risk Counseling and Services (CRCS)	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.
E.	Partner Counseling and Referral Services (PCRS)	A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.



F.	Health Communications/ Public Information (HC/PI)	<p>The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience. Print Media: These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage. Hotline: Telephone service (local or toll-free) offering up-to-date information and referral to local services, e.g., counseling/testing and support groups. Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations. Presentations/Lectures: These are information-only activities conducted in-group settings; often called "one-shot" education interventions.</p>
G.	Other Interventions	<p>Category to be used for those interventions funded with CDC Announcement 99004 funds that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level interventions (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.</p>



Results from 2009 Survey of Kentucky DEBI 's

DEBI Provider Survey Results

In May of 2009 the HIV/AIDS Branch distributed a survey to providers of DEBIs in order to assess the provider's ability to implement the assigned curriculum as well as their opinions about the effectiveness of the interventions. The survey tool provides feedback on the following interventions: SISTA, Many Men, Many Voices, Safety Counts, and Healthy Relationships.

The survey tool covered 4 categories of information that the HIV/AIDS Branch wanted to collect: Recruitment, Implementation, Tailoring and Adapting, and Effectiveness. One area that we wish we had included on the survey was Retention. Even though we are able to derive the actual retention from monthly data collection, it would have been interesting to collect the information from the provider's perspective. Most providers indicated that retention was an issue in implementing the interventions. Results of the survey are broken down by category of data collection for each listed intervention.

1. Healthy Relationships

The HIV/ AIDS Branch provides funding for 4 prevention specialists to conduct Healthy Relationships. At the time of this survey only one position was filled by a prevention specialist who had actually implemented the intervention.

Recruitment: The provider indicated using personal invitations, outreach, support groups, social networks and community leaders as recruiting efforts for the intervention.

Implementation:

The provider indicated difficulty recruiting in terms of all MSM, Female, and Heterosexual Males clients. Homogenous grouping made it difficult to meet recruitment goals. The provider indicated difficulty retaining participants through the complete intervention. All core elements of the intervention were met.

Tailoring and Adapting:

The provider indicated tailoring the intervention in the following ways: Shortening the delivery time, Multiple sessions per day, Recruitment by sub-populations, combined sessions.

Effectiveness:

The provider indicated that the intervention was received by participants somewhat well, that they indicated intent to change behavior, and that he thought they would be somewhat successful changing behaviors.



2. Many Men, Many Voices (“3MV”)

The HIV/ AIDS Branch provides funding for 7 prevention specialists to conduct Many Men, Many Voices. All 7 of the prevention specialists funded to provide this intervention responded to the survey. 3 of the 7 had very little experience providing this intervention, but had provided it within weeks of the survey.

Recruitment:

The providers reported the following methods of recruitment: Personal Invitations, Outreach, Social Networks, Care providers, Other Interventions, Testing, Accepted Referrals, Flyers, E-mails, and Community Recruiters.

Implementation:

The providers reported the following difficulties with implementing the intervention: Funding Issues (getting funds from agency), Recruiting, Retention, Agency Restrictions (type of restrictions not explained). Some core elements were missing from some series, specifically; Enhance Self-esteem, Partner Communication, Social Support, Relapse Prevention. The omission of core elements is of great concern to the HIV/AIDS Branch. Technical assistance will be provided to the providers reporting the omissions.

Tailoring and Adapting:

The providers reported tailoring the intervention in the following ways: Shorter Delivery Time, Multiple Sessions per Day, Tailored for Sub-populations, Combined Sessions.

Effectiveness:

The providers reported that the interventions were received by participants very well or somewhat well, with the majority responding somewhat well. All but one provider reported participants indicated intent to change behaviors. The one who reported low intent to change behavior among participants noted that most participants were already practicing safer behaviors. Providers reported that they think participants will be somewhat to very successful changing behavior.

Providers added the following comments:

Once I got everything into place the participants really enjoyed it.
I had to tie the intervention to community events.
I would love to try this intervention as a web-conference.
I received positive feedback from participants.

3. SISTA

The HIV/ AIDS Branch provides funding for 5 prevention specialists to conduct SISTA. One provider was a recent hire and had not yet implemented the intervention. The remaining 4 providers completed the survey.

Recruitment:

The providers reported using the following recruiting strategies: Personal Invitations, Outreach, Testing, Referrals from other providers, Social Networks, Flyers, and Support Groups.



Implementation:

The providers reported the following difficulties with implementing the intervention: Funding, Recruiting, Retention, Lack of Interest. Providers reported delivering all of the core elements of the intervention.

Tailoring and Adapting:

The providers reported the following strategies for tailoring the intervention: Shorter Delivery Time, Multiple sessions in the same day, Combined Sessions, Tailored for Sub-populations, Used a Skilled Caucasian Facilitator.

Effectiveness:

The providers unanimously reported that the intervention was very well received. They reported that participants reported intent to change behaviors and that they thought participants would be somewhat to very successful at changing behavior.

Providers added the following comments:

SISTA is an excellent program.
You must provide childcare.

4. Safety Counts

The HIV/AIDS Branch provides funding for 5 prevention specialists to conduct Safety Counts. One of the positions at a contracted agency was vacant at the time of the survey. The other 4 prevention specialists completed the survey.

Recruitment:

The providers reported using the following recruitment strategies: Personal Invitations, Outreach, Other Interventions, Testing, Social Networks, Outside Referrals, and Rehab Programs.

Implementation:

The providers reported the following difficulties with implementation of the intervention: Funding, Agency Restrictions, Recruitment, and Retention. Providers reported all core elements were delivered.

Tailoring and Adapting:

The following strategies were used to tailor the intervention: Shorter Delivery Time, Tailored for sub-populations, Combined Sessions.

Effectiveness:

The providers reported that the intervention was not well received by participants. Very little intent to change behavior was noted among participants and the providers did not feel that participants would be successful changing behaviors.

Providers added the following comments:

We lack agency support for this intervention.



Comments from HIV/AIDS Branch:

In the Implementation section of the survey providers uniformly indicate issues around recruitment and retention. This has prompted the scheduling of technical assistance in these areas. Our CDC project officer has assisted us with scheduling training provided by AED for September 24th. Follow-up training specifically designed for recruitment, retention, and delivery issues of the interventions Safety Counts, 3MV, and SISTA should be provided in November, depending on CDC travel restrictions.

The issue of core elements not being delivered in 3MV occurred among inexperienced providers. Technical assistance has been delivered for the MSM Initiatives Coordinator. Further monitoring will be conducted with these providers.

Funding was listed as a difficulty related to implementation. It was specifically indicated that getting funds from the contracted agencies for the intervention was a problem on some surveys, but funding was listed on other surveys without explanation. The HIV Prevention Grant Administrator addressed agency policy for accessing prevention money with all contract agencies. Monitoring of this issue will be continued by the program coordinators and issues will be reported to the grant administrator. The second possible issue funding (insufficient funds to conduct the interventions) will be addressed in a quarterly training exercise on budgeting for an intervention in November 2009. Since funding is currently flat, no additional money is expected to be provided for interventions, but this is something that may have to be addressed further after the November training.

Safety Counts had less favorable responses on the survey than any of the other interventions. The IDU Initiatives Coordinator is looking for other interventions suitable for delivering harm/risk reduction messages to IDU. He also has worked very closely with providers to identify ways to tailor Safety Counts to make it more effective. He will continue to evaluate this intervention.

In addition to the prevention specialists listed above, there are two who target MSM/IDU who could have responded in the section for 3MV or Safety Counts. One of these positions was vacant and the other occupied by a new hire who had only participated in the provision of an intervention under the supervision of co-workers.



STRATEGIC OVERVIEW OF SELECTED INTERVENTIONS

POPULAR OPINION LEADERS

This intervention involves the identification of popular "opinion leaders" among the targeted community to serve as endorsers of the need for behavior change to their own circle of friends and acquaintances. This intervention involves conducting an extensive pre-intervention survey to bar patrons, training bar staff to identify "opinion leaders," recruitment and six week training of "opinion leaders," contracting with "opinion leaders" to educate and encourage their friends to practice safer sex, regularly scheduled contacts with "opinion leaders", and post-intervention survey for bar patrons.

MSM/POL is a Community Level Intervention (CLI) due to its-use of local bars and clubs of potential clientele. It is also labeled as an Individual Level Intervention (ILI) due to one on one personal contact with bar and club patrons. Even though there is an obvious barrier to targeting HIV positives in this forum, the opinion leader should concentrate on those that are thought to be involved in high-risk behavior.

- A. POTENTIAL IMPACT OF STRATEGY TO PREVENT INFECTIONS: Rated as high, due to proactive nature of one-to-one communication and peer support from a friend talking to a friend approach.
- B. COST EFFECTIVENESS OF STRATEGY: Initially high to moderately high cost due to expense of evaluation of surveys, payment of stipends to "opinion leaders", training expenses, and staff time to maintain contact. Cost decreases after evaluations of the first implementation occurs.
- C. THEORETICAL BASIS OF STRATEGY: Diffusion of Innovation (Rogers, 1983; Kelly, et al., 1991). Social Cognitive Theory (Bandura, 1986). Theory of Reasoned Action (Fishbein & Middlestadt, 1989). Multi-component State Model (Prochaska et al., 1994).
- D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS, AND PREFERENCES: High due to indigenous nature of intervention.
- E. AVAILABILITY OF OTHER RELATED RESOURCES: DEBIs.

Diffusion of Effective Behavioral Interventions (DEBIs)

These interventions recognize that psychosocial factors are often triggers for engaging in unprotected behaviors. These multi-session workshops do not focus on "instructing" participants on the mechanics of safer sex. Instead, the focus is on providing a supportive setting for experiential learning (co-lead by a trained mental health professional, when possible, and the appropriate HIV prevention team member) designed to improve interpersonal relationship skills, increase self-esteem, remove



social-isolation and cognitive-isolation, increase coping skill for handling stress, and increase self-awareness of behaviors. These interventions recognize the need to bridge mental health services with HIV prevention efforts.

These interventions represent one of the longest periods of time that a client or at risk individual may be in a teachable platform designed solely to reach their population. This will open opportunities for the outreach team to instill a sense of responsibility among those that are positive. With the understanding that there is a limit to the long term effectiveness of the risk reduction approach, these interventions target HIV positives, their sex partner(s) and at risk associates. The intervention emphasis must be on Harm Reduction when participants choose to engage in risky sexual practices or judgment impairing activities.

DEBIs are group level interventions (GLI). DEBIs have been selected targeting five risk groups. They are: HIV+, MSM, IDU, MSM/IDU, and High-Risk Heterosexual. The number of workshops for each population will be determined by prioritized populations. The planning should also place the most emphasis on HIV positives, African-Americans and Hispanic. Even though the Transgender population is not specifically mentioned in the above populations, they remain an entity of all priority populations. A specific Transgender workshop should be included in the MSM/IDU and High-Risk Heterosexual workshop series. All workshop participants should be evaluated for enrolment in Comprehensive Risk Counseling and Services (CRCS) (formerly known as Prevention Case Management).

- A. POTENTIAL IMPACT OF STRATEGY TO PREVENT NEW INFECTIONS: High. On going contacts with participants increase potential impact. Impact also increases when groups with disproportionate rates of infection are targeted or when the intervention targets HIV positive persons.
- B. COST EFFECTIVENESS OF STRATEGY: Low to moderate. Cost associated with contracting with regional HIV prevention team worker (HIV+, MSM, MSM/IDU, IDU and Heterosexual).
- C. THEORETICAL BASIS OF STRATEGY: Information-Motivation-Behavioral Skills Model (Fisher and Fisher, 1992). Theory of Gender and Power (DiClemente and Wingood, 1995).
- D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS, AND PREFERENCES: High, issues are built in due to indigenous nature of intervention.
- E. AVAILABILITY OF OTHER RELATED RESOURCES: "Key Peer Opinion Leader" intervention for MSM patronizing gay bars.

PUBLIC SEX ENVIRONMENTS (PSE) OUTREACH INTERVENTION

This intervention's primary purpose is to connect via one-to-one communications with individuals who may not be reached by more traditional interventions. The principle here is to meet people on their "turf." This intervention involves training individuals to safely go to PSEs in teams and provide information, support, and referrals. Extensive



preparations are required for this intervention, including the consent and cooperation of various agencies, institutions, and local governments.

- A. POTENTIAL IMPACT OF STRATEGY TO PREVENT NEW INFECTIONS: Moderately high due to connecting a low impact approach (brief public encounters) with very high prevalence target groups (Sex for trade/sale workers and non-gay identified MSMs).
- B. COST EFFECTIVENESS OF STRATEGY: Moderate. Expense of training, traveling, tracking persons reached, and stipends.
- C. THEORETICAL BASIS OF STRATEGY: Theory of Planned Behavior, (Ajzen, 1988).
- D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS AND PREFERENCES: Clear understanding that workers are not to approach, but be approached and are not to condemn sexual behavior of target group. Workers are there to increase awareness of risks (HIV/AIDS, legal, physical, social, and family) and provide information, condoms, and referrals.
- E. AVAILABILITY OF OTHER RELATED RESOURCES: N/A, many from target PSE group cannot be reached by other means.

COMMUNITY AWARENESS/MOBILIZATION INTERVENTION

This intervention (targeting (MSM, MSM/IDU, IDU, Heterosexual) recognizes the need to take into account the targeted community's culture, social, and behavioral norms in HIV prevention planning. This intervention involves contracting with an establishment, most likely a bar or community center, to provide a safe gathering place for the target population. Peer leaders from the target community will be identified, trained, and paid a stipend to serve as safer sex information "diffusion agents", to host the social event for their community and provide needed support, referrals, condoms and information. A core group will be maintained to continue the intervention activities and events.

- A. POTENTIAL IMPACT OF STRATEGY TO PREVENT INFECTIONS: High due to proactive nature of one-to-one communication and peer support. Also high due to "grass root" creation of the intervention via direct input from targeted community.
- B. COST EFFECTIVENESS OF STRATEGY: Moderate to high. Additional expense of renting facility, given current environment, a necessary expense.
- C. THEORETICAL BASIS OF STRATEGY: Diffusion of Innovation, (Rogers, 1983; Kelly et al., 1991). Social Cognitive Theory, (Bandura, 1986). Theory of Reasoned Action, (Fishbein & Middlestadt, 1989). Multi-component Stage Model, (Prochaska et al., 1994). Multi-component Stage Model, (Prochaska et al., 1994).
- D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS AND PREFERENCES: High, intervention is directly based on input from the targeted community.
- E. AVAILABILITY OF OTHER RELATED RESOURCES: Empowerment workshops.



STREET OUTREACH

The Prevention Specialists providing outreach do one-to-one counseling, referrals, encourage and arrange counseling and testing, distribute bleach kits and latex condoms. All street outreach will include harm reduction information for IDU.

- A. POTENTIAL IMPACT OF STRATEGY TO PREVENT NEW INFECTIONS: High due to connecting a low impact approach (brief public encounters) with very high prevalence target groups (IDUs and persons with a history of substance abuse/addiction, MSM, MSM/IDU, and Heterosexual). Street outreach provides the most reliable gateway to prevention case management.
- B. COST EFFECTIVENESS OF STRATEGY: Moderate, expense of funding for outreach workers.
- C. THEORETICAL BASIS OF STRATEGY: Theory of Planned Behavior (Ajzen, 1988).
- D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS AND PREFERENCES: Non-judgmental approach is essential to accessing difficult-to-reach populations. Increased contact contributes to awareness and effective referrals.
- E. AVAILABILITY OF OTHER RELATED RESOURCES: N/A, many from the targeted populations cannot be reached by other means.

HIV+ CRCS

In order to maximize resources for Comprehensive Risk Counseling and Services (CRCS) for HIV+ individuals, the former CPG recommended in the 2002 plan, a pilot program to identify those individuals most likely to engage in unsafe behaviors. Development of the intervention at one (1) counseling and testing site, (preferably a high volume site), would involve a triage approach using markers to identify candidates for CRCS at the time of post-test counseling. (See "The Unsafe Behaviors of Persons Living With HIV/AIDS: An Empirical Approach to Developing New HIV Prevention Interventions Targeting HIV-Positive Persons, Rosser, Gobby & Carr, Journal of Sex Education and Therapy Vol. 24, no.1 & 2.)

Recent public information has been presented from numerous studies regarding the percentage of HIV positives that have failed numerous AIDS drug therapies, giving new credence to the necessity for proactive CRCS approach for HIV+ individuals.

Since 2002, CRCS has been expanded so that every Prevention Specialist carries a small case load within their target population. These individuals will either be HIV positive or determined to be high risk HIV negative. In addition, the CRCS for HIV positives pilot project has been expanded to all three regions with one full time CRCS Provider in the East and West region, and two in the North Central Region.

At all times PSs doing CRCS should keep a record of the level of development that the client has reached or the level at which the client elected to discontinue the program. The levels are known as the "Stage of Change Rating". They are:

Pre-contemplation



Contemplation
Preparation
Action
Maintenance

Prevention Specialists must be cautioned when being trained that their position involves management of the client only. When there are other needs that the client may have, the PS should direct the client to the proper Care Provider that is capable of administering the specific need of the client.



HIV TESTING AND PARTNER COUNSELING AND REFERRAL SERVICES (PCRS)

PCRS Goals, Objectives, Methods and Activities 2009 – Continued from 2008

Objective 1 - Throughout 2009, maintain an accessible network of HIV Counseling and Testing Sites (CTS), which provide quality service to clients.

Methods - At present, there are 209 CTS sponsored by the Kentucky Department for Public Health (DPH). Sites include local health departments and satellite clinics, community health centers, high schools, community based organizations, Planned Parenthood and hospitals that serve substance abusers. Non-invasive testing is also presently available at off-site facilities who provide services to populations most adversely affected by HIV/AIDS. Specimens at these sites are tested by the OraSure and OraQuick test kits. The intent of these off-site test centers is to encourage high-risk populations to learn their serostatus and to adopt safer sex and needle sharing practices. Clients who test positive are also provided with the knowledge that they need to quickly access health care. The OraSure and OraQuick sites are proving to be an effective way to provide counseling and testing services to men who have sex with men, injection drug users and other high-risk populations who are often reluctant to present to local health departments to receive health services. Funds sufficient for the testing of approximately 3000 OraSure/OraQuick clients are presently available.

In 2009, all 120 counties in Kentucky had at least one public health clinic where persons may voluntarily present for HIV counseling and testing. All counselors at these sites will have been trained in a two-day course entitled HIV Counseling and Partner Notification conducted by certified trainers who are staff members of the Kentucky STD Program or the HIV Prevention Program. Clients who seek services at a CTS will usually have to call the site and make an appointment. Some sites, however, have sufficient staff to provide service on a walk-in basis. CTS will be urged to ensure that the delay between date of request and date of service receipt is kept to a minimum of two or three work days. Delays exceeding one week will be unacceptable. All clients will be advised that services can be provided on either a confidential or anonymous basis and given the right to decide which they prefer. Health department counselors will, however, stress to clients to seriously consider confidential testing because the confidentially tested HIV infected client who fails to return voluntarily for post-test counseling will be assigned for follow-up by a Disease Intervention Specialist (DIS) to ensure that post-test counseling is achieved, arrange for partner notification and referral for counseling and testing for HIV and other STDs, referral for other medical services including tuberculosis skin testing, contraceptive and/or prenatal care, if needed or indicated, and referral to health care providers for further HIV/AIDS diagnostic testing including CD4 and viral load testing. HIV infected patients will be routinely provided



with the name, address and telephone number of an AIDS Care Coordinator who can assist the patient with a variety of needs (medical, financial, social, housing, legal) if the client contacts the coordinator and requests help.

Local health departments have expanded HIV services to include patients assessed to be at-risk for HIV infection who attend family planning, prenatal, tuberculosis and sexually transmitted disease clinics. HIV counseling and testing at jails and juvenile detention centers has been undertaken by some health departments. Although most health departments do not provide prenatal services, those that do routinely offer HIV testing as part of their initial examination. Pregnant women served at these sites have the right to refuse HIV testing but very few actually do. Regardless of where a client receives HIV counseling and testing services in a DPH sponsored CTS, the following basic rules apply:

*Every client will receive face-to-face counseling from a counselor who has been trained in the HIV Counseling and Testing and Partner Notification course taught by a certified instructor.

*Clients have the right to refuse testing and, if tested, have the right to choose whether the test will be confidential or anonymous.

*All post-test counseling will be done face-to-face after the client has been properly identified as being the person tested. No post-test counseling or notification of a test result will be done by telephone or mail.

CTS operation brings with it the responsibility to assure that patients receive quality services delivered in a professional manner and setting by well-trained and competent staff. Service delivery at each CTS will be closely monitored and personal visits will be made by STD Program administrators and supervisors to a site when it is observed that deficiencies exist or if complaints are received from clients about the quality and/or sensitivity of service delivery at a site.

Evaluation - supervisors and administrators of the STD and HIV prevention programs will monitor all activities performed at each CTS. Specific outcome indicators that will be measured and reported in progress reports include:

- 1) Updated listing for all CTS,
- 2) New sites added during a quarter,
- 3) Number of new personnel trained in HIV Counseling and Testing and Partner Notification courses
- 4) Statewide and individual site reports of all CTS, including OraSure and OraQuick test sites, compiled from data collected from an optical scan HIV Counseling and Testing Form completed for every client receiving services. These data will also be collected in the PEMS data system.

Objective 2 - Throughout 2009, promote and assess the availability of comprehensive counseling and testing services by maintaining a level of health care providers (public, private, and military) who have received training in courses approved by the Kentucky Department for Public Health. Emphasis will be placed on expanding services to include additional agencies who serve clients who use and /or abuse narcotics.



Method - As courses are planned, area hospitals, drug treatment centers, university student health centers, and correctional facilities located near course sites will be offered the opportunity to have staff members attend. Facilities who have trained staff may remain an independent counseling and testing service or become an official Kentucky DPH CTS. Those who elect to be an official CTS must agree to pretest counsel all clients prior to testing, offer the client the option of being tested anonymously or confidentially, test only when the patient elects to be tested, attempt to post-test counsel all clients tested, and to set up or arrange an interview with a DIS and an infected patient so that partner notification can be done. They must also agree to use the optical scan form for collecting data and to submit them in a timely manner to the Kentucky STD Prevention Program for data compilation and review. Non public health facilities who elect to become a CTS must submit all specimens to the Division of Laboratory Services (DLS) for processing and properly identify specimens on an official DLS form for HIV specimen testing. DLS will process specimens free of charge.

Selected non-public health facilities trained in HIV counseling will be encouraged to become an official CTS but those who remain independent will have received the same training as counselors in a CTS. They will also have better understanding of patient care and services available through public health programs for infected patients who have limited or no access to health care

Evaluation - Progress toward achieving this objective will be measured as follows:

- 1) Documentation of new non-public health facilities added as an official CTS
- 2) Documentation as to the number of employees at new sites who were provided training.
- 3) Monthly, quarterly, semi annual, and annual reports from individual sites and a statewide basis showing the number of clients served ,demograhics of clients served, risk assessment of clients ,and test outcome.

Objective 3 - In 2009, maintain a test acceptance rate of at least 95% for all patients pre-test counseled in health department sponsored STD clinics.

Method - DIS and nurses serving patients with an STD or suspected exposure to an STD will emphasize to the patient that by virtue of being infected with an STD they are at increased risk of being infected with other STDs including HIV/AIDS infection. Patients will receive pre-test counseling for HIV and encouraged to be tested for HIV infection. Counselors in STD clinics will refer to the HIV test as the AIDS virus test because it is felt that many STD patients do not know that the HIV test is the test used to detect the virus that causes AIDS. STD patients will first be provided appropriate care for the STD infection they have and then referred to a counselor where they will receive basic information and educational materials about HIV and AIDS. They will then be offered and encouraged to be tested for HIV but assured that refusal to accept testing will not negatively impact or prevent their ability to receive health care services at the facility or any other clinic operated by a local health department. Patients who elect testing will be tested confidentially and advised that it will be necessary for them to return to the clinic in two weeks to learn their results and receive additional (post-test) counseling. In order to assure that a greater number of STD patients receive HIV/AIDS information, CTS services, when possible, will be provided while the patient is waiting to receive their STD examination.



Evaluation - Quarterly, semiannual and annual assessments will be made of the number of STD patients at public clinics provided HIV/AIDS information, pre-test counseling, testing and post-test counseling services. The specific documents used for data collection will be the HIV Counseling and Testing Report (optical scan form) developed by the CDC and the PEMS form. These forms will be initiated on every STD patient approached and will enable us to accurately measure activity at each specific site as well as aggregate data on a state-wide basis. Data will be collected and tabulated by staff assigned to the STD Program.

Objective 4 - In 2009, confidentially or anonymously test at least 95% of CTS clients who receive pre-test counseling. Estimated number of pre-test counsels each year will be 19000 with 18000 tests performed.

Method - Brochures, handouts and pamphlets listing CTS locations will be distributed at public clinics statewide. Private, public and military care providers will be updated as to CTS locations by accessing information from the DPH Website and by periodic articles in EPI Notes and Reports, a DPH publication sent to over 8200 health care providers monthly. Newspapers and radio stations will be alerted about public awareness campaigns and asked to broadcast or print CTS locations in areas where awareness initiatives are being conducted. In order to achieve a high test acceptance rate, clients attending CTS will have the option of receiving either confidential or anonymous services. Confidential services will be emphasized by counselors, as will procedures in place for the protection of privacy. During pre-test counseling the following will be stressed:

- 1) Educate the patient about HIV/AIDS infection including risk factors and modes of transmission.
- 2) Assess the patients' risk of infection.
- 3) Assist the patient with developing a plan to adopt safer sex/ needle use practices.
- 4) Explain what a negative, positive and indeterminate test result means and does not mean.
- 5) Let the patient decide whether to be tested. Care will be taken to ensure that the counselor neither talks a client into or out of being tested.
- 6) Emphasize to the patient the need to voluntarily return for his/her test result and post-test counseling and of the importance, if the test is positive, that all sex/needle sharing partners within the previous two years, and spousal partners within the previous ten years, be informed of possible exposure. All CTS services will be monitored to ensure that counseling is non-judgmental and sensitive to the needs of patients.

Evaluation - Data will be compiled and presented as part of quarterly, semiannual, and annual reports which will be sent to each CTS and which will be reviewed by the administrative staff of the Kentucky Sexually Transmitted Disease Program and HIV Prevention Program. These reports will also be forwarded to the CDC. Specific documents from which data will be compiled are:

- 1) The HIV Counseling and Testing Report Form initiated on every client served in a CTS. The form will provide information as to the clients age, sex, race, risk factors, reason for seeking services, county of residence, identification of the CTS site where service was sought, date of test and result if tested and date of post-test counseling if the client returns.



- 2) HIV CTS logs maintained at each CTS.
- 3) The Division for Laboratory Services Human Immunodeficiency Virus Serology (DLS form 197) completed on all persons tested in a CTS.

Objective 5 - In 2009 achieve at least a 70% return rate for post-test counseling for all persons tested (confidentially or anonymously) in a CTS and at least a 50% return rate for STD clinic patients.

Method - At the time of pretest counseling, counselors will emphasize to clients that there is nothing to be gained from testing and deciding not to return to learn their test result. Clients will be informed that the result, whether negative or positive, serves as a guide as to how to alter life styles and adapt safer sex and needle use practices. Clients tested by OraQuick procedure are virtually assured to receive post-test counseling because the test result will be available within 20 minutes of collection. To ensure a higher rate of return for post-test counseling when blood draws are performed, counselors will emphasize the following to clients:

- 1) Prior to testing, each client will be asked to verbally consent to return for post-test counseling.
- 2) Each client tested will be given a specific date and time to return for post-test counseling. The date and time will be entered on a piece of paper and the client will be asked to put the paper in a place where it will not be lost or easily forgotten.
- 3) Clients will be advised to call the site to ascertain that the test has returned and to reschedule another date if the result is not available. Clients will also be instructed to call the CTS to reschedule an appointment if they are unable to attend on the date scheduled.

In addition to the measures described above, STD patients will receive the following messages:

- 1) Confidential testing will be strongly advocated for STD patients but anonymous testing will remain available to patients who will not accept confidential HIV testing. STD patients seen at the Specialty Clinic, Louisville, and at the Lexington-Fayette County Health Department HIV/STD Program will be advised that a counselor will be available to provide post- test counseling without delay.
- 2) Staff time and other resources permitting, high risk STD patients who accept confidential service and test negative but fail to return for post-test counseling, may be mailed a second appointment within three days of the missed appointment.
- 3) All patients testing positive who are confidentially tested in a CTS or STD clinic who fail to meet their scheduled post-test counseling date, will be assigned follow-up by a DIS within three days of the missed appointment.
- 4) Post-test counseling in the field will be done when possible, but only when the setting is one in which complete privacy is assured.

Evaluation - Achievement toward measuring whether 70% of all clients tested in a CTS and whether 50% of clients tested in STD clinics are post-test counseled will be assessed from data collected from the following documents:

- 1) HIV Counseling and Testing Report form and the PEMS data document. These optical scan forms will be completed on every client attending a CTS and on those approached in STD clinics. Monthly, quarterly semi-annual, and annual reports will



be prepared and submitted to the state and the CDC.

- 2) HIV Counseling and Testing logs maintained at CTSs which include dates of pre and post-test counseling, test results if testing was done, and information as to whether the client was seen by a member of the STD or HIV prevention staff or by local health personnel.

Objective 6 - In 2009, increase the number of positive patients tested in a CTS who receive post-test counseling to at least 90%. (Baseline 84% in 2005)

Method - Many of the methods described in objective 5 to return clients for post-test counseling also apply to this objective. However, since targeted clients in this objective are HIV positive, they are of special concern because:

- 1) They are infectious.
- 2) They need appropriate risk reduction counseling.
- 3) They need to work closely with counselors to insure that sex/needle sharing partners and spouses are notified of exposure.
- 4) They need prompt medical, dental, social and human health services available through a CTS or through referral to other care providers.
- 5) They need to be referred to an AIDS Care Coordinator who can assist them in obtaining medical, financial and other services that are not provided by the CTS.

Patients tested confidentially, (who provide truthful information about their identity) present less problems because if they fail to return for post-test counseling their name, address and other locating information are available for follow-up by a DIS staff member. Unfortunately, those tested anonymously and who fail to return voluntarily cannot be followed. To ensure a higher rate of return for post-test counseling when anonymous or confidential testing is done with client assessed to be at high risk for HIV, counselors will:

- 1) Inform the client that they are high risk because of sexual/ needle sharing practices
- 2) Determine if the client has already developed signs and symptoms of HIV disease (weight loss, night sweats, fever, lymphadenopathy, diarrhea, white spots or unusual blemishes in the mouth, etc.) and if so, arrange for an immediate medical assessment by a physician.
- 3) Reemphasize to the client that they must return to learn their results and that a positive result indicates need for additional testing, medical evaluation and possible treatment with medicines that have proven to be very effective in delaying the on-set of AIDS and associated opportunistic infections.
- 4) Assure the client that there is nothing to fear about the counseling and testing service they received or will receive and resolve any concerns the client has which could result in a decision of not voluntarily returning for results.

Evaluation - Area supervisors and administrators of the Kentucky STD Program central office and administrators with the HIV Prevention Program off-site testing facilities will keep constant vigil on CTSs to ensure that every effort is being made to provide post-test counseling to clients testing positive for HIV. Counselors who have difficulty in returning patients for post-test counseling will be provided remedial training (audit and /or demonstration counseling sessions by a supervisor) to identify weaknesses in counseling techniques and to recommend and demonstrate methods that could possibly improve performance. Data collected from optical scan forms will be the basis for measuring objective achievement. Reports will be produced for each site on a



regular basis and composite reports will be forwarded to the CDC on a semi-annual and annual basis.

Objective 7 - In 2009, improve the quality of services provided to clients by Kentucky DPH sponsored CTSs by conducting the following activities:

- 1) Conducting HIV Counseling and testing classes at various locales throughout the state on an as needed/indicated basis.
- 2) Continue the practice of providing each DIS assigned to the STD Program stationed in Louisville, Lexington, Bowling Green and Florence with at least two audit/demonstration counseling sessions by a supervisor each quarter.
- 3) Improve the quality of counseling and testing services at all sites by developing half day workshops which address issues related to the proper scheduling of appointments, intake sensitivity issues, assessing risks factors and assisting clients with developing a risk reduction plan, assisting patients with referrals for needed services and improving ability to inform partners of exposure and need for counseling and testing.

Methods -The STD Program and HIV Prevention Program will work jointly on setting up courses at various locations throughout the state. The courses will be targeted at new employees of health departments and off-site test center employees who will be serving clients. Re-training will be offered to counselors who have not received up-dated training for three or more years.To encourage attendance, every effort will be made to keep the number of attendees to 15 or less and to select locations that are accessible to attendees without need of overnight travel and per-diem costs. Re-training will be directed to sites where review of optical scan forms suggests services are not being offered or poorly provided. Any verbal or written complaint received by the STD Program or HIV Prevention Program will be immediately investigated and remedial training will be provided when deemed necessary. Re-training will also be achieved by videotapes prepared by the HIV Program that deal with basic issues related to privacy, sensitivity and quality service delivery. DIS employed by the STD Program will be audited at least once quarterly, more often if needed, by their supervisor during a pre-test or post-test counseling session with a client. DIS will receive a written appraisal of their performance by the supervisor within 24 hours of the audit. The written appraisal will highlight portions of the session that were performed well and those in need of improvement. Remedial training will be provided if performance is substandard.

Evaluation - Quarterly, semi-annual and annual assessment will be made to determine the number of new counselors trained and the number who receive remedial training. The assessments will also include the number of video tapes reviewed for training and the number of personal visits made to sites by STD or AIDS staff to correct deficiencies and to address issues with sites from which complaints were received.

Objective 8 - In 2009, regularly assess the impact of HIV partner notification and other follow-up services for HIV positive individuals through activities performed by a DIS and through referral made by infected clients.

Method - At the time of post-test counseling, HIV infected clients will be advised of the crucial need to have all sexual partners within the previous two years and all marital partners within the previous ten years informed of possible exposure to HIV disease. HIV positive clients will be advised that informing of exposure can be done directly by



the client or by a DIS. Those electing to self-refer will be cautioned that doing self referral may compromise their right to privacy because the contact may divulge the information to other people who have no legitimate right to know about their HIV status. The DIS or counselor will then explain that the only way to assure that complete confidentiality is maintained is to let the DIS take full responsibility for informing contacts with the absolute guarantee that their name, or any other information, will not be revealed. Patients who prefer to self-refer will be provided with information that will be helpful to them when attempting the referral. Role plays will be conducted pointing out specific questions and reactions which the client may encounter and how to best answer and respond in a manner that satisfies curiosity and doubt and at the same time motivates the contact to seek counseling and testing. DIS assistance will also be offered when the client is unable to complete the referral or encounters difficulty in communicating with the contact. When DIS assistance is requested for partner notification, counselors will sensitively seek exposure history and locating and identifying information that will enable a DIS to complete the referral. Notification and referral attempts undertaken by a DIS will always be done in a manner which fully protects the infected client's identity and which avoids placing the contact in an awkward, compromising, or embarrassing position. Specific rules for notification include:

- 1) All referrals will be done face-to-face between the contact and the DIS.
- 2) No other person will be present when the referral is made except an interpreter if one is needed or a trainee who is accompanying the DIS.
- 3) Under no circumstance will a letter be mailed to or an appointment slip left at the residence of a contact which indicates exposure to HIV or AIDS
- 4) Telephone usage will be restricted to only informing a contact that it is important to meet them and discuss an urgent health matter. Under no circumstance will the telephone be used to inform the contact of exposure.
- 5) DIS will not go to a contact's place of employment to complete a referral unless the contact has agreed to meet the DIS and has assured that complete privacy can be maintained.

Evaluation - Area supervisors and STD Program management staff will monitor the performance of DIS as they conduct counseling sessions and perform field follow-up of HIV contacts. Semiannual and annual progress reports will be made available to the CDC, which will provide the following data and information:

- Total number of HIV infected clients who are post-test counseled.
- Total number of resident contacts named with sufficient information to initiate follow-up by a DIS.
- Total number of contacts residing outside of Kentucky with sufficient information to initiate follow-up.
- Total number of resident contacts located and informed of exposure and the number who elected to be tested for HIV.
- Total number of contacts located who were newly tested and found to be HIV positive, newly tested and found to be HIV negative, had previously tested positive for HIV, and the number who, after notification of exposure, refused to accept an HIV test.
- Total number of spousal notifications attempted and the results of those attempts.



SECTION
5b
STRATEGIES

OVERVIEW OF SPECIFIC TARGET GROUPS

MSM, Including AAMSM and MSMOC

The largest unmet issue in the area of MSMs and MSMOCs is the lack of community organizations and therefore the lack of "hands-on" community based efforts. Of the limited number of gay and lesbian organizations few are doing any HIV prevention or education besides providing brochures. The bulk of HIV prevention efforts for the gay community is provided by AIDS Service Organizations (ASO). There are also needs relating to MSMs who do not identify as "gay" who engage in high-risk activities such as sex with strangers. Gay youth are another area where little is being or can be done with the MSM community. There are limited interventions being conducted, especially with gay youth, which focus on the development or enhancement of skills to initiate or maintain safer sex practices and support maintenance of safer behaviors. Likewise, very few interventions that are directed at establishing or modifying community norms or values to promote behavior change exist outside those currently funded under the CDC Cooperative Agreement.

While there are numerous areas where services are not being provided for MSMs, there are areas where services are being provided. In the North Central region (Louisville) there may be duplication of efforts with regard to reaching gay and bisexual men through condom distribution and there is a great need to provide these products in an efficient, timely manner with better coordination among agencies. All county health departments provide anonymous and/or confidential counseling and testing, although there is a disparity in the quality of services among counties. Several health departments (Lexington-Fayette County, Jefferson County, and Northern Kentucky Independent Health Department) encourage testing for all populations and target MSMs specifically by posting information in adult bookstores, detention centers, and bars that are frequented by MSMs. On-site testing is also provided in all the gay bars in Lexington. Persons testing positive are referred to the Care Coordinator for their region. Many health departments, urban CBOs and other agencies are working together to improve infrastructure and to support HIV prevention/assessment.

IDU

As with other high-risk populations, there are few interventions targeting IDUs. A few local health departments distribute bleach kits and latex. All Health Departments provide anonymous and/or confidential testing. Individuals who test positive are referred to the Care Coordinator Program. Louisville, Lexington, and Paducah now



provide CRCS for IDUs. There is a tremendous need for legislation that would decriminalize possession of sterile injection equipment and residue. This legislation would create a platform for harm reduction practices. This would additionally develop and promote social norms and values that would offer support and decrease the stigma associated with substance abusers and IDUs. Several KHPAC members have independently lobbied for harm reduction legislation that would decriminalize efforts that are designed to reach IDUs. These measures began in the 2000 Legislature and have continued in subsequent legislative sessions without passage so far.

MSM/IDU

MSM/IDU are men who have sex with men and who also use intravenous drugs. While interventions have certainly targeted MSM and IDU, to date none have specifically targeted MSM who inject drugs. The issue relates to recognition of this community and finding MSM/IDU's that remain largely unrecognized in the North Central region. KHPAC recommends that the present emphasis should be on HIV positive MSM/IDUs and identifying candidates for CRCS. Interventions must also consider harm reduction techniques for this population. The continuing approach of prevention for positives for members of this community through CRCS may be the best approach for this population.

HETEROSEXUAL CONTACT with PWHIV, MSM, MSM/IDU, IDU

Kentucky has targeted African Americans, Hispanics, youth and women at risk for several years. Trends indicate that the HIV rates are on the rise in the heterosexual populations, particularly among women and youth. This risk group is often largely ignored in HIV prevention. Oftentimes, many African Americans, Hispanics, youth and women are at high risk of infection due to injecting drug use and/or their sexual interactions with IDU and MSM. However, interventions targeted towards heterosexuals as defined by CDC fail to address these relationships with MSM and IDU.

AFRICAN AMERICAN

There remain very few organizations that primarily serve the African-American population. The Louisville Jefferson County Minority AIDS Program that served this population exclusively with HIV prevention cancelled their contract in 2003. Many of the other organizations serving large numbers of African-Americans are tied to perceived societal "negatives", e.g., correctional facilities, drug treatment centers, homelessness, etc. This creates a void in the HIV prevention services to African-Americans and also allows for some dangerous myths and stereotyping. The impression is created that all African-Americans are drug abusers or criminals or that only African-Americans who are criminals or drug abusers are at risk for HIV. There is a great need for organizations based in the African American community to do work from an African-American perspective. Additionally, there remains a great need for services targeted to African-American youth and MSMOC.

All county health departments provide anonymous and/or confidential testing. There is a great deal of disparity in the quality of services offered among counties. Persons testing positive for HIV are referred to the Care Coordinator in their region. The



distribution of latex condoms is done by local health departments, but many at risk individuals would not or do not feel comfortable coming to the health departments to obtain condoms. Efforts should be focused on developing additional sites where people of color feel free to obtain prevention supplies.

On a community level, there are few interventions for at-risk populations who seek to reduce risk behaviors by changing attitudes, norms and practices through health communications, community mobilization and community wide events. Intervention specific activities for African-Americans include Soul Fest events, Roots and Heritage Festival, Jubilee, Balm in Gilead, and the African American and Hispanic Leadership Conference on AIDS.

HISPANIC

Every county health department now has access to interpreters. The Lexington-Fayette County Health Department provides two interpreters and several volunteers. Matthew 25 and Heartland Cares each have one interpreter. There are still issues of distrust, as many of the Hispanic/Migrant worker population are undocumented working immigrants.

From a former Hispanic CPG Member: “In the Hispanic community it is common, even for a married man with children, to go out and have sex with other men. They usually stay within their own community to seek out other men. Although it is known it is never talked about. I would say over 50% of married men go out on their wives with other men and alcohol and drugs does play a role. 75% to 80% of single Hispanic men will seek out some form of sex from other men. Hispanics have a macho problem and will seek MSM secretly within the Hispanic community. It is socially accepted but not talked about. Hispanic men would rather get a free blow job from a man than pay twenty dollars to a prostitute.”

MOTHERS WITH/AT RISK OF HIV

As with other risk groups, there are too few interventions that target mothers with/ at risk of HIV. The local health departments provide CTRPN.

The greatest concern for this risk group is the identification and access to women who are IDUs, sex trade workers, and/or partners of MSMs, bisexual men, or other high risk or infected individuals. Another significant need is the provision of services at times that these at-risk women are able to access them. As with other at risk groups there is the need to provide interventions that target community norms or values that promote and support safer practices, communication skills and access to latex products and perinatal prophylaxes for infected women.

TRANSGENDER

The University of Kentucky Needs Assessment Report provides evidence of Transgendered men on the DL (“down low”) also being un-reached. Additional anecdotal evidence from former CPG members underlines the need for pilot efforts to reach these populations.

From a Transgendered former CPG Member: “Men on the DL tend to want the illusion of the female, but because sometimes they choose to be penetrated and do not want



this act to take place by another man, they go to transies. DL brothers should be included with the transies because they are the trade. A good term for people on the DL as well as transies could be Bridge Crossers, because they are living the life style of both worlds. Infection rates of transies are very high because most of them tend to make a living on the streets, because being accepted and hired on a normal job is not very easily achieved.”



SECTION
5c
STRATEGIES

FINDINGS AND RECOMMENDATIONS

EVALUATION

KHPAC met over several meetings to prioritize interventions for the year 2010. (See section on Population Prioritization)

The following report is guided by the HIV/AIDS epidemiology profile of Kentucky, 2009 SCSN, and the 2007 Needs Assessment. Accepted and proven evidence shows that all new HIV infections are a result of direct and indirect contact with an HIV positive individual. Therefore, in order to combat the spread of HIV, the concentrated effort of interventions must be directly aimed at those that are HIV positive and those most at risk of becoming infected with HIV.

KHPAC members chose to focus more on details of existing interventions and the introduction of new approaches than on a grading system using the prioritization tool. The committee decided the prioritized list from the 2009 Revised Prevention Plan would be used as a guide for the 2010 Plan. KHPAC believes it is important to spread the funding across the full range of interventions and pilot programs. The approach of funding every intervention and program to some extent may be the only way of evaluating as quickly as possible the practicality of any single project.

A large percentage of interventions are directed toward HIV positives. However, there is a limit to how much personal contact and guidance that the average client is willing to allow. There must be a concentrated effort among PSs to instill a sense of responsibility among those who are HIV positive.

Since there is an assumed limit on the effectiveness of risk reduction behaviors, KHPAC recommends that the focus of all interventions be based on harm reduction principles. When HIV positive or high-risk clients choose to engage in risky sexual, drug related, or judgment impairing activities, the principle of harm reduction allows clients to engage in these activities in a more responsible manner. The focus of this three-year planning cycle has been on expanding efforts in CRCS. A youth centered intervention continues to be a critical need. Youth are a major concern within the epidemic.



RECOMMENDATIONS

EASTERN AND NORTHERN REGION

Cultural and rural geographic barriers are the main deterrents to effective outreach in these regions of Kentucky. Recommendations are increased public media campaigns and increased PSE approaches that are now allowed during times of high activity. We believe a sector of the Hispanic population in this region can be reached through community mobilization. A higher concentration of CRCS specific to IDUs is also necessary in this region.

NORTH CENTRAL REGION

In Jefferson County, the groups that remain at highest risk with the greatest level of unmet need are biological and transgendered women. Prevention strategies, such as DEBIs should be designated to address these communities.

WESTERN REGION

Rural Western Kentucky continues to lack an effective number of CBOs. Capacity Building is needed immediately to serve this large area. Concentrated African American and Hispanic populations continue to be the most underserved and under represented. The most effective intervention seems to be with MSM PSs and PSE outreach as often as possible. Community Mobilization efforts are addressed for this region in this section under Community Mobilization requests. The time consuming travel of this geographic area is a great barrier. More cost effective interventions are being considered for this region.

CAPACITY BUILDING GUIDELINES

Capacity building efforts should be used to reach organizations that are interested in becoming contracted CBOs that will be addressing the concerns of emerging minority populations. It is assumed that in order to reach a specific population, a culturally sensitive CBO needs to be in place to first reach out to volunteers for assistance with this population and then to offer culturally inclusive Prevention Specialists, the needed contact with this population. The need for direct contact with capacity building efforts is seen in the Eastern and Western regions. The transgender and Hispanic communities are lacking interventions. Individuals should be recruited to work in their own communities, targeting all risk groups with special emphasis on transgendered and Hispanics, organizing outreach and peer-to-peer influence at a grass roots level.

COMMUNITY MOBILIZATION

Community Mobilization money needs to be made available for continuation of community awareness initiatives. These community mobilization events should address the needs of at risk communities. The successful local and statewide organizational efforts that need continued funding as well as new funding are:

- a. Come Together Kentucky Conference
- b. The KY Conference on HIV/AIDS and Hepatitis
- c. Owensboro/Henderson Dust Bowl
- d. National Black HIV/AIDS Awareness Day



- e. World AIDS Day
- f. Pride Fair of Louisville
- g. National HIV Testing Month
- h. Latino/Hispanic HIV/AIDS Community Awareness Activities

OUTREACH TO HISPANIC POPULATIONS

While existing epidemiological data lacks reliable figures of transmission rates among members of Kentucky's exploding Hispanic population, anecdotal evidence suggests a pressing need for effective outreach. The existence of seasonal migrant workers and a less mobile, more stable Hispanic community working in year-round industries indicates a two-pronged approach.

The DPH has established a very good working relationship with the Area Health Education Centers in Kentucky and the Bluegrass Farmworker Clinic who provide services to the Hispanic and Latino communities.

MINORITY AND INDIGENOUS PREVENTION SPECIALISTS

The Prevention Plan must not overlook the need for culturally specific and indigenous CBO's and PSs (formerly CHOWs) contracted for their targeted at risk populations. For instance, CBOs that work with IDUs should be staffed with former IDUs or people with highly specific education and credentials relative to that community. This applies as well to MSM, MSM/IDU, MSMOC, HIV + etc.

Support should be given to CBOs or individuals qualified to address a gap in prevention efforts. Shortfalls in prevention should be addressed by using Capacity Building funds to increase the ability of CBOs to qualify as a contracting organization as well as recruit, hire and retain indigenous PSs specific to their targeted at risk populations.

OTHER RECOMMENDATIONS AND CONCERNS

NEEDLE EXCHANGE

The number one recommendation of KHPAC is, as in the past, needle exchange programs. Kentucky paraphernalia laws prohibit the possession, sale or distribution of injection equipment preempting any plans for needle exchange programs. The introduction of harm reduction principles for IDU's has been an incremental process and particularly difficult in agencies traditionally based on abstinence only substance abuse programs.

While no official endorsement of needle exchange program has been forthcoming from DPH, the commissioner did, in an interview with a Lexington television station, state his "belief" that such programs work. A lack of political will by Kentucky lawmakers to revise statutes to decriminalize activities related to needle exchange programs remains the largest single barrier to HIV prevention statewide. DPH should provide leadership in this area.

CTS EVALUATION

KHPAC recognizes the importance of Counseling and Testing Services in the prevention process. In 2001 the University of Kentucky evaluated sites throughout the state. The UK evaluation cited numerous problems with the protocols used by the testing sites. The evaluation cited problems beginning with appointment information and continuing with pre-test and post-test counseling of clients. A plan to address these recommendations is listed in the gap analysis section.



MSM/IDU

For 2010, MSM/IDU has been prioritized as the number five at-risk population in Kentucky. PS assignments were directed to regional needs, (1) MSM/IDU PS for Western Kentucky, (2) PS's for North Central and (1) for Eastern Kentucky. Continued training and adjusting of approaches to this community are a necessity if significant results are to be expected in this population. In spite of these efforts, this population continues to be underserved and IDU PSs continue to be disconnected with this population. MSM/IDU indigenous workers are desperately needed in this community.

YOUTH

It should be stressed that while Youth at Risk (YAR) is not prioritized as a separate target population, it is highly prioritized as a component of all target populations. KHPAC believes that interventions targeting young MSM/IDU, MSMOC, MSM and all risk groups are of major concern. It is a recognized problem, that with the longevity of this disease, a generation gap exists in planning proper intervention strategies. Initiatives to properly convey the realities of this disease to future generations must not only be creative to be effective, but must derive its design from the at risk group. CBOs and outreach workers must develop component programs with the input of at risk youth as an ongoing part of their prevention efforts.

STREET OUTREACH, PSE OUTREACH AND OFF-SITE TESTING

Previous recommendations have stressed the importance of street outreach, effective PSE outreach and off-site testing.

Using OraSure and OraQuick and other technologies to increase testing in all high-risk populations, contracts must require interventions to take place at the corresponding time of day or night when high-risk behaviors occur. Contracts must require training for PSs in effective outreach strategies, counseling and testing protocols, harm reduction training/utilization.

These combined activities will serve to reduce HIV, STD, TB, and Hepatitis transmission.

PROGRAM OVERSIGHT

Intervention oversight and implementation is directed in two different ways, either by state oversight delegated by statutes and contract language, or by independent contractor evaluation. We recommend that the daily intervention work report should list the number of daily hours worked and the hours of the day that the work took place. Without a comparison of the time of day that the work took place, there is no way to determine if the intervention is taking place at peak hours of activity. Comparing the two timelines will allow for more efficient scheduling and coordination between PSs and Initiative Coordinators.

With implementation of PEMS and the purchase of PEMS hardware, more accurate monitoring and evaluation data will be available to assist in the assessment of the effectiveness of specific interventions.

SURVEILLANCE AND REPORTING

HIV case reporting data has been available since December 2007. HIV data will assist in more clearly identifying emerging at risk populations.





How Will Kentucky Get There?

1. Performance Measures, Goals, Objectives and Strategies:

The Comprehensive Prevention Plan is a roadmap to guide Kentucky's Prevention program with performance measures, goals, objectives and effective strategies to address the prevention needs and gaps with appropriate interventions that have been identified. The priority challenges identified for the Comprehensive Plan are broken down into the following categories:

GOALS

1. Collaborations (Internal DPH Collaborations and the Departments of Medicaid and Medicare Services)
2. Develop a List of a Wide Range of Stakeholders
3. Provide Oral Health Providers with Educational Material on HIV Prevention
4. Clarify regulation 902 KAR 2:020.
5. Cultural Competency
6. Mandatory Testing of Pregnant Women
7. Service Integration
8. Correctional Initiatives: HIV education, testing and linkage to care and treatment services - upcoming
9. Transportation
10. Internet-Based Interventions
11. Faith-Based Intervention
12. Partnerships with African American churches and Indigenous organizations
13. Rapid Testing
14. CTS Refresher Course
15. HIV and Substance Abuse
16. Science-Based Comprehensive Education Bill



SECTION 1. How Will Kentucky Get There?

Increase Collaboration between community based organizations, clinics and local health departments

Short and Long -Term Goals

Collaboration: 1

1. Ensure that the internal DPH taskforce examine collaborative opportunities to establish coordination between HIV/STI prevention and the Kentucky Care Coordination program. This task force will also work on ensuring a seamless link for newly diagnosed individuals. Steps to reaching goal include obtaining information from local agencies on services currently offered. Enhance collaboration activities between organizations providing services

Performance Measure	Action Step	Responsible Parties	Goals
<ul style="list-style-type: none"> • Reduce the burden of unmet need by at least 5% by December 2012 • Establish at least one LHD and Ryan White partnership by December 2012. • Task force to established by 2009 • 2010-2012 For implementation 	<ul style="list-style-type: none"> • Perform unmet need data matching with VA • Gather data and information to support future statewide expansion of the project. 	DPH Task Force: HIV branch, Communicable Disease, STD, Immunization branch managers	<ol style="list-style-type: none"> 1. Reduce the burden of unmet need by identifying/diagnosing early PLWHA and linking them to care and treatment services. 2. Establish a partnership with a local health department and Ryan White entity to provide regional comprehensive mobile services in eastern and south central Kentucky.

SECTION 2. How Will Kentucky Get There?

Develop a List of a Wide Range of Stakeholders
Short and Long -Term Goals

Resource Inventory:1

Develop a comprehensive list of stakeholders that provide prevention care and support services.



Performance Measure	Action Steps	Responsible Parties	Goals
<ul style="list-style-type: none"> • Have resource inventory ready by December 2010 • Have prevention section of resource inventory completed by October 1, 2009 	<ul style="list-style-type: none"> • Transform the database into a searchable tool by December 2010 • List to be distributed to parties outside our networks such as family care providers, local health departments, mental health and substance abuse, jails, and prisons. List to be posted on DPH, HIV website, college and university health centers, high school resource centers, etc. 	<p>HIV Branch and IT department</p>	<ol style="list-style-type: none"> 1. Develop comprehensive list by December 2010 2. Distribute list by June 2011



SECTION 4. How Will Kentucky Get There?

**902 KAR 2:020 Recommendation Pertaining to Disease Surveillance - Include language regarding the inclusion of more health care facilities
Short and Long -Term Goals**

902 KAR 2:020: 1

Clarify regulation 902 KAR 2:020. Disease Surveillance to clearly identify what entities are required to report new HIV and AIDS cases.

KHPAC recommends that the Cabinet revise 902 KAR 2:020 Section 7 (1) so that the regulation is more inclusive, regarding which healthcare providers and facilities are required to report diagnosed cases of HIV and AIDS.

Performance Measure	Do	Responsible Parties	Goals
By August 2009	<ol style="list-style-type: none"> 1. HIV/AIDS Branch to make recommendation to Cabinet 2. Follow up with responsible parties to see if the cabinet will promulgate it. 3. HIV Branch to report back to KHPAC 4. KHPAC to follow up on feedback by writing letters 	<p>HIV Branch</p> <p>HIV Branch</p> <p>HIV Branch</p> <p>KHPAC</p>	<ul style="list-style-type: none"> • Include language regarding the inclusion of more health care facilities



SECTION 5 How Will Kentucky Get There?

**Cultural Competency
Short and Long -Term Goals**

Collaboration:1:

HIV Branch to provide cultural competency training to all DPH funded service providers within HIV/AIDS service area. Training open to non DPH funded agencies.

Performance Measure	Action Step	Responsible Parties	Goals
<ul style="list-style-type: none"> • HIV Branch to provide cultural competency training to all DPH funded service providers, training is open to non DPH funded agencies at least three times a year • HIV Branch to provide online cultural competency course by 2012 	<ul style="list-style-type: none"> • Seek SEMI participation in the AAHLC, with the goal of allowing participation in the HIV courses for interpreters and participants. • Secure interpreting services for KHPAC meetings • Provide cultural competency workshops for 2009-2010 for the HIV state conference and AAHLC • Seek agency that already has relevant pre and post tests for HIV 101 course. 	<p>HIV Branch</p>	<ul style="list-style-type: none"> • Collaborate with available medical health interpreters to provide them with HIV 101 courses and provide interpreters at relevant forums • DPH to provide HIV 101 to associations, service providers and other stakeholders



SECTION -7. How Will Kentucky Get There?

**Service integration - Perinatal
Short and Long -Term Goals**

Collaboration: 1
HIV/AIDS Branch to collaborate with Adult and Child Health program to determine the structure of their HIV perinatal accountability services and data collection system with service.

Performance Measure	Action Step	Responsible Parties	Goals
<ul style="list-style-type: none"> By March 2010 HIV Branch staff to have initial meeting with ACH program Second meeting TBD 	<ul style="list-style-type: none"> Check with ACH to see if prenatal testing data is available (collect data if available) If not assist ACH in developing a shared data collection system 	DPH Staff – Tom Collins	2010 and beyond

**SECTION. 8 How Will Kentucky Get There
Correctional Initiatives
Short and Long -Term Goals**

Collaboration:
Part B & Prevention Services: The HIV prevention program Kentucky will collaborate with Part B Services Program, the STD & TB programs, and the Department of Corrections to develop and implement a targeted HIV education, testing & linkage to care services pilot project during the initial intake process of inmates at the LaGrange correctional facility (responsible for intake processing for all state male inmates and is the medical facility housing the largest number of HIV+ inmates). Also, a refresher HIV education course and targeted testing to inmates with the highest HIV risk factors will be provided during their stay at this location.

Performance Measure	Action Steps	Responsible Parties	Goals
1. By December 31, 2009 the Part B grantee staff in collaboration with the HIV prevention program, the STD & TB programs, and the Department of Corrections will complete 100% of the design & development of	<ol style="list-style-type: none"> Request TA through the CDC CRIS system for subject matter expert to guide corrections initiative efforts & provide training. HIV prevention and care staff to research and collect sample projects from other states. 	<ol style="list-style-type: none"> Part B grantee and HIV prevention staff. HIV/AIDS and Communicable Disease Branches 	<ol style="list-style-type: none"> Reduce the burden of unmet need by identifying incarcerated PLWHA and linking them to care and treatment services. Provide basic HIV education, risk reduction and behavior



<p>the pilot project</p> <ol style="list-style-type: none"> 2. By December 31, 2010, a 100% of incoming inmates identified as “at-high-risk for HIV infection” will be provided with HIV education, testing & linkage to care services during the initial intake process. 3. By December 2011, commence providing to a 100% of inmates at high risk for HIV infection, incident based testing, continuing peer education, group behavioral change interventions, and linkage to treatment and care while housed at LaGrange. 	<ol style="list-style-type: none"> 3. Compile a resource inventory of relevant resources and partner/referral agencies. 4. Convene task force of relevant stakeholders to identify and outline action steps and project activities. 5. Design pilot project components (education program, testing project, peer based initiative, behavioral change intervention, linkage to treatment and care services). 6. Conduct cost analysis and identify key personnel to staff project. 7. Commence initial project activities in 2010. 	<ol style="list-style-type: none"> 3. KY Department of Corrections 4. DOC, DPH and KHPAC 	<p>change skills to inmates at high risk for HIV infection.</p> <ol style="list-style-type: none"> 3. Link HIV+ exiting inmates to care and treatment services. 4. Reduce the HIV transmission rates among inmates and from inmates to the general population. 5. Enhance collaboration activities between organizations providing services that are relevant to incarcerated persons and exiting inmates. 6. Develop an inmate specific and comprehensive resource inventory list. 7. Gather data and information to support future statewide expansion of the project. 8. Collaborate with stakeholders including KHPAC to develop and promulgate inmate testing bill
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SECTION 9. How Will Kentucky Get There?

**Transportation
Short and Long -Term Goals**

Prevention: 1

Explore additional resources to provide transportation to outreach workers in rural areas

Performance Measure	Action Step	Responsible Parties	Goals
<ul style="list-style-type: none"> By the next grant cycle, review contracts to enhance transportation to rural areas. 	<ul style="list-style-type: none"> Explore alternative methods such as internet to reach rural populations Implementation of new contracts, with revisions to emphasize travel to rural areas 	HIV Branch	By June 2010 <ul style="list-style-type: none"> Work with contract supervisors to determine the efficiency of current travel spending and make recommendations to provide transportation to outreach workers in rural areas by June 2010



SECTION 10 How Will Kentucky Get There?			
Internet-Based Intervention Short and Long -Term Goals			
Prevention: 1 Develop and implement statewide and internet-based outreach program			
Performance Measure	Action Step	Responsible Parties	Goals
<ul style="list-style-type: none"> Negotiate a contract for the internet service for MSM internet interventions by Dec. 2009 Begin implementation of MSM online intervention by April 2010 Explore expansion of online intervention to other at-risk populations by 2012 	<ul style="list-style-type: none"> Develop and implement an internet-based outreach venue for MSM as a pilot project Explore opportunities to reproduce project to other at-risk populations methods such as internet to reach rural populations 	HIV Branch	<ul style="list-style-type: none"> Negotiate a contract for the internet service for MSM internet interventions by Dec. 2009 Begin implementation of MSM online intervention by April 2010 Explore expansion of online inter

SECTION 11 How Will Kentucky Get There?			
Faith-Based Short and Long -Term Goals			
Prevention: Expand faith based HIV initiatives to a wide array of faith communities			
Performance Measure	Action Step	Responsible Parties	Goals
	<ul style="list-style-type: none"> Collaborate with non African-American faith-based organizations to explore opportunities for HIV testing, education within a wide range of faiths 	HIV Branch	By 2013



SECTION 12 How Will Kentucky Get There?

**Short-Term Goal
HIV Prevention**

Prevention:

The HIV Prevention Program will continue efforts to partner with African-American churches and indigenous organizations.

Measurement	Action Item	Staff	Goal/s
<p>By December 31, 2009, the HIV Prevention program will continue to develop efforts to partner with African-American churches, indigenous organizations, and educational groups.</p>	<p>1. HIV Prevention Staff will develop a list of churches and target them for collaboration to address HIV issues.</p> <p>2. HIV Prevention Staff will continue to sponsor the African-American Latino Leadership Conference that includes a Faith Based Initiative.</p> <p>3. The HIV Prevention Program will offer Capacity Building Funds to nontraditional partners, including churches and education groups, to host events targeting disproportionately affected populations focusing on HIV education and testing.</p>	<p>1. HIV Prevention Staff</p>	<p>1. Increase efforts to partner with African-American churches, indigenous organizations, and educational entities to educate, address, and foster service delivery regarding HIV.</p> <p>2. Decrease HIV stigma and increase awareness within African American communities.</p> <p>3. Timely identification of African American PLWHA and improvement of linkage to care and treatment services.</p>



SECTION 13 How Will Kentucky Get There?

**Rapid Testing
Short and Long -Term Goals**

Prevention: 1

Attempt to increase access to rapid testing across the state

Performance Measure	Action Step	Responsible Parties	Goals
	<ul style="list-style-type: none"> • Collaborate with stakeholders to explore the feasibility of implementing rapid testing • Participate in the test 1 million campaign to increase the number of African Americans who are aware of their status 	<p>Tom Collins – HIV AIDS Branch</p> <p>Black AIDS Institute</p>	<ul style="list-style-type: none"> • Continue to advocate for rapid testing and collaboration efforts achieve by June 2010 • Add five additional rapid testing sites with concentration on substance abuse treatment centers, student health centers, job corps by December 2010 <p>2010</p> <ul style="list-style-type: none"> • Increase by 50% of testing among blacks by June 2010 • Put on 10 testing events



SECTION 14. How Will Kentucky Get There?

**CTS Refresher Course
Short and Long -Term Goals**

Prevention: 1

Develop and implement a CTS refresher course to improve skills for CTS

Performance Measure	Action Step	Responsible Parties	Goals
<ul style="list-style-type: none"> • Course development - Completed • By June 2010 send out refresher recommendation to providers 	<ul style="list-style-type: none"> • Implement a CTS refresher course for LHD staff who have received initial training more than 5 years ago. • Send out refresher recommendation to providers • Put course on the state training website – TRAIN for participants to register by June 2010 		<p>2009 - 2010</p> <ul style="list-style-type: none"> • Course has been developed – Ready to implement • Inform CTS locations of availability of refresher course • Get course listed on TRAIN



SECTION 16 How Will Kentucky Get There?

**Science-Based Comprehensive Sex Bill
Short and Long -Term Goals**

SECTION 15. How Will Kentucky Get There?

**HIV and Substance Abuse
Short and Long -Term Goals**

Substance Abuse: The HIV Branch working with the Kentucky Part B Program will evaluate and assess the HIV Unmet Needs of areas in the State with the Highest Level of substance abuse, provide Education and Training to the Substance Abuse Centers in the Identified Area, and facilitate linkage to prevention, testing, and care & treatment services

Performance Measure	Action Step	Responsible Parties	Goals
<p>1. By December 31, 2010 the Part B staff will contact 100% of the identified substance abuse centers. By December, 2011, the HIV Branch will commence provision of HIV education and enhanced linkages to testing, care and treatment services within the identified homeless centers</p>	<ul style="list-style-type: none"> • The HIV/AIDS Branch will develop an inventory of relevant providers in the regions with the highest prevalence of substance abuse. • Part B & HIV prevention staff will meet with staff from the identified substance abuse centers. • The HIV/AIDS Branch will provide education and TA. for substance abuse center staff. • 3. The HIV/AIDS Branch will develop a service program to be implemented within the identified centers 	<p>HIV/AIDS Branch</p>	<ul style="list-style-type: none"> • Improve linkages and retention in care of substance abusers in order to reduce the burden of unmet need. • Improve HIV competency of substance abuse center staff • Improve early identification of substance abusers who are PLWHA



Legislation: 1

Collaborate with stakeholders to promulgate science-based comprehensive education Bill

Performance Measure	Action Step	Responsible Parties	Goals
	<ul style="list-style-type: none">Identify nontraditional youth venues and provide education and testing	Collaborate with KDE comprehensive School Health Initiative	<ul style="list-style-type: none">2010



SECTION
6
CONCLUSION

CONCLUSIONS AND RECOMMENDATIONS FOR PROGRAM COORDINATION

LINKAGE OF PRIMARY AND SECONDARY SERVICES

Many of the linkages are accomplished through referrals. The state maintains referral lists for prevention and care services. Some of the HIV PSs and health educators providing prevention interventions distribute pocket cards with referral sources and phone numbers for CTRPN and HIV Care Coordinators. Any individual who is targeted for prevention is encouraged to seek HIV testing, often through the use of OraSure or OraQuick. Individuals who seek testing are given information on sources of prevention and treatment. Individuals are also referred to substance abuse treatment, physicians, social services organizations, and AIDS Service Organizations (ASO). Individuals who test positive are referred to the Care Coordinator Program where coordination of many services occurs, and they are entered into HIV reporting. The services coordinated include travel, assistance with activities of daily living, physician referrals, drug and insurance assistance programs, legal aid services, etc. Many of the services provided to HIV positive individuals are funded through both state dollars and Ryan White CARE dollars and HOPWA.

THE LINKAGE OF PRIMARY AND SECONDARY SERVICES GOALS FOR 2010:

GOAL 1: Develop a comprehensive checklist of activities prescribed in this plan.

Objective 1: DPH to ensure that the goals and objectives of this plan are outlined in a time frame, and that all items are assigned to specific parties.

Objective 2: KHPAC will collaborate with DPH in monitoring all items on the checklist. Progress reports on this goal will be made semi-annually to KHPAC. This report should include a comparison of the year-end activities report to the application.

GOAL 2: Provide primary and secondary prevention services and/or referrals to all individuals who present for testing in Kentucky.

Objective 1: Ensure that all clients who test positive for HIV whether through PSs or CTSS receive HIV Care Coordinator Program referral, appropriate medical referrals, and social services referrals if indicated, as well as partner notification.

Objective 2: HIV positive and high-risk negative individuals are to be exclusively targeted for primary and secondary prevention activities.



Objective 3: Ensure that Care Coordinator clients who continue to practice high-risk behaviors are referred for CRCS and PS interventions. Develop a system to track these referrals.

Continued, Revised, or New Objective? Continued from 2009 Plan.

Activities:

1. The state should monitor and evaluate existing referral systems currently in place.
2. Continue to provide training for prevention specialists and other staff on referrals and existing resources.
3. Continue to provide training for Care Coordinators and other staff on referrals and existing prevention resources.

GOAL 4: Enhance linkages between HIV/AIDS Branch and TB Branch.

Objective 1: The DPH branch should ensure that clients who test positive for HIV are referred for TB assessment. Ensure that clients who test positive for TB are referred for HIV counseling and testing.

Continued, Revised, or New Objective? Continued from 2009 Plan

Activities:

1. Monitor and evaluate existing referral systems of TB and HIV testing programs currently in place.
2. Evaluate documentation of initial referrals and determine method of verifying client utilization of referrals to services.

LINKAGES WITH OTHER HIV PREVENTION RELATED ACTIVITIES

The HIV/AIDS epidemiological surveillance data, CTRPN data, and youth and adult behavioral survey results are utilized for development of the epidemiology profile. The CTRPN activities are addressed in this Comprehensive HIV Prevention Plan. Behavioral surveillance (both adult and youth) basic data and trend analysis data are utilized in planning interventions.

Coordination with STD, TB, Substance Abuse, Mental Health Services: Many referrals for HIV CTRPN occur through or at STD, specialty clinics and HIV CTS in local health departments. In addition, substance abuse clinics refer clients to various programs like CTRPN. Counseling and testing training is provided to individuals who perform these services. The PSs who target IDU and other substance abusers encourage individuals to get counseling and testing and treatment for drug abuse. Representatives of STD and CTRPN programs participate as advisors for KHPAC. Many PSs offer HIV OraSure testing in the field to targeted populations.

The Comprehensive School Health Program provides training to individuals on STDs, substance abuse, mental health, and HIV prevention. STD prevention and education and drug abuse prevention education is provided to the schools as dictated by local jurisdiction.



Coordination between public and nongovernmental programs: The DPH, local health departments, other government agencies, and private organizations work cooperatively in HIV prevention through the community planning process and the delivery of interventions and services. (See 'Introduction and Overview of KHPAC Process' for additional information).

ASSISTANCE AND SUPPORT ACTIVITIES

Recommendations regarding epidemiologic and behavioral surveillance: Epidemiologic data needed to enhance assessment include more accurate assessment of the size of the at risk populations targeted and minority and migrant worker populations and assessment of their risk. Migration data of individuals to and from areas with establishments that cater to at risk populations is needed as well. Migration data on individuals who travel out of counties and the state for counseling and testing, diagnosis, and treatment is needed.

KHPAC also requested data on methamphetamine use as a risk factor for HIV, as well as a comparison of rural and urban data be included in the Epidemiological Profile.

EVALUATION OF PLANNING PROCESS

This year has been the third year of working as the integrated Kentucky HIV/AIDS Planning and Advisory Council. KHPAC completed a survey in March and a focus group session of community stakeholders to gather information on how members felt about the community planning process and their part in it. KHPAC members report an overall sense of encouragement regarding the members of KHPAC working together to achieve the goals set out before them. PIR is ensured through recruitment and meeting facilitation. KHPAC members have worked hard together to learn the various components of KHPAC. Team building is emphasized to assist in recognizing and utilizing the similarities and differences among members. Some newer members indicated that they would benefit from mentoring.

KHPAC has continued integrate as many of the products as possible into cohesive documents, in order to fully integrate care, prevention and legislation and policy recommendations.

TECHNICAL ASSISTANCE ACTION PLAN FOR 2010 - 2011

1. Targeted Population Prioritization Tool (Prevention)
2. Cultural Competency
3. Orientation
4. Prioritization of Services Tool (Care and Services)
5. Resource Allocation Tool (Care and Services)

Following the completion of this plan, KHPAC members will be meeting to determine the most effective tools/ technical assistance to be implemented to further support the integration of Care, Prevention and Legislation, as well as meet the expectations of CDC, HRSA and KRS 214.640. KHPAC will continue to collaborate with DPH. Specific product related technical assistance will be used throughout the year to ensure that KHPAC members have in depth knowledge and appropriate tools to conduct the work before them.

