



The 2021 Kentucky HIV Integrated Prevention and Care Plan

September 2016

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Executive Summary

Since the submission of the last Kentucky Statewide Coordinated Statement of Need (SCSN) in 2012, the Kentucky Department for Public Health has been focused on expanding HIV prevention and testing services; developing new partnerships and providers for Ryan White Part B Services; and has begun investment in new HIV surveillance software that will result in real-time notification of new HIV cases.

This SCSN is designed to align with the National HIV/AIDS Strategy (NHAS) that was updated in July of 2015. The Kentucky HIV/AIDS Strategy emphasizes the four key components of the NHAS: 1) reduce new HIV infections; 2) increase access to care and improve health outcomes for people living with HIV; 3) reduce HIV related health disparities and health inequities; and 4) achieve a more coordinated national response to the HIV Epidemic. The Kentucky Integrated HIV Prevention and Care Plan also ties every goal and objective to the national goals and objectives.

The NHAS also discusses the disproportionate effect of HIV on many communities including: communities of color; the Lesbian, Gay, Bisexual and Transgender (LGBT) community; and youth. The Kentucky 2017 – 2021 SCSN has sought feedback and recommendations from communities of color and the LGBT community through a statewide series of focus groups, surveys and stakeholder feed-back sessions. The suggestions and recommendations of the needs assessment process was used to write this report, as well as create the Kentucky Integrated HIV Prevention and Care Plan, which will serve as the HIV/AIDS Branch guide for the next four years.

Kentucky has experienced a manageable number of new HIV cases over the last 10 years. The HIV Prevention Section has focused on training certified HIV testers and providing education and training and testing supplies to reach every at-risk community in the state. The Ryan White Part B Program has expanded services and increased partner agencies with a goal of every client achieving an undetectable viral load. These efforts will not be sufficient to meet the needs of the state going forward.

There are new pressures affecting the HIV/AIDS Branch that will require expanding our focus on women and women of color, People Who Inject Drugs (PWID), and young African American, Hispanic and white gay and bi-sexual men. In addition, HIV Prevention services must evolve to seek out these at-risk populations and provide culturally appropriate testing. The Ryan White Part B Program must design core medical and support services that reach HIV positive individuals in urban centers and rural “hollers.” The goal must be to continue to improve testing, access to care and patient outcomes.

The Kentucky 2017-2021 SCSN is the result of a collaboration between persons living with HIV, community representatives, AIDS Services Organizations (ASOs), public health departments, clinical providers, and the Kentucky HIV/AIDS Branch. The outcome of this collaborative effort is the SCSN that will serve as the template for the Commonwealth of Kentucky HIV Prevention and Ryan White Part B Services.

Introduction

The 2021 Kentucky HIV Integrated Prevention and Care Plan

The Kentucky HIV Surveillance, HIV Prevention, and Ryan White Part B Programs have developed the 2017-2021 Kentucky HIV Integrated Prevention and Care Plan to serve as the framework for the HIV/AIDS Branch for the next four years. The 2017-2021 Kentucky SCSN will provide the goals and objectives for the following activities: HIV Prevention and Testing, statewide HIV education and outreach efforts, and Ryan White Part B core medical services and support services. The Integrated HIV Prevention and Care Plan includes expansion of existing activities and services as well as the development of new programs including:

- Development and Implementation of a Rapid-Rapid HIV Testing Program,
- Development and Implementation of a new Linkage to Care Program,
- Startup of the statewide HIV “Helpline”,
- Participation in the Department of Public Health HCV/HIV prevention and testing program,
- Assisting with the Expansion of the Syringe Exchange Program,
- Expansion of Ryan White Part B Services,
- Cultural Competency Training and Outreach in Low-Income Urban and Rural Communities

This document was created through the collaboration of HIV consumers, advocates and stakeholders throughout Kentucky. The Planning Committee was formed by the Kentucky HIV/AIDS Planning and Advisory Council with participation from additional community representatives and HIV service providers. The emphasis of all of the planning, focus groups, and surveys has been the linking of the National HIV/AIDS Strategy (NHAS) to the final prevention and care plan.

The outcome of this year-long effort is a comprehensive document that effectively merges both the activities, goals and objectives of the HIV Prevention Section and the Ryan White Part B Services Program. This document truly shows the collaborative effort between the CDC Prevention funded activities and the HRSA funded Part B services.

The 2017-2021 Kentucky HIV Integrated Prevention and Care Plan will result in expanded HIV testing throughout Kentucky, faster entry into care settings for newly diagnosed HIV clients and tracking, outreach and intervention for persons who are HIV positive who have been lost to care. In addition, the HIV/AIDS Branch will emphasize the expansion of services in low-income and minority communities. The projected result of the implementation of this plan will be better health outcomes through achieving stable and undetectable HIV viral load levels for all persons with HIV living in Kentucky.

Section I: Statewide Coordinated Statement of Need/Needs Assessment

A. Epidemiologic Overview

A: Epidemiologic Overview:

1. Socio-Economic Description of Kentucky
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HIV/AIDS Epidemiological Profile for KY

Overview:

This section describes the HIV/AIDS epidemic in Kentucky, based on data reported to the Kentucky Department for Public Health as of December 31, 2015. It provides demographics of those newly diagnosed and those living with HIV disease, such as gender, race/ethnicity, age, and mode of transmission. The burden of HIV disease in Kentucky will be described, showing disease rates and trends among different demographic and behavioral groups. A geographic and behavioral profile will be included as well. Lastly, risk indicators for HIV disease will be discussed, including: persons unaware of their status and/or testing late for HIV, an estimate of persons with unmet needs for HIV care, risk indicators from survey data at the population level, drug overdose data and a vulnerability assessment of Kentucky's counties for HIV/HCV among drug users.

Understanding HIV Disease Surveillance Data:

The following terms and definitions may be helpful in understanding terminology used in this section.

- **HIV (Human Immunodeficiency Virus):** A retrovirus that infects the helper T cells of the immune system, resulting in (missing text)
- **AIDS (Acquired Immunodeficiency Syndrome):** Advanced stage of HIV infection characterized by severe immune deficiency. Diagnosed by the presence of at least one of 26 opportunistic illnesses or a CD4+T-lymphocyte count of less than 200 cells/ml of blood. T-lymphocyte count takes precedence over the CD4 T-lymphocyte percentage, and a percentage of less than 14% of the total white blood cells (lymphocytes) is considered only if the count is missing.
- **HIV Disease:** Persons with a diagnosis of HIV infection regardless of stage of disease. This includes persons with HIV (non-AIDS), as well as those who have advanced stages of the disease, i.e., AIDS.
- **Date of Diagnosis:** The date of an individual's initial HIV disease diagnosis.
- **Concurrent Diagnosis:** Both HIV and AIDS are diagnosed within a 30-day period.
- **Sex:** Sex designations in this report are based on a person's sex assignment at birth. According to the CDC, *Transgender* is an umbrella term that is used to identify persons whose sex assigned at birth does not match current gender identity or expression. Data for transgender persons are not presented in this report because information on gender identity (a person's internal understanding of his or her gender or the gender with which a person identifies) is not consistently collected or documented in the data sources used by HIV Surveillance Program. HIV surveillance personnel collect this information, when available, from sources such as case report forms submitted by health care or HIV testing providers and medical records, or by matching with other databases (e.g., Ryan White program data). In May 2012, CDC issued guidance to state and local programs on methods for collecting data on transgender persons and working with transgender-specific data. However, characterization of HIV infection among transgender persons in Kentucky requires supplemental data from special studies.
- **Age:** The designation "adults and adolescents" refers to persons aged 13 years and older; the designation "pediatric" refers to persons aged less than 13 years at time of initial HIV diagnosis.
 - **Current Age:** An individual's age or age group as of June 30, 2015.
 - **Age at Diagnosis:** An individual's age or age group at the time of initial HIV disease diagnosis.
- **Race and Ethnicity:** Ethnicity categories include Hispanics and non-Hispanics. Data for all non-Hispanics are displayed in combination with their racial groupings which include:
 - White (non-Hispanic)
 - Black or African American (non-Hispanic)
 - Other, including; Asian, Native Hawaiian or other Pacific Islander, American Indian or

Alaska Native (non-Hispanic)

- **Transmission Category**: Classification used to summarize the behavior or event most likely responsible for disease transmission. Each case is only included in a single transmission route.
 - **Men Who Have Sex With Men (MSM)**: Men who report having sexual contact with other men.
 - **Injection Drug Use (IDU)**: Individuals who report injecting nonprescription drugs.
 - **MSM/IDU**: Men who report having sex with other men and also inject nonprescription drugs.
 - **Heterosexual Contact**: A person reporting specific heterosexual contact with a person known to have, or to be at high risk for, HIV infection e.g., an injection drug user, a bisexual male (females only), or a person with hemophilia/coagulation disorder.
 - **Female Heterosexual Contact (FHC)**: Different than heterosexual contact above and applies only to persons whose birth sex is female. It includes a female who does not fit in the heterosexual contact category above, with no reported injection drug use, but reported sexual contact with a male and no additional information about the male's HIV status or behaviors. This category was accepted by the CDC in 2010 and Kentucky's data were revised starting with the June 2012 annual report to incorporate it. Cases previously categorized as "undetermined" and meeting these criteria were re-classified.
 - **Hemophilia**: Individuals receiving clotting factor for hemophilia/coagulation disorder.
 - **Perinatal**: Individuals born to a mother with HIV or a mother with an exposure history listed in the transmission category hierarchy.
 - **Blood Transfusion/Organ Transplant**: Individuals who received blood transfusions or organ transplants. Individuals with a transfusion date listed after March 1985 are considered cases of public health importance and are followed to verify the mode of transmission.
 - **Undetermined/No Identified Risk (NIR)**: Individuals reporting no exposure history to HIV through any of the modes listed in the transmission category hierarchy above.

Description of Kentuckians Newly Diagnosed with HIV Disease:

As of December 31, 2015, a total of 9,725 cumulative HIV infections had been reported among Kentuckians to the Department for Public Health’s HIV/AIDS Surveillance Program since AIDS reporting started in 1982. The numbers of new HIV infections diagnosed over the most recent ten years are presented in the table below, along with the percentage from each year that have progressed to AIDS. Of the 3,486 HIV infections diagnosed over the most recent ten years, 1,250 (44%) had progressed to AIDS as of June 30, 2015.

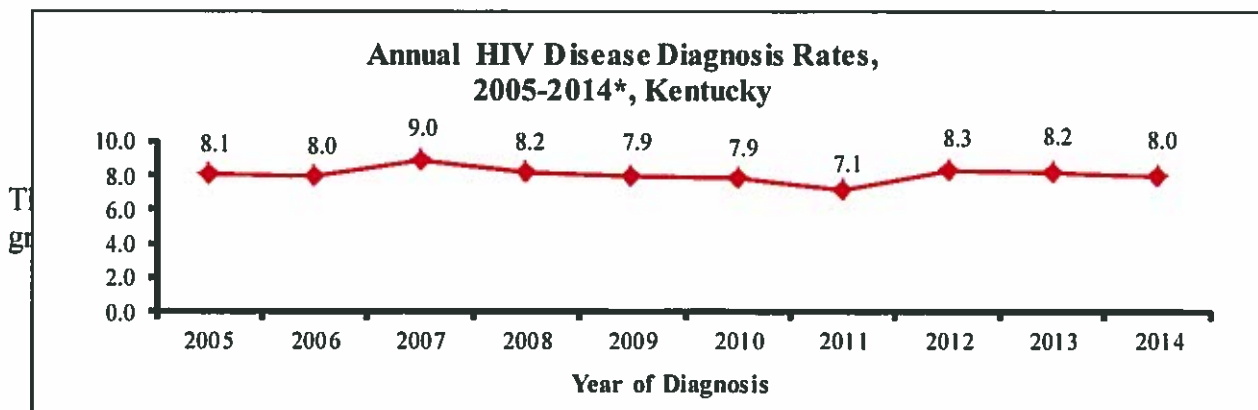
Number of HIV Infections per Year of Diagnosis (2005-2014[†]) and Percentage that Progressed to AIDS in the Course of Illness, by December 31, 2015, Kentucky

Year of HIV Diagnosis	TOTAL HIV/AIDS*	Percentage that Progressed to AIDS [†]
	No.	%
2005	337	55%
2006	339	58%
2007	381	49%
2008	353	50%
2009	342	43%
2010	344	42%
2011	311	43%
2012	365	34%
2013	362	33%
2014	352	30%
TOTAL	3486	44%

*Total HIV infections regardless of disease progression.

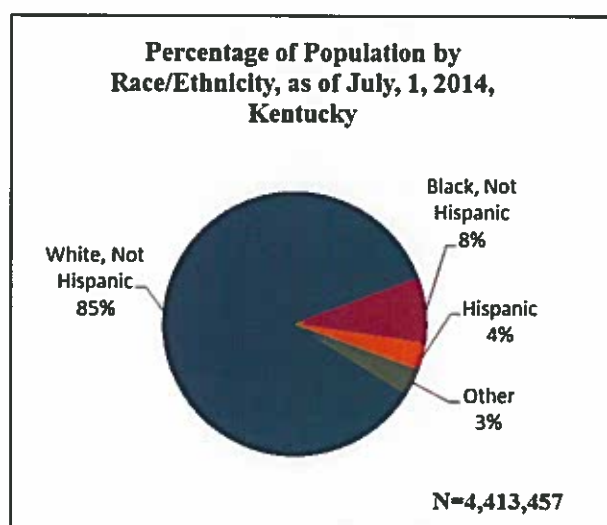
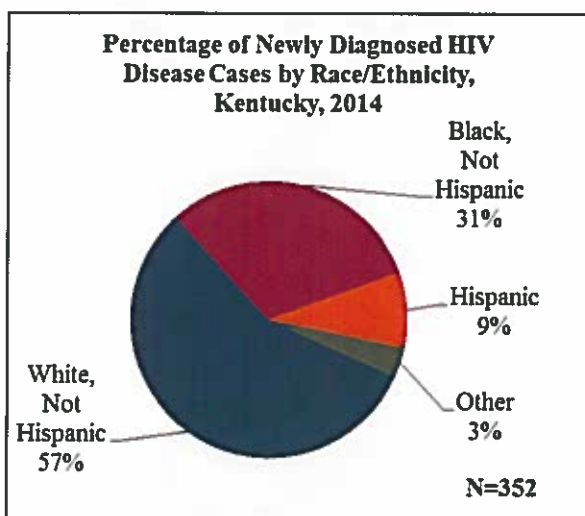
[†]Data reported through December 31, 2015.

The annual HIV diagnosis rates among Kentuckians are presented in the figure. The annual HIV diagnosis rate has remained fairly steady from 2005 to 2014, with slight fluctuations between 67.1 to 9.0 cases per 100,000 population.



Race/Ethnicity:

By Race/ethnicity, the majority of new diagnoses in 2014 were white, non-Hispanics (57%), followed by black, non-Hispanics (31%). A comparison of new HIV cases among minorities to their representation in the general population in 2014 shows significant disparities as highlighted in the charts below. Blacks accounted for 31% of new HIV cases diagnosed in 2014, yet comprised just 8% of Kentucky's population in 2014. Similarly, Hispanics accounted for 9% of newly diagnosed HIV cases in 2014, yet comprised only 4% of Kentucky's population in that same year.



Rates of new diagnoses by race/ethnicity and sex are presented in the table, further highlighting racial disparities.

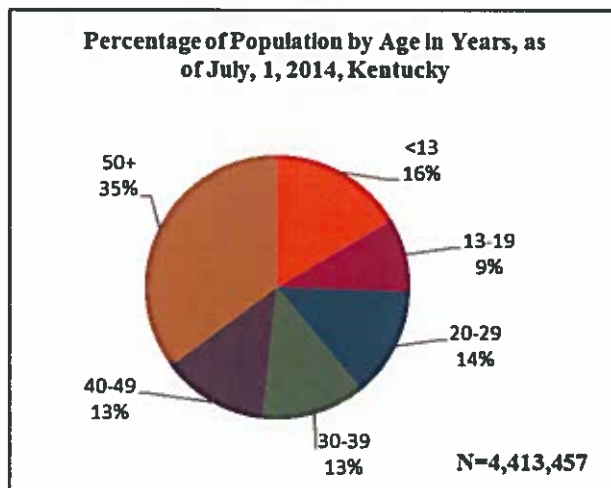
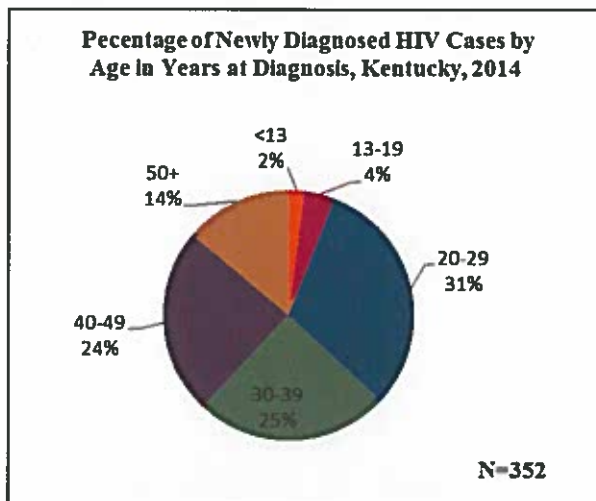
Race/Ethnicity	Male		Female	
	No of Cases	Rate*	No of Cases	Rate*
Hispanic	29	35.6	2	†
Black, not Hispanic	80	45.5	30	16.8
White, not Hispanic	172	9.3	27	1.4

*Rate per 100,000.

†Rates are not published when cell size is less than 10.

Age at Diagnosis:

The figures below shows the percentage distribution of Kentucky's population based on 2014 population estimates by age, which can be directly compared to the percentages in each age group that were newly diagnosed in 2014. HIV-related disparities by age are highlighted by these two graphs. Higher percentages of new diagnoses occurred among persons in age groups 20-29, 30-39, and 40-49 years, in comparison to the proportion of these groups in the general population.



Rates of new diagnoses (table) were higher among blacks across all age groups, in comparison to whites in 2014. These differences in rates of new cases in 2014 were highest among 20-year-olds and 30-year-olds at time of diagnosis. However, the rates among blacks in all age groups were four-five times higher than the rates among their white counterparts of the same age group. Rates among Hispanics are not presented due to small numbers.

Number and Rate of New HIV Diagnoses by Age at Diagnosis and Race/Ethnicity[§], Kentucky, 2014				
Age at Diagnosis	Black not Hispanic		White not Hispanic	
	No of Cases	Rate*	No of Cases	Rate*
20-29	39	66.8	60	12.2
30-39	24	50.4	49	10.0
40-49	21	47.8	54	10.8
50+	12	12.3	31	2.2

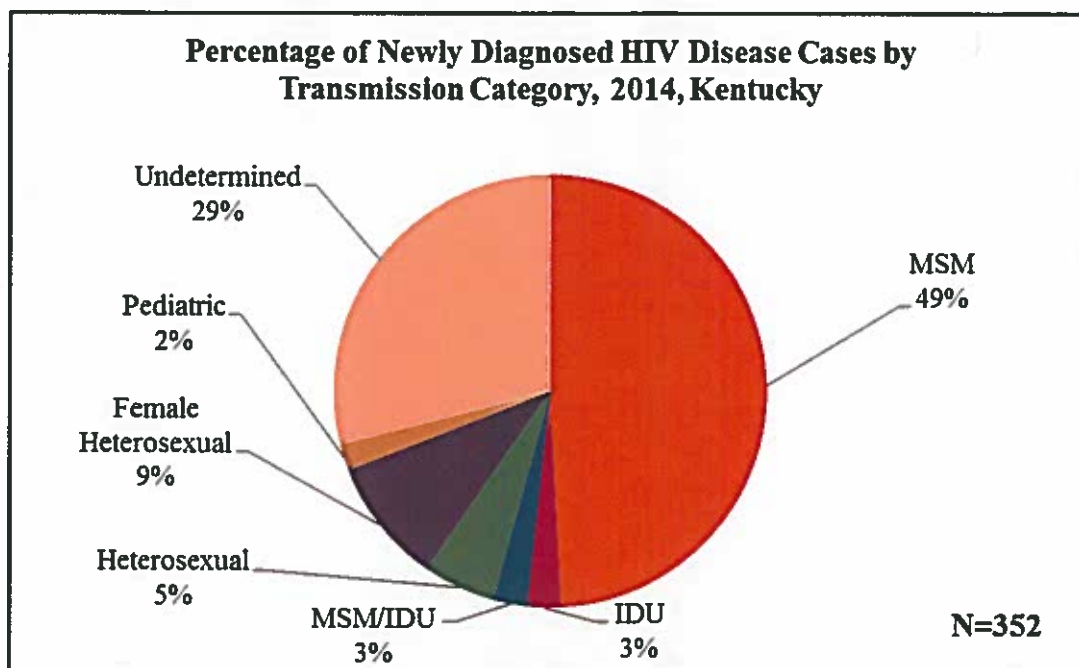
[§]Rates among pediatric cases (<13 years), teens and Hispanics by age at diagnosis not published due to small numbers.

*Rate per 100,000.

†Rates not published when cell size is less than 10.

Transmission Category:

In 2014, the majority of Kentuckians newly diagnosed with HIV disease identified their primary mode of transmission as MSM (49%). Five-percent reported heterosexual contact, while 9% reported female heterosexual contact with a male with unknown risk factors. Only 3 percent identified IDU as their primary mode of transmission and an additional 3% were a combination of MSM/IDU. Two-percent of new HIV cases in 2014 were among pediatrics under the age of 13. Twenty-nine percent of Kentuckians were reported with an undetermined mode of transmission.



Description of Kentuckians Living with HIV Disease:

As of December 31, 2015, a cumulative total of 9,725 HIV/AIDS cases have been reported in Kentucky, including 91 pediatric cases. Of these, 6,304 (65%) were still living as of December 31, 2015. The demographic distribution of living cases is displayed below.

HIV Disease Prevalence among Kentuckians by Demographic and behavioral characteristics as of December 31, 2015

Demographic Group/ Exposure Category	HIV DISEASE PREVALENCE THROUGH DEC 31, 2015	
	<i>HIV Disease Prevalence is defined as the number of people living with HIV/AIDS as of the date specified.</i>	
<i>Race/Ethnicity</i>	Number	% of Total
White, not Hispanic	3,630	58%
Black, not Hispanic	2,123	34%
Hispanic	344	5%
Other	207	3%
Subtotal	6,304	100%
<i>Sex</i>		
Male	5,128	81%
Female	1,176	19%

Demographic Group/ Exposure Category	HIV DISEASE PREVALENCE THROUGH DEC 31, 2015	
Subtotal	6,304	100%
<i>Current Age as of 12/31/15 (Years)</i>	Number	% of Total
<13 years	72	1%
13 - 19 years	290	5%
20 - 29 years	2,099	33%
30 - 39 years	2,006	32%
40 - 49 years	1,318	21%
50+ years	519	8%
Subtotal	6,304	100%
<i>Adult/Adolescent Transmission Category</i>		
Men who have sex with men	3,408	55%
Injection drug users	476	8%
Men who have sex with men and inject drugs	256	4%
Heterosexual	901	14%
Female Heterosexual Contact	275	4%
Hemophilia/Blood Transfusion/Transplant/Other	18	<1%
Risk not reported or identified	898	14%
Subtotal	6,232	100%
<i>Pediatric Exposure Categories</i>	Number	% of Total
Perinatal exposure, mother with HIV	28	81%
Pediatric Hemophilia	4	6%
Pediatric no risk reported	10	14%
Subtotal	72	100%

Notes:

Percentages may not total 100% due to rounding.

Cases were Kentuckians at time of initial HIV diagnosis, regardless of current residence.

Behavioral profile of Kentuckians living with HIV disease:

Demographic characteristics for the top three behavioral groups are presented in the following tables. White adults/adolescents account for the highest number of living HIV cases diagnosed among MSM and MSM/IDU (2,464 cases). The majority of white MSM and MSM/IDU adults/adolescents were aged 25-44 years old at time of diagnosis (68%). This finding is similar across all racial/ethnic groups, with the majority of black (53%) and Hispanic adults/adolescents (73%) being diagnosed in this age group. Among black and Hispanic adult/adolescent MSM and MSM/IDU, the second highest percentage of living cases is in the 13-24 age group (37% and 15%, respectively), whereas among whites, the percentage of infections among those aged 13-24 and 45-64 years old is similar.

Living HIV Diagnoses among Adult/Adolescent Men who have Sex with Men* (MSM) by Race/ Ethnicity, through December 31, 2015, Kentucky.

Age at Diagnosis	White		Black		Hispanic		Total	
	No.	%	No.	%	No.	%	No.	%
13-24	396	16%	347	37%	23	15%	766	22%
25-44	1686	68%	495	53%	115	73%	2296	64%
45-64	374	15%	95	10%	19	12%	488	14%
65+	8	<1%	4	<1	0	0%	12	<1
Total	2464	100%	941	100%	157	100%	3562	100%

*Includes persons with MSM/IDU mode of transmission

Data not inclusive of persons with other/unknown race/ethnicity

Note: Percentages may not total 100% due to rounding

Among adult/adolescent Kentuckians living with HIV disease who reported IDU as their primary mode of transmission, similar numbers of black and white cases were reported. A significantly smaller number of IDU cases are Hispanic. Across all racial/ethnic groups, the majority of cases were aged 25-44 years old at time of diagnosis (70% and 74% among whites and Hispanics respectively, 58% among blacks). Similar percentages of persons aged 13-24 years old at the time of diagnosis were reported across each racial/ethnic group. Persons aged 65+ years old accounted for <1% of IDU cases.

Living HIV Diagnoses among Adult/Adolescent Injection Drug Users (IDU) by Race/ Ethnicity, through December 31, 2015, Kentucky.

Age at Diagnosis	White		Black		Hispanic		Total	
	No.	%	No.	%	No.	%	No.	%
13-24	28	13%	26	12%	4	15%	58	13%
25-44	151	70%	126	58%	20	74%	297	65%
45-64	35	16%	65	30%	3	11%	103	22%
65+	1	<1%	0	0%	0	<1%	1	<1
Total	215	100	217	100	27	100	459	100

Data not inclusive of persons with other/unknown race/ethnicity

Note: Percentages may not total 100% due to rounding

Among adult/adolescent Kentuckians living with HIV disease who reported heterosexual contact as their primary mode of transmission, similar numbers of black and white cases were reported. A significantly smaller number of heterosexual cases are Hispanic. Across all racial/ethnic groups, the majority of cases were aged 25-44 years old at time of diagnosis (64% among whites and blacks, 59% among Hispanics). A higher percentage of persons aged 13-24 years old at the time of diagnosis was reported among Hispanics (27%), in comparison to 18% among blacks and 20% among whites. Persons aged 65+ years old accounted for <1% of heterosexual cases.

Living HIV Diagnoses among Adult/Adolescent Heterosexual Contacts* by Race/ Ethnicity, through December 31, 2015, Kentucky.

Age at Diagnosis	White		Black		Hispanic		Total	
	No.	%	No.	%	No.	%	No.	%
13-24	76	20%	74	18%	18	27%	168	20%
25-44	247	64%	261	64%	39	59%	547	64%
45-64	63	16%	68	17%	9	14%	140	16%
65+	2	<1%	2	<1%	0	0%	4	0%
Total	388	100%	405	100%	66	100%	859	100%

*Includes heterosexual contact with a person with HIV or at high risk for HIV

Data not inclusive of persons with other/unknown race/ethnicity

Note: Percentages may not total 100% due to rounding

There are 72 Kentuckians diagnosed as pediatric cases still living with HIV disease as of December 31, 2015. The majority of living pediatric cases (81%) were due to perinatal transmission through an HIV-infected mother; four cases were reported with a primary exposure route of pediatric hemophilia or coagulation disorders, and ten had no exposure history reported. Sixty percent (43 cases) of the 72 pediatric HIV cases are blacks, compared to 36% (26 cases) whites and 4% (3 cases) of other races.

Number and Percentage of Living Pediatric⁽¹⁾ HIV Disease Cases By Transmission Route and Race/Ethnicity through December 31, 2015, Kentucky

Transmission Route	White, Not Hispanic		Black, Not Hispanic		Other ⁽²⁾ Unknown		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Pediatric Hemophilia/Coagulation Disorder	4	15	0	0	0	0	4	6
Perinatal Exposure, Mother with HIV	19	73	36	84	3	100	58	81
Pediatric risk not identified or reported	3	12	7	16	0	0	10	14
TOTAL⁽³⁾	26	100	43	100	3	100	72	100

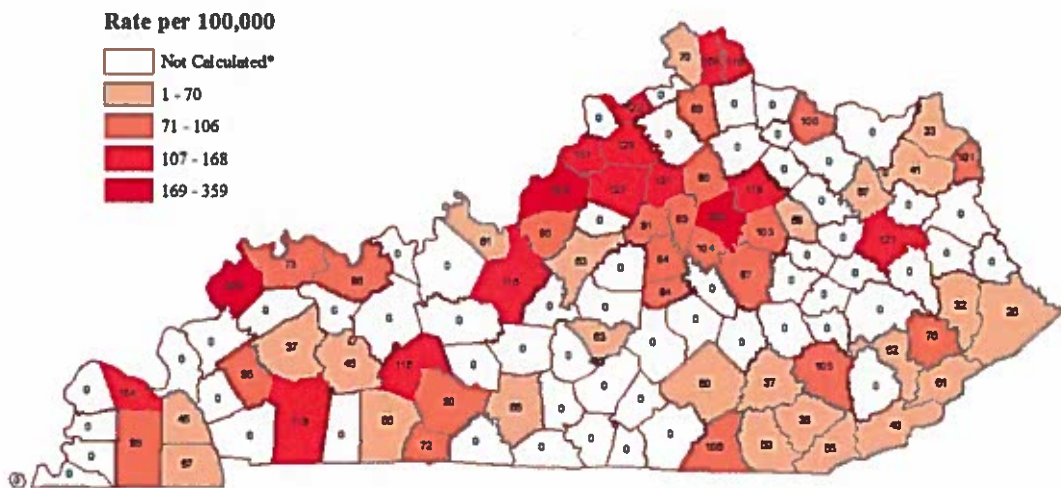
(1) Cases are classified as Pediatric if they are less than 13 years of age at time of diagnosis.

(2) Other includes Hispanics and persons of other races.

(3) Percentages may not total 100% due to rounding.

As of December 31, 2015, there were a total of 6,304 Kentuckians living with HIV disease. The map below presents prevalence rates per 100,000 population in each county. This is the rate of Kentuckians diagnosed while living in the specified county at time of diagnosis and not necessarily the current residence. At the end of 2015, Kentucky's prevalence rate was 142 per 100,000. Several counties exceeded this state rate: Jefferson County (359 per 100, 000), Fayette County (292 per 100, 000), Union County (266 per 100, 000), Kenton County (168 per 100, 000) and McCracken County (154 per 100, 000).

**HIV Disease Prevalence Rates (per 100,000)
by County of Diagnosis through December 31, 2015**

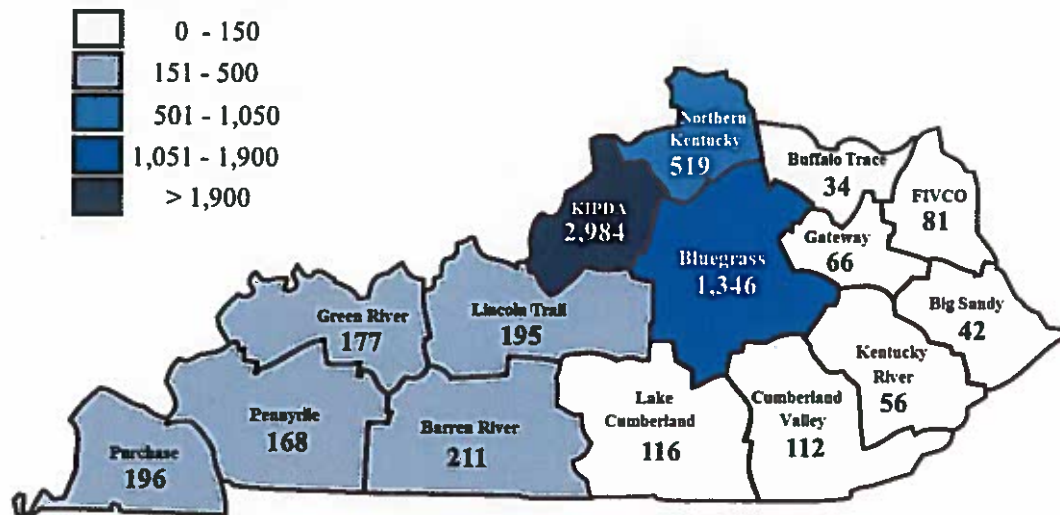


*Prevalence rates not published if number of living cases is less than 10. Presented on the map as an arbitrary 0.
1 case missing residential county information at time of diagnosis

The geographic distribution of living HIV cases by Area Development District (ADD) of residence at time of HIV diagnosis is displayed below. Data show that almost half of cases (2,984) were residents of KIPDA ADD at time of diagnosis. The Bluegrass ADD had the second highest number of cases (1,346) followed by Northern Kentucky (519). The eastern part of Kentucky has the smallest number of diagnoses reported.

Living HIV Disease Diagnoses by Area Development District (ADD) of Residence at Time of HIV Diagnosis through December 31, 2015, Kentucky

Living HIV Disease Diagnoses by ADD



1 case missing residential County information at time of diagnosis.

Demographic and behavioral characteristics of persons residing in the top three ADDs are displayed in the following tables.

KIPDA ADD Living HIV Diagnoses by Sex, Age at Diagnosis, Race/Ethnicity, and Transmission Category, through December 31, 2015, Kentucky

Characteristics	Total HIV Diagnoses	
	N	% ⁽¹⁾
<u>SEX</u>		
Male	2420	84
Female	564	19
<u>CURRENT AGE AS OF 12/31/15</u>		
<13	11	<1
13-19	21	1
20-29	354	12
30-39	550	18
40-49	786	26
50+	1262	42
<u>RACE/ETHNICITY-Females</u>		
White, Not Hispanic	169	30
Black, Not Hispanic	340	60
Hispanic	20	4
Other/Unknown	35	6
<u>RACE/ETHNICITY-Males</u>		
White, Not Hispanic	1253	52
Black, Not Hispanic	961	40
Hispanic	104	4
Other/Unknown	102	4
<u>TRANSMISSION CATEGORY</u>		
MSM	1593	53
IDU	212	7
MSM and IDU	108	4
Heterosexual	402	13
Female Heterosexual	149	5
Pediatric	29	1
Other	6	<1
Undetermined	485	16
TOTAL	2894	100

Percentages may not total 100% due to rounding

Northern Kentucky ADD Living HIV Diagnoses by Sex, Age at Diagnosis, Race/Ethnicity, and Transmission Category, through December 31, 2015, Kentucky

Characteristics	Total HIV Diagnoses	
	N	% ⁽¹⁾
<u>SEX</u>		
Male	425	82
Female	94	18
<u>CURRENT AGE AS OF 12/31/15</u>		
<13	≤5	≤5
13-19	≤5	≤5
20-29	56	11
30-39	93	18
40-49	140	27
50+	224	43
<u>RACE/ETHNICITY-Females</u>		
White, Not Hispanic	60	15
Black, Not Hispanic	26	28
Hispanic	**	**
Other/Unknown	≤5	≤5
<u>RACE/ETHNICITY-Males</u>		
White, Not Hispanic	334	79
Black, Not Hispanic	68	16
Hispanic	**	**
Other/Unknown	≤5	≤5
<u>TRANSMISSION CATEGORY</u>		
MSM	297	57
IDU	30	6
MSM and IDU	17	3
Heterosexual	76	15
Female Heterosexual	21	4
Pediatric	**	**
Other	≤5	≤5
Undetermined	67	13
TOTAL	519	100

Percentages may not total 100% due to rounding

** Data not released for confidentiality reasons

Bluegrass ADD Living HIV Diagnoses by Sex, Age at Diagnosis, Race/Ethnicity, and Transmission Category, through December 31, 2015, Kentucky

Characteristics	Total HIV Diagnoses	
	N	% ⁽¹⁾
<u>SEX</u>		
Male	1140	85
Female	206	15
<u>CURRENT AGE AS OF 12/31/15</u>		
<13	7	<1
13-19	10	1
20-29	148	11
30-39	301	22
40-49	362	27
50+	518	38
<u>RACE/ETHNICITY-Females</u>		
White, Not Hispanic	76	37
Black, Not Hispanic	103	50
Hispanic	21	10
Other/Unknown	6	3
<u>RACE/ETHNICITY-Males</u>		
White, Not Hispanic	759	67
Black, Not Hispanic	255	22
Hispanic	108	9
Other/Unknown	18	2
<u>TRANSMISSION CATEGORY</u>		
MSM	818	61
IDU	96	7
MSM and IDU	67	5
Heterosexual	167	12
Female Heterosexual	41	3
Pediatric	**	**
Other	**	**
Undetermined	138	10
TOTAL	1346	100

Percentages may not total 100% due to rounding

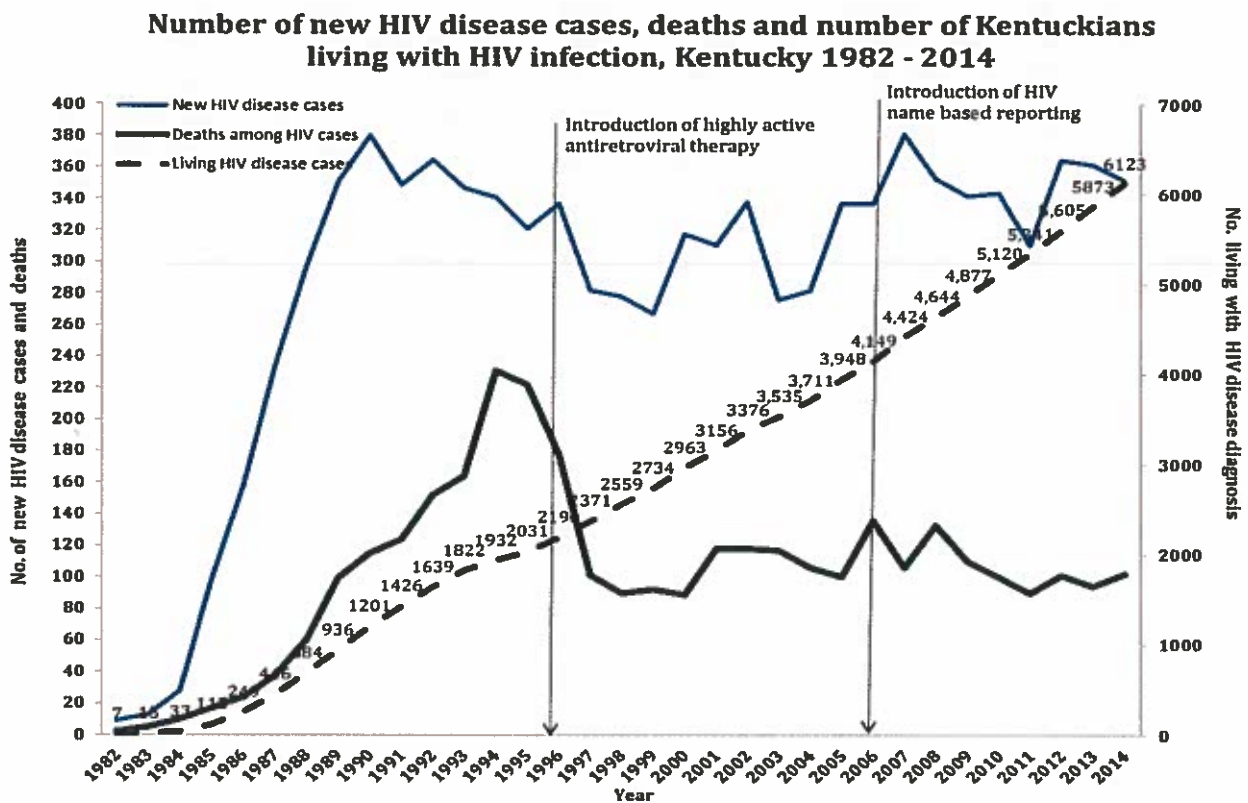
** Data not released for confidentiality reasons

Description of the burden of HIV in Kentucky:

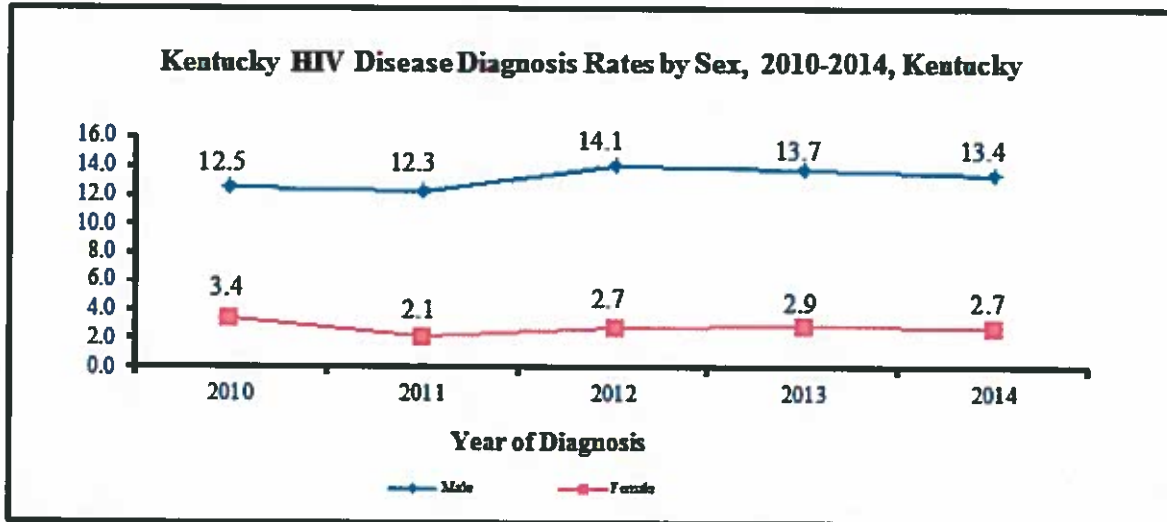
The HIV/AIDS epidemic continues to have a significant impact on the public health of Kentucky residents. Some of the most significant current rates, trends and geographic locations will be highlighted, showing populations most impacted.

HIV disease rates and trends:

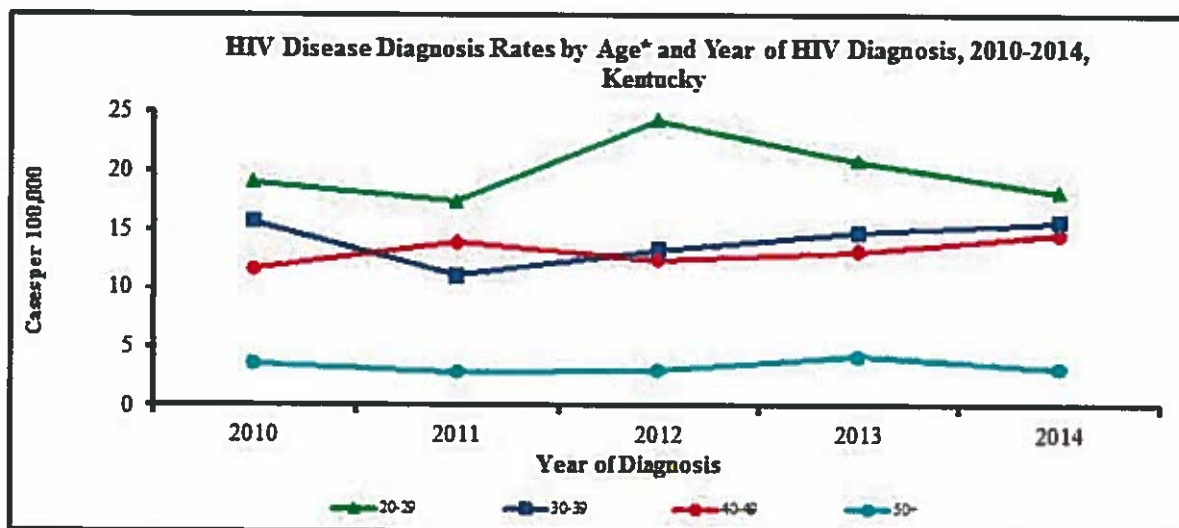
The chart below shows trends in the number of new HIV disease cases, deaths (of any cause) and number of Kentuckians living with HIV disease at the end of each year, between 1982, when the first Kentuckian was diagnosed to 2014. As the number of new infections increases or fluctuates each year and as deaths among those living with the disease started to taper off in the mid-1990s with the introduction of antiretroviral therapy, the number of persons living with HIV in Kentucky has seen an upward trend from seven cases in 1982 to 6,123 Kentuckians living with HIV in 2014.



Data for the most recent five years show annual diagnosis rates among males to be higher than those among females. These rates fluctuated between four to six times higher for males compared to females.



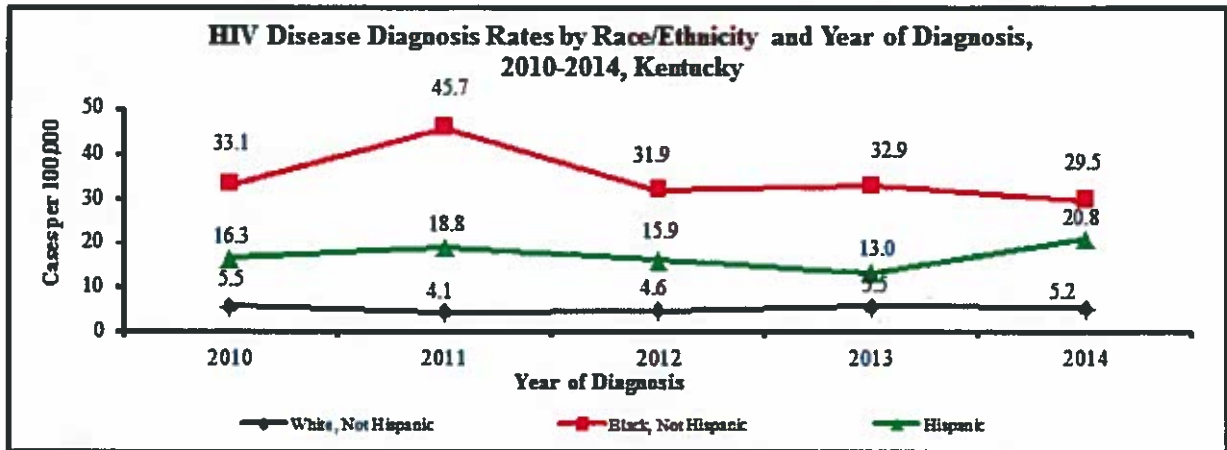
The diagnosis rates among Kentuckians aged 20-29 years reveal an upward trend while rates in the 30-39 and 40-49 year age groups fluctuated only slightly over the five year period. The yearly diagnosis rates among those 50 years and over have also remained stable over the five year period shown.



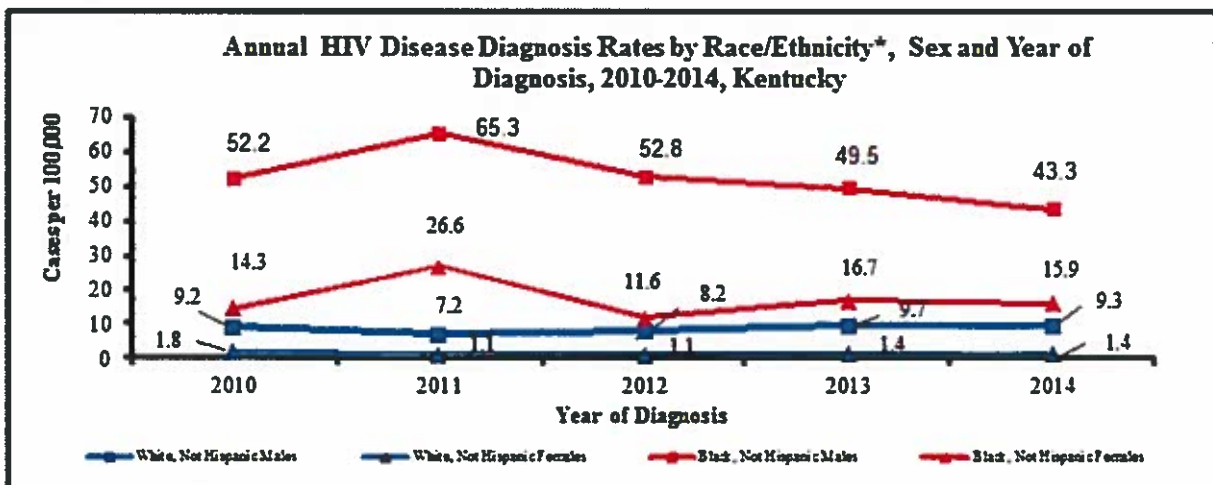
*Due to a small number of cases reported, rates are not presented for age groups 0-12 and 13-19 years old.

The overall trends for blacks and Hispanics show slight variations between 2010 and 2014, while the trends among whites have remained steady. The HIV diagnosis rates among blacks were 6.9

times higher than those among whites on average. Among Hispanics, the diagnosis rates were 3.4 times higher on average than those among whites.



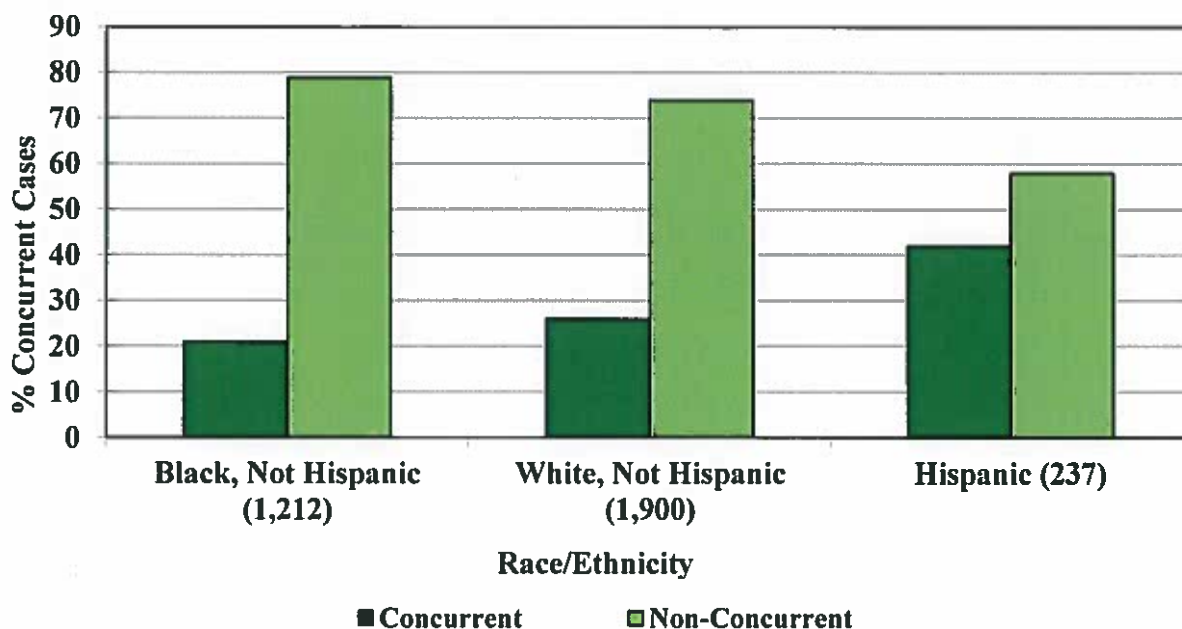
Over the most recent five years of data available (2010-2014), black males and black females had consistently higher rates of new diagnoses in comparison to their white counterparts. The HIV diagnosis rates among black males fluctuated between 4.6 to 9 times higher than that of white males. The rates among black females were 7.9 to 24 times higher than those of white females over the five year period.



*Rates for Hispanics are not included due to a small number of cases reported.

Concurrent Diagnoses and Late Testers:

Over the most recent ten years of the most complete data (2005-2014), there have been a total of 3,484 Kentuckians diagnosed with HIV disease. Of these, a quarter (880 cases) had progressed to AIDS within 30 days of the initial HIV diagnosis (also known as concurrent diagnoses). A third of concurrent cases were aged 40-49 years at time of diagnosis and the second highest percentage of concurrent diagnoses was among those aged 30-39 years at time of diagnosis (29%). The distribution of concurrent diagnoses within each behavioral group was highest among those reporting IDU (37% of all IDU cases) and among those without a risk factor identified (29% of all no-risk cases). The distribution within each racial/ethnic group is displayed in the figure below.

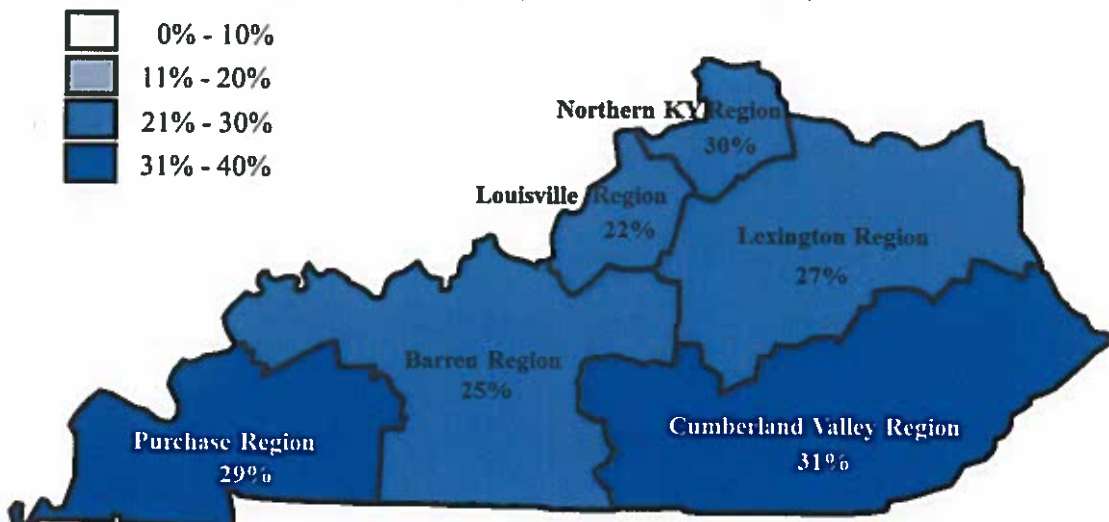


The distribution of all HIV disease cases diagnosed between 2005-2014 is displayed in the table below.

HIV Disease Diagnoses (2005-2014) by Care Coordinator Region	Number of Cases
Barren	352
Cumberland Valley	202
Lexington	902
Louisville	1,557
Northern Kentucky	272
Purchase	199
Total	3,484

The percentages of total HIV cases within each care coordinator region that were concurrently diagnosed with AIDS are displayed in the map below.

% Concurrent within Care Region : January 1, 2005- December 31, 2014



1 case missing residential information

Indicators of risk for HIV Disease in Kentucky:

Early Identification of Individuals with HIV/AIDS (EIIHA)/Unaware Estimate

Estimated number of Kentuckians living with HIV infection who were unaware of their status at the end of 2014*.

This estimate applies the estimated back calculation (EBC) methodology to the State's proportion of concurrently diagnosed HIV/AIDS cases within a 30 day period. Over the most recent ten years (2005-2014), 25% of Kentuckians diagnosed with HIV disease were also diagnosed concurrently with AIDS within 30 days.

At the end of 2014, there were 6,123 Kentuckians living with HIV infection (regardless of progression to AIDS). Therefore, using the EBC methodology, an estimated 2,041 Kentuckians are living with HIV infection and unaware of their status.

Kentucky undiagnosed estimate= $(0.25/0.75) * 6,123 = 2,041$ persons.

*Data are from the Kentucky Department for Public Health and current as of December, 31 2015.

Reference:

Campsmith, M., Rhodes, P., Hall, H. I., Green, T. A. (2010). Undiagnosed HIV Prevalence Among Adults and Adolescents in the United States at the End of 2006. *J Acquir Immune Defic Syndr.* 2010;53:619–624.

Burden of HIV Mortality:

Table below shows the reported number of deaths and death rates among persons diagnosed with HIV infection in Kentucky who were reported as deceased by health care providers, the Office of Vital Statistics, or an alternate data source as of December 31, 2015. Death data include deaths reported among persons diagnosed with HIV disease regardless of cause of death. There were 78 deaths among persons with HIV per 100,000 population in Kentucky as of December 31, 2015. The mortality rate was higher among males (135 per 100,000 population) than females (23 per 100,000 population), which is consistent with higher proportions of HIV diagnoses being male. Among both males and females, blacks had a higher mortality rate in comparison to whites: black females 11.5 times higher than white females and black males 4.4 times higher than white males. Hispanics had the lowest mortality rate in comparison to other races, though Hispanic females had a higher mortality rate than white females.

Overall, black males, black females and white males with HIV had higher mortality rates than the overall mortality rate of 78 per 100,000 population.

Cumulative Number of Deaths among Persons with HIV Disease and Death Rates in Kentucky, by Race/Ethnicity and Sex, as of December 31, 2015

Race/Ethnicity	Males			Females			Total		
	No.	%	Rate*	No.	%	Rate*	No.	%	Rate*
White, not Hispanic	2009	69%	109	237	47%	12	2246	66%	60
Black, not Hispanic	844	29%	476	248	49%	138	1092	32%	306
Hispanic	44	2%	53	9	2%	13	53	2%	35
Other	19	<1%	37	11	2%	21	30	1%	29
Total	2916	99%	135	505	100%	23	3421	100%	78

*Rate per 100,000 population as of December 31, 2015

Data in the following table are from the Kentucky Office of Vital Statistics and represent deceased persons for whom an HIV infection or AIDS was listed as the leading cause of death in 2014. The HIV/AIDS mortality rate was highest for blacks (3.4 per 100,000) and Hispanics (2.6 per 100,000) compared to whites at 0.8 per 100,000. This disparity is similar among minority groups by sex as well.

Resident Number of Deaths due to HIV Disease* and Death Rates in Kentucky, by Race/Ethnicity and Sex, 2014†

Race/Ethnicity	Males		Females		Total	
	No.	Rate*	No.	Rate*	No.	Rate*
White, not Hispanic	27	1.5	5	0.3	32	0.8
Black, not Hispanic	6	3.4	6	3.3	12	3.4
Hispanic	3	3.6	1	1.4	4	2.6
Total	36	1.7	12	0.5	48	1.1

*Rate per 100,000 population

†Death data from 2014 is preliminary

Estimate of Unmet Need:

The estimate of persons living with HIV disease in Kentucky is updated at the beginning of every calendar year. The most current estimate available is of persons living with HIV at the end of 2014 who had unmet need in calendar year 2014 (assessed at least 12 months after the reporting period-2014).

1. Estimation methods:

The following methodology was used to estimate unmet need in 2014 for HIV-related primary care for persons living in Kentucky at time of HIV diagnosis.

First: Definition of care:

“Care” was defined as having a laboratory result collected within the 12 month period January 1, 2014 through December 31, 2014, having care through the Kentucky HIV/AIDS Care Coordination Program (KHCCP) or through Medicaid.

Second: Population estimates:

Numerator: Kentucky HIV cases (as defined in the denominator) who did not have laboratory data collected in 2014 and did not receive care through KHCCP or Medicaid.

Denominator: Persons residing in Kentucky at time of initial HIV diagnosis, diagnosed by December 31, 2014 and living at any point in 2014.

Third: Three databases were utilized, with cross program collaboration:

- i. *The enhanced HIV/AIDS Reporting System (eHARS).* eHARS is the surveillance database that contains population-based demographic and clinical data on reported HIV infections diagnosed among Kentuckians living in or out of jurisdiction and among residents of other States diagnosed in Kentucky.
- ii. *CAREWare database.* CAREWare is free, scalable software used to manage and monitor HIV services within the Ryan White Part B Program. It houses data from the Kentucky HIV/AIDS Care Coordination Program (KHCCP) that tracks demographics and client utilization of core and supportive services. It also houses Kentucky AIDS Drug Assistance Program (KADAP) data.
- iii. *The Medicaid database.* Medicaid is a state administered Program available only to those individuals and families who fit into an eligibility group that is defined by federal and state law. Additional information at: <http://www.cms.hhs.gov/MedicaidGenInfo/>

Forth: Methodology and Population Estimates:

- I. The eHARS database was used to determine persons diagnosed with HIV disease while residing in Kentucky at the time of initial HIV diagnosis. Kentucky cases included in this analysis were those diagnosed as of December 31, 2014 and living at any point in 2014. Laboratory data in eHARS were then used to determine whether or not Kentuckians diagnosed had a viral load assay, or CD4+ assay collected in 2014. Data were assessed 12 months after the reporting period to account for reporting delays among persons who were diagnosed closer to the end of 2014 and had not yet established care. Kentucky cases *without* a laboratory test collected in 2014 were then matched with data from the Ryan White Part B Program, and Medicaid data.
- II. Ryan White Part B's Kentucky HIV/AIDS Care Coordination Program (KHCCP) data were used to further assess Kentucky cases in eHARS who had no record of laboratory tests collected in 2014, but who received HIV related primary care through the Part B Program (CAREWare data).
- III. Medicaid data were used in the final analysis to determine Kentucky cases in eHARS who had no record of laboratory tests collected in 2014 and were not reported as receiving care in the CAREWare database, but received medical attention through Medicaid services with lab procedures related to HIV disease including Current Procedural Terminology (CPT) codes: 86361 (CD4 absolute count only), 86359 (CD4 total count), 86360 (CD4 and CD8 absolute count ratio), and viral load tests including codes 87534, 87535, 87536 and 87390.

Limitations:

- I. The estimate does not account for in and out migration because the Surveillance Program doesn't always receive notification when people move out of the state. Consequently, since in and out migrations were unaccounted for, this may have slightly adjusted the unmet need estimate due to the mobility of persons receiving care in and out of Kentucky. Additionally, there is reporting delay associated with deaths; therefore dead persons may have been misclassified as "out of care" though this should be minimal.
- II. The use of anti-retroviral therapy was not included in the definition of care because HIV surveillance does not collect this information routinely. However, preliminary analyses show that clients on therapy regularly have CD4+ and or viral load assays to measure efficacy of treatment regimens, minimizing the risk of unmet need misclassification.
- III. Although the Framework requests the number of persons who are aware of their status, HIV/AIDS surveillance has not captured HIV status awareness routinely. Thus, the estimates in the Framework include persons who meet the described criteria above, whether aware of their status or not. The numbers in the framework are different than the data presented in the epidemiologic profiles due to different HIV/AIDS diagnosis date restrictions (only persons living and diagnosed with HIV disease by December 31, 2014).

Population Sizes	Value	Data Source(s)
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- IV. The Care Coordination Program has experienced some structural changes in the last 2-3 years and this analysis is missing data from one region that represent at least 40% of Kentuckians served by the Program.

- V. Lastly, Kentucky is bordered by seven states and it is common for treatment to be sought at the nearest medical facility, which may be in a neighboring state. Unless the tests are done by a reference laboratory, there is no way to guarantee that all laboratory tests being performed in private out-of-state facilities are being reported to Kentucky surveillance. However, the Program participates in inter-state de-duplication with other surveillance programs nationwide, with guidance from the CDC; therefore some information on migrant cases is obtained that way.

2. Assessment of unmet need:

i. Demographic and Regional Analysis of Those Not in Care

The Unmet Need Framework shows that for the time period January 1, 2014- December 31, 2014, there were an estimated 2,989 Kentuckians living with HIV non-AIDS (PLWH, non-AIDS) and 3,134 persons living with AIDS (PLWA) for a total of 6,123 Kentuckians living with HIV disease (PLWHA).

During the year 2014, there were 2,040 (33%) PLWHA estimated to be out of care. Of those, 1,146 (56%) were PLWH, non-AIDS and 894 (44%) were PLWA.

Among the 2,040 PLWHA that were out of care in 2014, 82% were male.

By race/ethnicity, the majority of PLWHA with unmet need were white, non-Hispanic (52%). Thirty-eight percent were black, non-Hispanic and 8% were Hispanic.

By sex and race/ethnicity, among females, the percentage of unmet need cases was similar among black, non-Hispanic females (44%) and white, non-Hispanic females (45%). Hispanic females accounted for 8% of all females with unmet need. An additional 3% of females with unmet need were persons of other races, including American Indians/Alaskan Natives, Native Hawaiian/Pacific Islanders and persons of multiple races. Among males however, the majority of unmet need cases were white, non-Hispanic males (53%). Black, non-Hispanic males accounted for 36% of unmet need cases, Hispanic males accounted for 8% of unmet need cases and males of other races for 3%.

By current age as of December 31, 2014, unmet need was highest among Kentuckians aged 50+ (40%), followed by those aged between 40-49 years (27%), Kentuckians aged between 30-39 years (19%) and 13% were 20-29 years old. Teens and pediatric cases <13 years accounted for <1% of unmet need each.

By primary mode of transmission, men who have sex with men (MSM) accounted for half (50%) of PLWHA with unmet need, with an additional 4% exposed through MSM/IDU contact.

Population Sizes		Value		Data Source(s)
Row A	PLWA ¹	3,134		Enhanced HIV/AIDS Reporting System (eHARS)
Row B	PLWH ² , non-AIDS	2,989		Enhanced HIV/AIDS Reporting System (eHARS)
Row C	Total PLWH/A ³	6,123		Enhanced HIV/AIDS Reporting System (eHARS)
Care Patterns		Value		Data Source(s)
Row D	Number of PLWA who received HIV primary medical care during the 12-month period January 1, 2014-December 31, 2014	2,240		eHARS database, Ryan White Part B Program and Medicaid data. Number of persons living with AIDS who had a viral load assay and/or a CD4+ assay in eHARS, care through the Ryan White Part B Program, or care through Medicaid in the 12 month period.
Row E	Number of PLWH/non-AIDS who received the specified HIV primary medical care during the 12-month period January 1, 2014 - December 31, 2014	1,843		eHARS database, Ryan White Part B Program and Medicaid data. Number of persons living with AIDS who had a viral load assay and/or a CD4+ assay in eHARS, care through the Ryan White Part B Program, or care through Medicaid in the 12 month period.
Row F	Total number of HIV+ who received the specified HIV primary medical care during the 12-month period January 1, 2014 - December 31, 2014	4,083		eHARS database, Ryan White Part B Program and Medicaid data. Number of persons living with AIDS who had a viral load assay and/or a CD4+ assay in eHARS, care through the Ryan White Part B Program, or care through Medicaid in the 12 month period.
Calculated Results		Value	Percent	Calculation
Row G	Number of PLWA who did not receive the specified HIV primary medical care	894	28.5%	Value = A - D Percent = G/A
Row H	Number of PLWH/non-AIDS who did not receive the specified HIV primary medical care	1,146	38%	Value: B - E Percent: H/B
Row I	Total HIV+ not receiving the specified HIV primary medical care (quantified estimate of unmet need)	2,040	33%	Value: G + H Percent: I/C

Twelve percent of PLWHA with unmet need were exposed through heterosexual contact and 4% through female presumed heterosexual contact, which includes females who have not injected drugs but have had sexual contact with a male whose HIV status or behaviors are unknown. Nine percent were exposed through injection drug use (IDU) and 19% of PLWHA with unmet need had no risk factor identified.

Lastly, the pattern of unmet need by care coordinator region is also similar to prevalence patterns, with the highest proportion of unmet need cases among residents of the Louisville region (50%), followed by residents of the Lexington region (18%), and Northern Kentucky region (12%). Residents of the Barren region accounted for 9% of unmet need, Purchase region and Cumberland Valley residents for about 5% each.

ii. Trends associated with the past 5 years regarding Unmet Need

The trends among Kentuckians with unmet need for the most recent five year period (2010-2014) will be assessed. It is imperative to note that slightly different methodologies were used to calculate unmet need for each of these calendar years; hence direct comparisons should not be made.

Trends by sex show that the majority of PLWHA who had unmet need in the most recent five years were male (about 83% for all years). By race/ethnicity, white non-Hispanics accounted for the majority of unmet need cases at 52% in 2010 and 2011, 54% in 2012 and 52% each in 2013 and 2014. Black non-Hispanics accounted for the second highest percentage of persons with unmet need in Kentucky at 41% in 2010, 39% in 2011 and 38% each in 2012, 2013 and 2014. Hispanics accounted for the smallest percentage of unmet need cases at about 7% each year.

Trends by age at time of HIV diagnosis show that the highest percentages of persons having unmet need were aged 20-29 years over the 5 year period (between 36-38%). HIV infected children less than 13 years at time of HIV diagnosis accounted for the lowest percentage of unmet need each year at <1% of total cases.

By mode of transmission, the trend of persons with unmet need shows the highest percentages among males who reported sexual contact with other males (MSM) at about half of cases for each year. Persons reporting heterosexual contact or injection drug use (IDU) accounted for about the same proportion of cases with unmet need over the five year period (about 9-12% each year). Persons with no risk factor identified accounted for almost a quarter of cases between 2010-2011, for 24% each in 2012, 2013 and 2014.

Lastly, the highest percentages of persons with unmet need were residents served by Louisville, Lexington, and Northern Kentucky Care Coordinator regions.

3. Framework for unmet need:

¹ Persons living with AIDS, who had a Kentucky residence at time of HIV diagnosis.

² Persons living with HIV- not AIDS, who had a Kentucky residence at time of HIV diagnosis.

³ Persons living with HIV and/or AIDS, who had a Kentucky residence at time of HIV diagnosis. Data are current as of December 31, 2015, therefore not similar to data presented in the epidemiologic profile. These tables compare persons living with HIV and/or AIDS with met needs to those with unmet needs through eHARS Database, Ryan White Part B Program data and Medicaid data.

Behavioral Risk Factor Surveillance System (BRFSS) Data:

The Behavioral Risk Factor Surveillance System (BRFSS) is a cross-sectional telephone health survey jointly sponsored by the Centers for Disease Control and Prevention (CDC) and the Kentucky Department for Public Health (KDPH). The survey is randomly administered to non-institutionalized civilian adults aged 18 or older living in a household. Participation in the survey is strictly voluntary. Personal identifying information, such as a person's name or address, is not collected. The BRFSS is a nationwide surveillance tool. In Kentucky, the BRFSS has been conducted continuously since 1985. The survey collects uniform, state specific data on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases that affect the adult population.

In 2014, 67.1% of adults in Kentucky had never been tested for HIV disease. This estimate was higher compared to 65.9% in the United States. The prevalence of HIV testing did not significantly differ by gender. Kentuckians with a high school diploma as their highest level of educational attainment had slightly higher estimates of adults never being tested compared to those with some post-high school education, though the differences were not significant. A higher proportion of adults with annual household income of \$15,000 or more had never been tested for HIV, compared to those with household income of less than \$15,000 per year. However, this estimate was not statistically significant.

The prevalence of white adults who have never been tested for HIV was higher when compared to other adults, as shown in the table below.

Kentucky Adults by HIV Testing Status and Race/Ethnicity (Ever Been Tested), 2014					
	White, non-Hispanic	Black, non-Hispanic	Hispanic	Other, non-Hispanic	Multiracial, non-Hispanic
YES					
Percent (%)	30.5	52.7	43.8	41.0	57.5
95% CI	28.9-32.2	44.9-60.5	29.4-58.2	27.7-54.3	43.5-71.6
Number	2107	344	43	52	61
NO					
Percent (%)	69.5	47.3	56.2	59.0	42.5
95% CI	67.8 - 71.1	39.5 - 55.1	41.9 - 70.6	45.7 - 72.3	28.5 - 56.5
Number	6519	538	58	86	97

Almost 90% of adults aged 65+ years had never been tested for HIV, which was the highest estimate compared to other age groups, as shown in the table below.

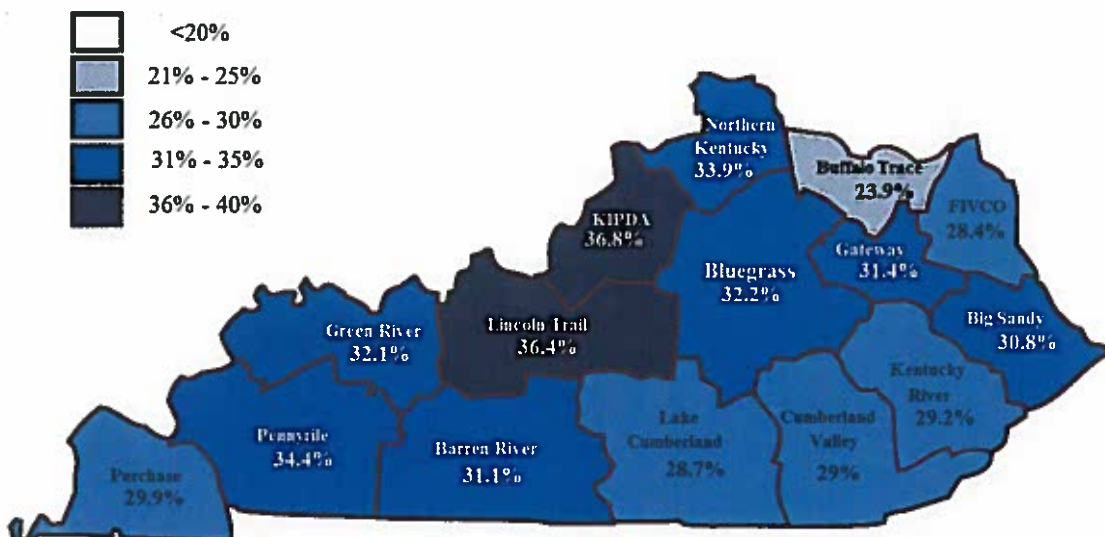
Kentucky Adults by HIV Testing Status and Age (Ever Been Tested), 2014						
	18-24	25-34	35-44	45-54	55-64	65+
YES						
Percent (%)	28.2	50.9	48.7	37.2	24.1	10.7
95% CI	22.7-33.8	46.0-55.9	44.4-53.0	33.7-40.6	21.4-26.8	9.0-12.5

Number	111	350	529	659	575	400
NO						
Percent (%)	71.8	49.1	51.3	62.9	75.9	89.3
95% CI	66.3-77.3	44.1-54.0	47.0-55.6	59.4-66.3	73.2-78.6	87.5-91.0
Number	276	371	567	1130	1936	3064

The distribution of Kentucky adults who had ever had an HIV test in 2014 by Area Development District shows that more of the rural districts of the state had a higher prevalence of their residents never having been tested for HIV disease, compared to the more urban areas.

Kentucky's Adult Population (Age 18-64 Years) who Had Ever Been Tested for HIV Disease by Area Development District (ADD), 2014

% Adults Ever Had HIV Test by ADD



References:

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Aug 19, 2016]. URL: <http://www.cdc.gov/brfss/brfssprevalence/>.

Kentucky Behavioral Risk Factor Surveillance System Survey Data. Department for Public Health, Cabinet for Health and Family Services, Frankfort, Kentucky, [2014]

Youth Risk Behavior Survey (YRBS) Data:

The Kentucky YRBS is conducted as part of a national effort by the U.S. Centers for Disease Control and prevention (CDC) to monitor students' health-risk behaviors in six priority areas. These six areas include injury and violence, alcohol and drug use, tobacco use, nutrition, physical activity, and sexual risk behaviors. These risk behaviors contribute to the leading causes of death, disability, and social problems among youth and adults in the U.S. Kentucky has been administering the YRBS since 1997. The survey is voluntary and is administered to a randomly selected sample of middle and high school students across the state.

Data from the 2015 high school survey show a total of 2,467 (11.6%) students had ever been tested for HIV. Prevalence of HIV testing was higher among female students (12.9%) than males (10.1%). The percentage of those ever receiving a test increased with grade level: there were 8% of 9th graders, 9.9% of 10th graders, 13.1% of 11th graders and 15.8% of 12th graders who had ever received an HIV test in 2015. By race/ethnicity, HIV testing was highest among Hispanic youth (22.4% of Hispanics), and second highest among multiracial non-Hispanic youth (15.6% of multiracial), and among black non-Hispanic youth (15.4% of blacks), compared to 10.1% of white non-Hispanic students ever having received an HIV test.

2015 YOUTH RISK BEHAVIOR SURVEY RESULTS

Kentucky High School Survey
Summary Tables - Weighted Data

QN9: Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)

	Percentage	Total 95% confidence interval	N	Percentage	Male 95% confidence interval	N	Percentage	Female 95% confidence interval	N
Total	9.1	(7.4 - 11.2)	2,568	11.5	(8.9 - 14.8)	1,235	6.6	(5.0 - 8.8)	1,316
Age									
15 or younger	9.3	(6.8 - 12.5)	1,067	11.4	(7.2 - 17.7)	474	7.3	(5.0 - 10.5)	584
16 or 17	8.5	(6.4 - 11.2)	1,188	11.1	(8.0 - 15.2)	589	5.8	(3.8 - 8.8)	596
18 or older	11.0	(7.8 - 15.1)	308	13.1	(7.8 - 21.1)	170	7.4	(4.3 - 12.2)	135
Grade									
9th	8.8	(5.8 - 13.1)	840	13.3	(7.8 - 21.7)	397	4.2	(2.8 - 6.3)	438
10th	11.2	(6.9 - 17.5)	646	11.0	(5.8 - 19.9)	317	11.3	(6.8 - 18.3)	328
11th	7.4	(5.3 - 10.2)	561	10.3	(6.1 - 16.7)	274	4.4	(2.3 - 8.0)	284
12th	8.1	(5.4 - 12.1)	486	9.7	(5.6 - 16.4)	232	5.9	(3.4 - 9.9)	251
Race/Ethnicity									
Black*	13.7	(8.0 - 22.4)	117	-	-	64	-	-	52
Hispanic/Latino	20.1	(12.6 - 30.7)	133	-	-	78	-	-	53
White*	7.6	(5.7 - 10.0)	2,087	9.8	(6.9 - 13.8)	984	5.2	(3.8 - 7.1)	1,097
All other races*	-	-	53	-	-	21	-	-	30
Multiple races*	5.0	(2.0 - 12.0)	107	-	-	46	-	-	61

Note: 9 students were excluded from this analysis.
*Non-Hispanic
N = Number of students in this subgroup.
- = Fewer than 100 students in this subgroup.

Reference:

Kentucky Youth Risk Behavior Survey (YRBS) Data. Department for Public Health, Cabinet for Health and Family Services, Frankfort, Kentucky, [2015]. [accessed Aug 22, 2016]. URL: <http://education.ky.gov/curriculum/CSH/data/Documents/CSH%202015%20High%20School%20Summary%20Tables%20YRBS.pdf>

Mortality Data by Drug Overdose:

Data from the Kentucky Office of Vital Statistics show that there were 1,069 Kentucky resident overdose deaths in 2014. In 2015, that number increased 14% to 1,218 Kentucky residents dying from drug overdose, even though 2015 data are still considered provisional. Drug overdose deaths are acute poisoning deaths due to prescription or illicit drugs. The epidemic of non-prescription opioid drug use has contributed to increased injection drug use which is a risk factor for HIV disease.

Many of the deaths reported involved more than one drug. The three fastest emerging drugs involved in overdose deaths in Kentucky were fentanyl, heroin, and gabapentin. The

involvement of fentanyl in Kentucky resident overdose deaths almost doubled from 128 deaths in 2014 to 230 deaths in 2015. Heroin related deaths increased from 225 in 2014 to 293 in 2015.

Over the last five years, Kentucky made significant improvement in capturing the drugs involved in overdose deaths by increasing the number of death certificates that list specific drugs contributing to deaths. The improved identification of contributing drugs should be taken into consideration when interpreting the increased number of deaths involving a particular drug. The trend of overdose deaths for the most recent five years is shown in the table below.

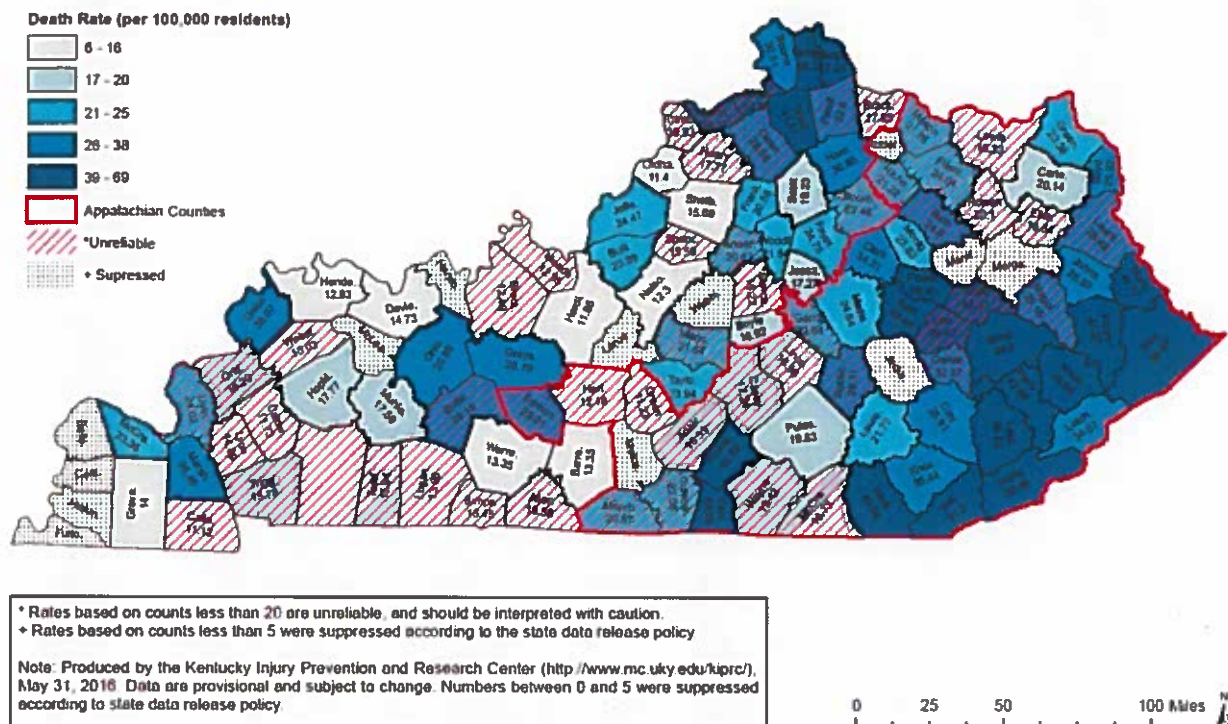
TOP TEN MOST COMMONLY LISTED DRUGS CONTRIBUTING TO KENTUCKY RESIDENT OVERDOSE DEATHS (Note: A death that involved two or more drugs was counted/reported under each relevant drug)	YEAR of DEATH				
	2011	2012	2013	2014	2015
HEROIN	42	131	205	225	293
FENTANYL	55	36	39	128	230
ALPRAZOLAM	269	201	182	168	178
GABAPENTIN	6	9	10	54	173 ^a
OXYCODONE	256	188	144	136	145
HYDROCODONE	195	159	169	157	118
MORPHINE	46	71	61	74	103 ^b
COCAINE	24	55	77	73	93
CLONAZEPAM	55	48	55	62	71
METHAMPHETAMINE	16	18	30	41	67
Total number of Ky resident overdose deaths (any drug, any intent)	1,020	1,032	1,003	1,069	1,218
Number (percentage) of the drug overdose deaths that listed at least one specific drug contributing to the overdose death	717 (70.3%)	732 (70.9%)	752 (75.0%)	832 (77.8%)	968 (79.5%)

^a The increase in the involvement of gabapentin could be due to increased testing in 2014-2015.

^b Morphine is a metabolite of heroin and some of the deaths with listed morphine could be in fact heroin deaths

The average death rates between 2012-2015 by County of Residence are displayed in the map below. Clinton County and Leslie County had the highest average death rates due to drug overdoses at 68.65 and 68.63 deaths per 100,000 residents respectively. The Appalachian part of the state also has the majority of the counties with the highest death rates.

Average Annual Drug Overdose Death Rate Based on Decedent's County of Residence 2012-2015



Reference:

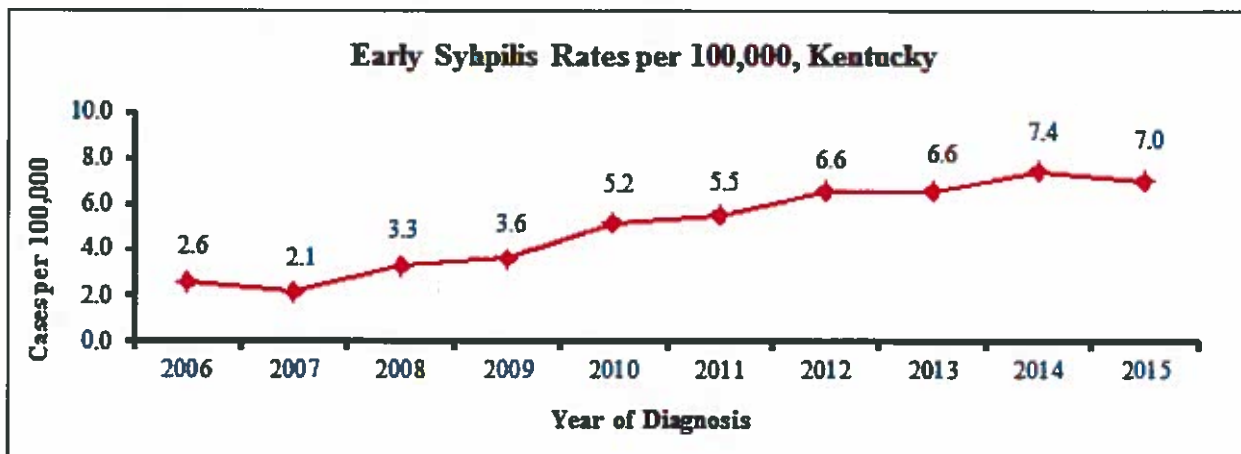
Kentucky Injury Prevention and Research Center. Kentucky Resident Drug Overdose Deaths Report. 2015. <http://www.mc.uky.edu/kiprc/programs/kdopp/reports/2015-drug-overdose-deaths.pdf> Accessed August 22, 2016.

Sexually Transmitted Disease (STD) Program Data

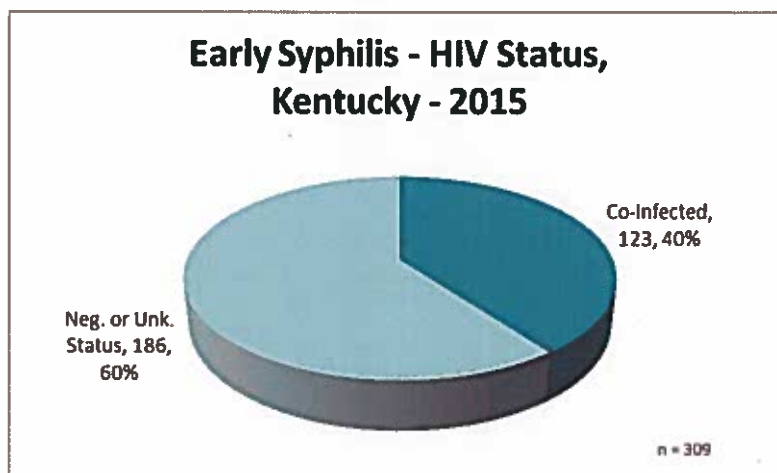
Data on STDs provide an indirect indicator of possible risk as they may serve as surrogate markers for unsafe sexual practices, which increases that population’s risk for acquiring and transmitting HIV infection. Epidemiologic studies suggest that STDs facilitate the spread of HIV.¹

Early Syphilis in Kentucky (Includes Primary, Secondary, Early Latent)

The early syphilis rate among Kentuckians between 2006-2015 has shown a steady increase from 2.6 cases per 100,000 population to 7.0 cases per 100,000 population, as shown in the chart below.



In 2015, there were 309 cases of early syphilis reported to the STD Program. Of those, 123 (39.8 %) were co-infected with HIV.



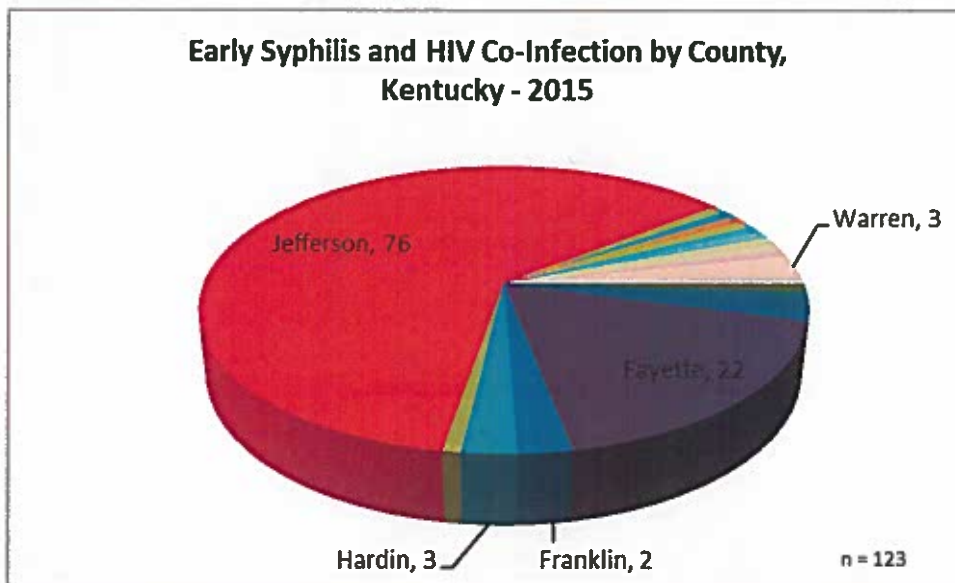
References

¹Wald A, Link K. Risk of human immunodeficiency virus infection in herpes simplex virus type 2-seropositive persons: a meta-analysis. *J Infect Dis* 2002 185:45-52

The rates of early syphilis/HIV co-infections diagnosed in 2015 were highest among males (5.6 per 100,000) compared to females (0.1 per 100,000). The rates were also highest among males aged 20-24 years (15.7 per 100,000), 40-44 years (14.8 per 100,000), 25-29 years (13.2 per 100,000) and 35-39 years (11.6 per 100,000).

The distribution of early syphilis/HIV co-infections in 2015 by County is shown below, with counties with the highest number of cases highlighted.

Early Syphilis and HIV Co-Infection by County, Kentucky - 2015



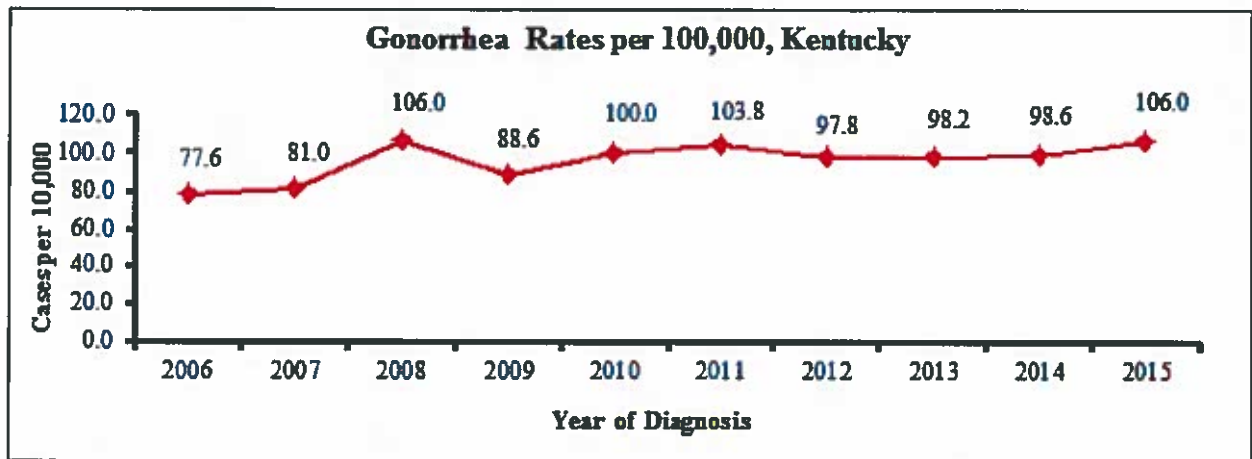
The distribution of early syphilis/HIV co-infections by mode of transmission and regional STD prevention area of residence at time of diagnosis is shown in the table below.

Risk Factors for Kentuckians Reported with Early Syphilis and HIV Coinfections, 2015

	2015 Regional STD Prevention Areas:					Kentucky Total
	Jefferson	Fayette	NKY	WKY	Barren River	
<u>Males</u>						
MSM	61	24	1	1	4	91
MSW	5	0	0	0	0	5
IDU	0	0	0	0	0	0
MSM/Sex w/IDU	0	1	1	0	0	2
Unknown Risk	13	8	1	1	0	23
Total Males	79	32	2	2	4	121
<u>Females</u>						
FSM	2	0	0	0	0	2
IDU	0	0	0	0	0	0
Sex w/MSM	0	0	0	0	0	0
Sex w/IDU	0	0	0	0	0	0
Hetero Sex w/HIV+	0	0	0	0	0	0
Total Females	2	0	0	0	0	2

Gonorrhea in Kentucky

The gonorrhea rate among Kentuckians from 2006-2015 showed an increase between 2006-2008, dropped in 2009 and has fluctuated slightly since, as shown in the chart below.



In 2015, there were 4,678 cases of gonorrhea reported to the STD Program. Of those, 129 (2.8%) were co-infected with HIV.

The rates of gonorrhea/HIV co-infections diagnosed in 2015 were highest among males (5.6 per 100,000) compared to females (0.3 per 100,000). The rates were also highest among males aged 25-29 years (31.6 per 100,000), 20-24 years (14.1 per 100,000), and 30-34 years (10.5 per 100,000).

The distribution of early gonorrhea/HIV co-infections by mode of transmission and regional STD prevention area of residence at time of diagnosis is shown in the table below.

Risk Factors for Kentuckians Reported with Gonorrhea and HIV Coinfections, 2015

Males	2015 Regional STD Prevention Areas:				Total
	Jefferson	Fayette	NKY	WKY	
MSM	81	15	5	4	105
IDU/MSM	3	0	0	0	3
MSW	2	0	0	1	3
HETERO/SEXw/HIV+	2	0	0	0	2
Unknown	7	2	0	0	9
TOTAL	95	17	5	5	122

Chlamydia in Kentucky

The chlamydia rate among Kentuckians from 2006-2015 showed an increase between 2006-2010, but has fluctuated slightly since, as shown in the chart below.

In 2015, there were 17,443 cases of chlamydia reported to the STD Program. Of those, 115 (0.7%) were co-infected with HIV.

The rates of chlamydia /HIV co-infections diagnosed in 2015 were highest among males (4.6 per 100,000) compared to females (0.7 per 100,000). The rates were also highest among males aged 25-29 years (16.2 per 100,000) and 20-24 years (14.8 per 100,000). The distribution by STD region of residence at time of diagnosis is shown below.

Regional Distribution for Kentuckians Reported with Chlamydia and HIV Coinfections, 2015

STD Regional Area	Chlamydia & HIV Cases	Chlamydia Cases	% Co-Infected by Region
Jefferson*	86	6,768	1.3%
Fayette	23	5,406	0.4%
Northern KY	2	1,730	0.1%
Barren River	0	956	0.0%
Western KY	4	2,583	0.2%
TOTAL	115	17,443	0.7%

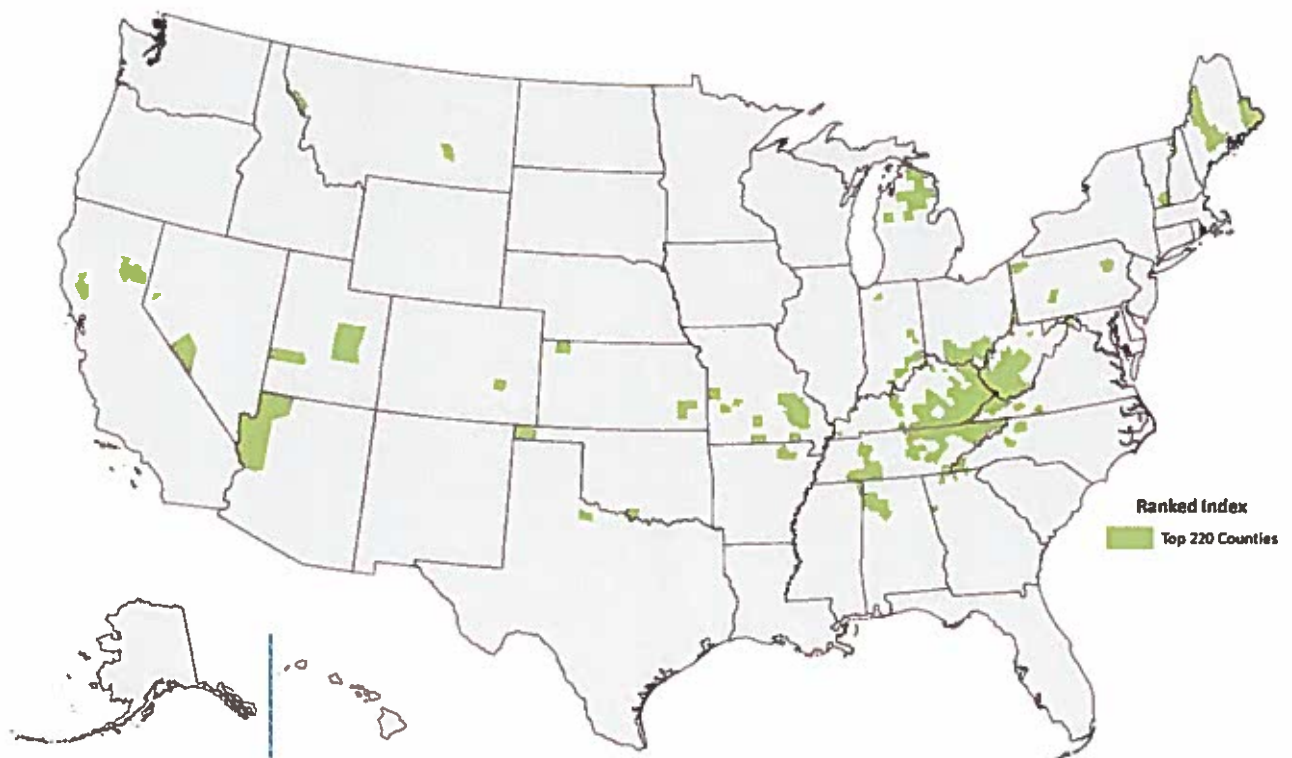
*Targeted CT screening & prevention activities in Jefferson County in collaboration with 550 Wings HIV Care Clinic.

CDC HIV/HCV Vulnerability Assessment:

A recent study assessed county-level vulnerability for the rapid spread of HIV among persons who inject drugs in the U.S. if the virus was introduced to these networks and new or continuing high rates of hepatitis C virus (HCV) infections. The study was in response to a recent HIV outbreak in Scott County, IN (approximately 35 miles from Louisville, KY), where injection drug use was responsible for the spread of HIV and HCV in outbreak proportions.

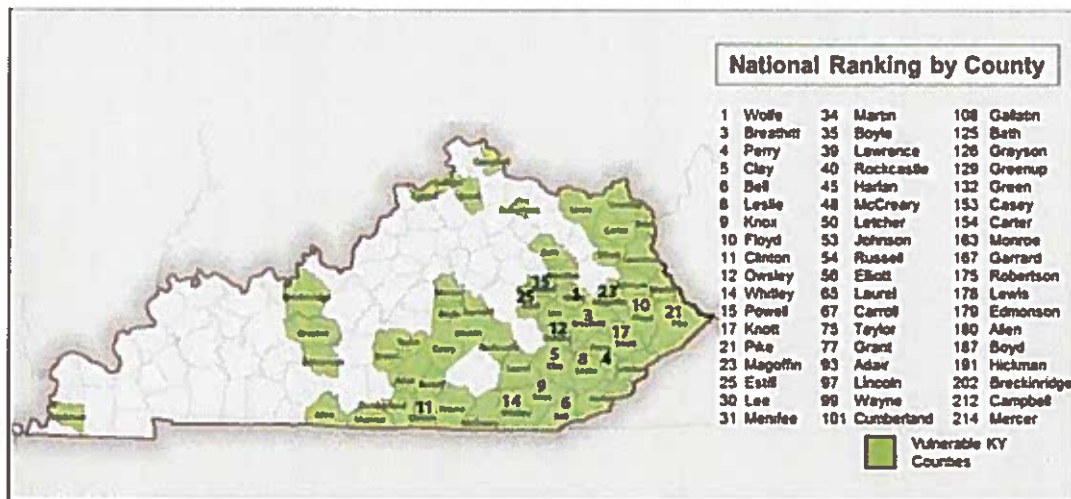
The study used confirmed cases of acute HCV infection reported to the National Notifiable Disease Surveillance System, 2012-2013, (as a proxy for IDU): drug overdose deaths, prescription opioid sales, per capita income, white, non-Hispanic race/ethnicity, unemployment, and buprenorphine prescribing potential by waiver. Based on these indicators, 220 counties in 26 states were identified as being in the 95th percentile of most vulnerable to outbreaks of HIV/HCV among IDU in those communities.

Vulnerability to Rapid Dissemination of HIV/HCV Infections Among Persons Who Inject Drugs



Kentucky was one of the 26 states, with the number one most vulnerable county in the U.S.: Wolfe County. Kentucky also had another 53 counties ranked in the top 220 vulnerable counties, accounting for a total of 45% of all Kentucky Counties. It is important to note that the risk for

introduction and spread of HIV infection into a vulnerable community will vary according to the estimated HIV proximity of the community and the community's IDU practices. A map of the affected Kentucky Counties is shown below. Most are in Appalachia, but the list includes the non-Appalachian counties of Hickman, Breckinridge, Grayson, Allen, Taylor, Boyle, Mercer, Carroll, Gallatin Grant and Campbell.



Counties deemed most vulnerable to outbreaks are green; top 25 of 220 in U.S. are numbered on map.

Source: <http://kyhealthnews.blogspot.com/2016/05/study-says-intravenous-drug-users-in.html>

Reference:

Van Handel, Michelle M MPH, Rose, Charles E PhD, *et al.* County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States [Abstract]. (2015). *JAIDS*. doi:10.1097/Q AI.0000000000001098

B: HIV Care Continuum

1. The Current Continuum of Care

Introduction

Individuals with HIV disease receive the most benefits from antiretroviral therapy (ART) if they are tested and diagnosed early, are engaged in regular care and are adherent to treatment. Engagement in HIV medical care, which consists of early linkage to and retention in care, has been shown to increase the chances of viral load suppression among people living with HIV/AIDS (PLWHA).¹ From a public health standpoint, poor engagement in HIV care can be a major impediment to reducing the risk of HIV transmission.²

In July 2010, the White House released the *National HIV/AIDS Strategy for the United States* (NHAS) which outlined a coordinated response to HIV in the nation. The Centers for Disease Control and Prevention (CDC) monitors health outcomes for persons living with HIV infection at the national level using the continuum of HIV care.

The continuum of care consists of six components:

- Living HIV Cases (Regardless of Diagnosis)
- Diagnosed HIV Cases
- Linkage to HIV Medical Care
- Retention in Medical Care
- Prescription of ART
- Suppression of Viral Loads

Methodology and Definitions:

This section will describe the continuum of care among Kentuckians diagnosed with HIV disease by December 31, 2013 and living through December 31, 2014. Laboratory data with a collection date in 2014 will be assessed for these individuals, utilizing the HIV surveillance system (eHARS) data set as of December 31, 2015, in order to account for reporting delays. Since it is a diagnosis-based continuum, comparisons to the national estimates should be done with caution.

HIV Infected –The number of Kentuckians who were diagnosed and aware, as well as unaware, of their HIV-positive status. The HIV surveillance office does not track the number of Kentuckians that are unaware of their HIV-positive status, so in order to obtain an estimate of those unaware of their HIV infection, a concurrent HIV and AIDS diagnosis was used as a surrogate measure. A concurrent HIV and AIDS diagnosis is defined as having an AIDS diagnosis within 30 days of an initial HIV diagnosis. The percentage of individuals diagnosed concurrently in 2014 was used to estimate the number of individuals living with HIV who are unaware of their infection. HIV infected was estimated using the following equations:

$$\text{HIV Unaware} = p/(1-p)*N$$

$$\text{HIV Infected} = \text{HIV Unaware} + N$$

Where p is the percentage of Kentuckians concurrently diagnosed with HIV and AIDS in 2014 and N is the number of Kentuckians diagnosed with HIV disease by 2013 and living at the end of 2014.

HIV Diagnosed – This includes all Kentuckians who were diagnosed with HIV disease by December 31, 2013 and living through December 31, 2014. The number diagnosed represents data reported to the HIV Surveillance Office. (Note that this is the overall denominator except for linkage to care calculations).

Linked to Care – Defined as newly diagnosed Kentuckians successfully linked to HIV medical care within 3 months of their initial HIV diagnosis. Kentuckians newly diagnosed in 2014 and living through the end of 2014 were used to estimate linkage to care. Linkage to care was calculated by the number of months between the HIV diagnosis date and initial medical care visit. Medical care visits were defined as having a CD4+ cell count or percent or viral load test. (Note that this is a different denominator than the other indicators.)

In Care – Also known as any evidence of care. Defined as having at least one HIV medical care visit during the 12-month period. The estimate of Kentuckians in care was obtained from eHARS cases diagnosed by 2013 and living through December 31, 2014. Viral load and CD4+ cell count and percent measurements collected in 2014 were used as measures for medical care visits.

Retained in Care – Defined as having at least two HIV medical care visits separated by \geq 3 months during a 12-month period. The estimate of Kentuckians retained in care was obtained from eHARS cases diagnosed by 2013 and living through December 31, 2014. Viral load and CD4+ cell count and percent measurements collected in 2014 were used as measures for medical care visits.

Viral Suppression – Defined as the number of Kentuckians who were diagnosed with HIV disease by December 31, 2013 and living through December 31, 2014. Persons were considered virally suppressed if they achieved a viral load of < 200 copies/ml. The most recent viral load result collected at any point in 2014 was considered.

Results:

Living HIV Infections (aware and unaware):

Persons unaware of their infection contribute nearly one third of ongoing transmission in the United States¹. The number of Kentuckians reported to HIV surveillance who are diagnosed by December 31, 2013 and living through December 31, 2014 was 6,123. Based on the methodology described above, the number of Kentuckians who are infected and unaware of their infection was estimated to be 1,829. This was derived from the 23% of HIV cases diagnosed concurrently with HIV/AIDS in 2014 - a concurrent diagnosis being a proxy indicator of being a late tester for a significant amount of time. Therefore, an estimated total of 7,952 Kentuckians were living with diagnosed or undiagnosed HIV infection at the end of 2014. It is essential for local prevention efforts to start with getting these persons tested in a timely manner and then actively linked into care and prevention services.

Linkage to care:

Kentuckians diagnosed in 2014 were assessed for linkage to care at any point during the three month period following their initial HIV disease diagnosis. Out of 352 newly diagnosed cases in 2014, 306 (87%) were linked into care within three months of diagnosis. This is represented by the third bar on the chart below.

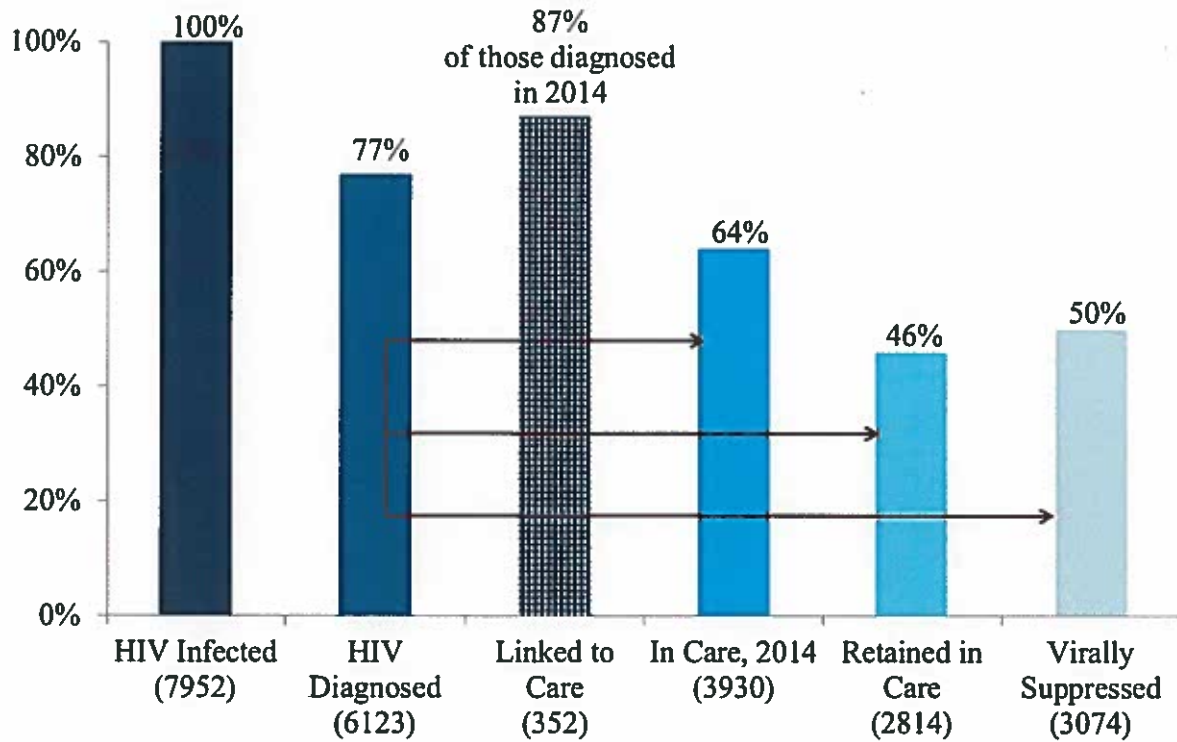
Diagnosed HIV Infections:

As of December 31, 2015, there were 6,123 Kentuckians diagnosed with HIV disease by December 31, 2013 and living through December 31, 2014. This is the overall denominator that will be used for the calculation of the continuum present as below.

Of the 6,123 diagnoses (representing 77% of the entire HIV infected population in Kentucky), 64% were in care at any one given point in time in 2014. Forty-six percent of diagnosed Kentuckians were retained in care. Half of diagnosed Kentuckians achieved viral suppression in 2014.

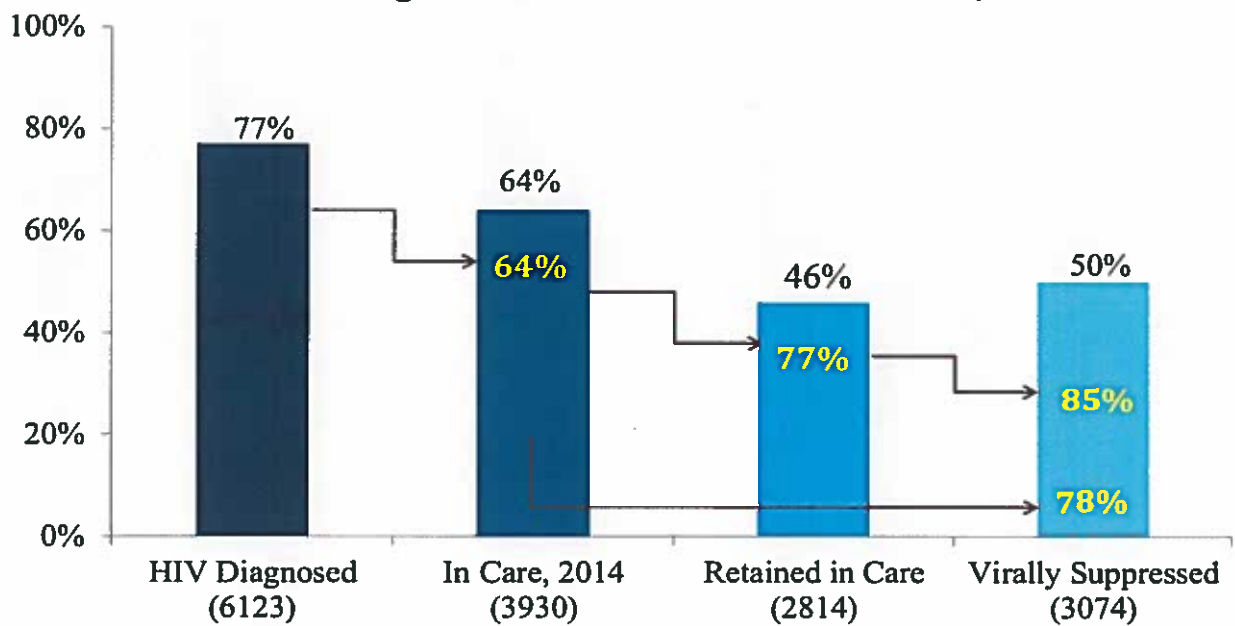
¹CDC. Prevalence of diagnosed and undiagnosed HIV infection-United States, 2008-2012. MMWR Morb Mortal Wkly Rep 2015; 64(24); 657-662. Available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6424a2.htm>

Percentage of HIV Infected Kentuckians Engaged in Selected Stages of the Continuum of HIV Care, 2014



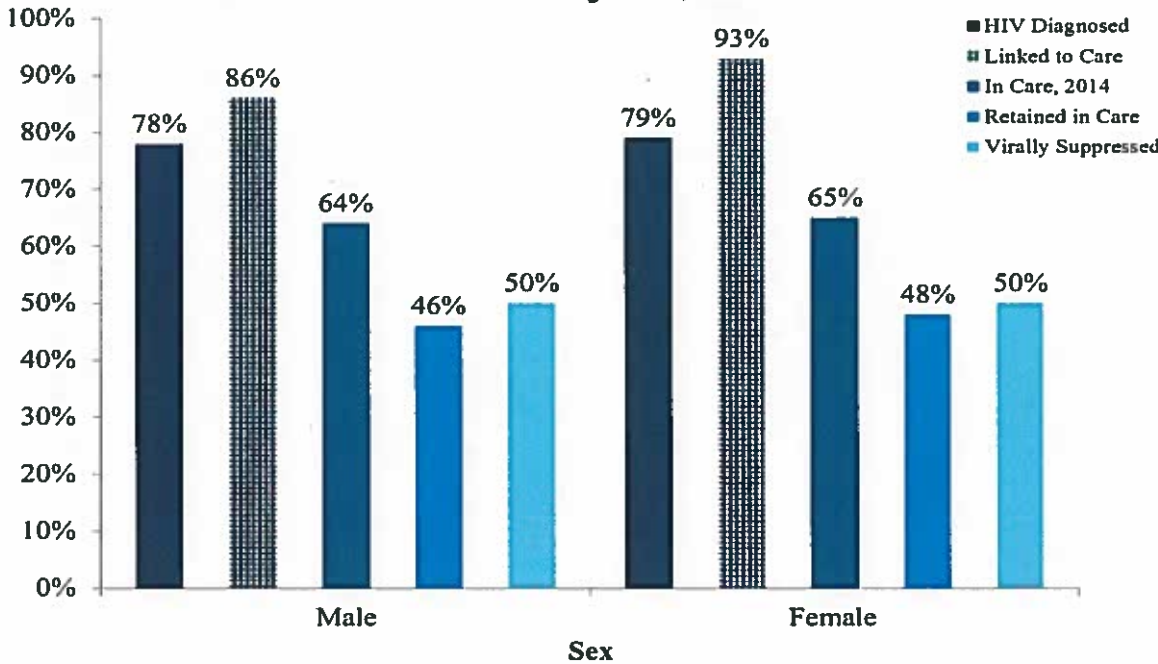
The chart below shows a step-wise distribution, along each stage of care. Of the 6,123 diagnoses, 64% were in care at any one given point in time in 2014. Of those in care, 77% were retained in regular care and of those retained in care, 85% achieved viral suppression. It's also noteworthy that of those who were engaged in care at any point in 2014 (regardless of retention levels), 78% achieved viral suppression; highlighting the fact that early engagement in care is associated with achieving viral suppression.

Percentage of HIV Diagnosed Kentuckians Engaged in Selected Stages of the Continuum of HIV Care, 2014



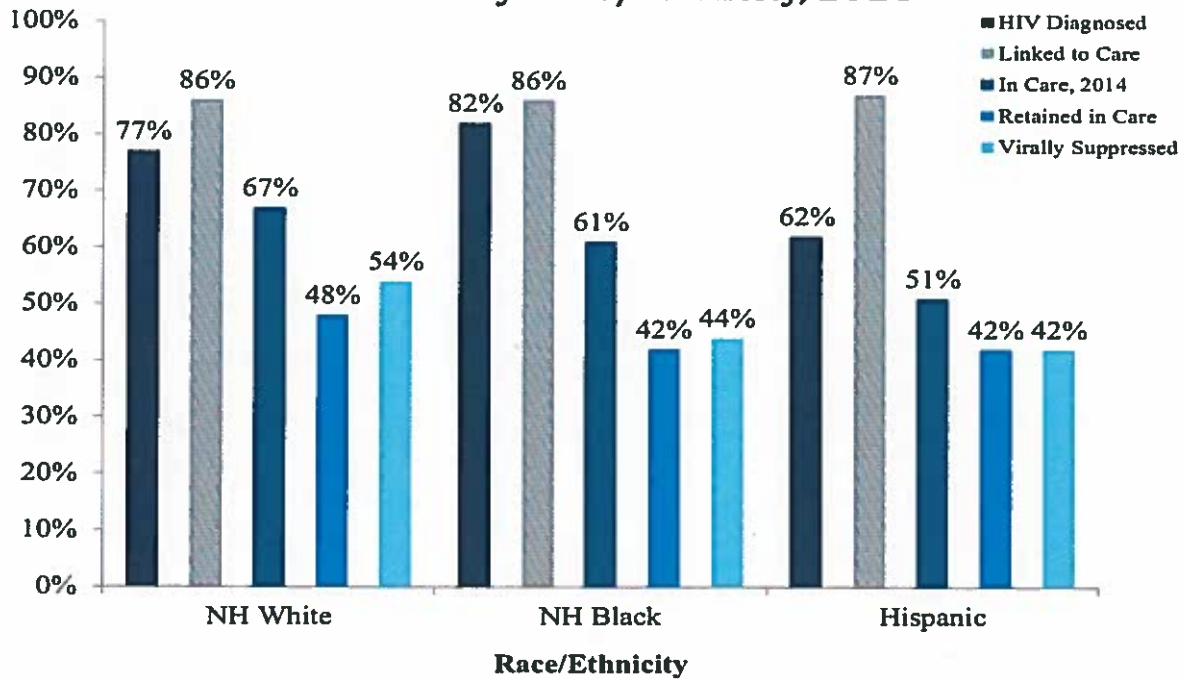
The distribution of the continuum indicators among diagnosed Kentuckians by Sex is shown below. There were fluctuating levels of engagement along the continuum among both males and females, but not much variation when compared. Females (93%) had higher levels of linkage to care than males (86%). Otherwise both males and females were similar on the other indicators, with both groups achieving 50% viral suppression.

Percentage of HIV Diagnosed Kentuckians Engaged in HIV Care by Sex, 2014



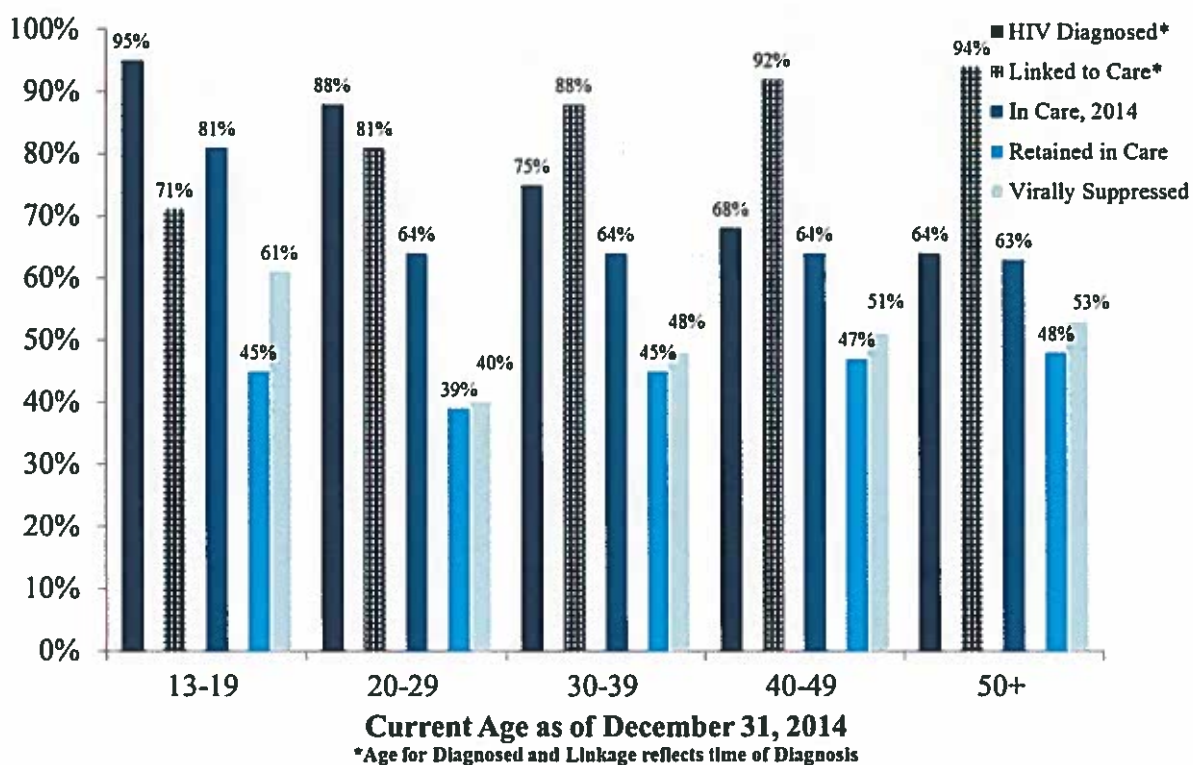
The distribution of the continuum indicators among diagnosed Kentuckians by race/ethnicity is shown below. Blacks had the highest levels of getting diagnosed; 82% compared to 77% among Whites and 62% among Hispanics. All racial/ethnic groups had similar proportions of persons getting linked into HIV-related medical care. Whites had higher proportions of engaging in care, remaining engaged in care and ultimately being virally suppressed in comparison to minorities.

Percentage of HIV Diagnosed Kentuckians Engaged in HIV Care by Race/Ethnicity, 2014

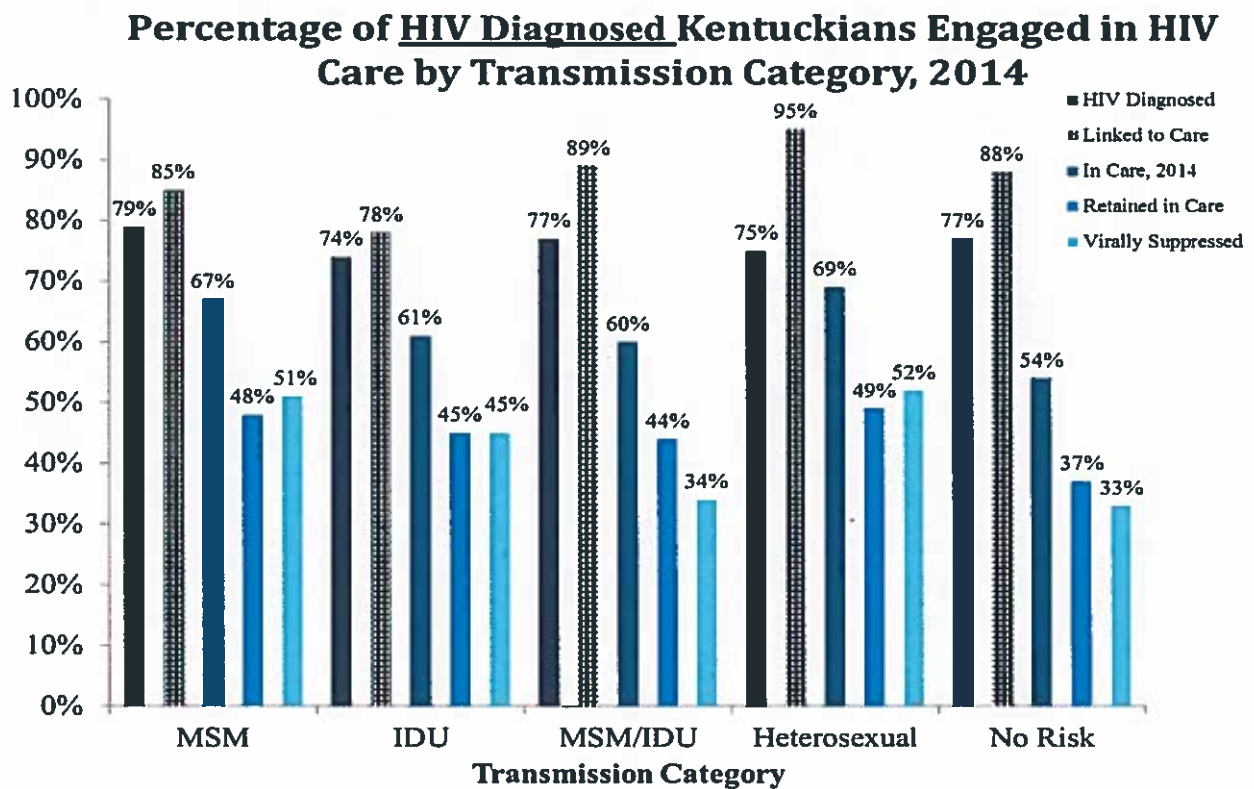


The distribution of the continuum indicators among diagnosed Kentuckians by age is shown below. Please note the different age markers for the different indicators on the chart. There are various fluctuations in the proportions of persons engaged at each stage of the continuum by age. The proportion of persons receiving a diagnosis seems to reduce with age, whereas the proportion linked to care increases with age. Even though more teenagers were enrolled in care in 2014 than any other age group at 81%, their retention levels are similar to other age groups perhaps signifying greater missed opportunities for keeping them continuously engaged once initially enrolled. Viral suppression was also highest among teenagers at 61%, compared to the other age groups. This might also be a result of amplification of percentages for small numbers reported in the teenage demographic (38 total cases diagnosed).

Percentage of HIV Diagnosed Kentuckians Engaged in HIV Care by Age, 2014

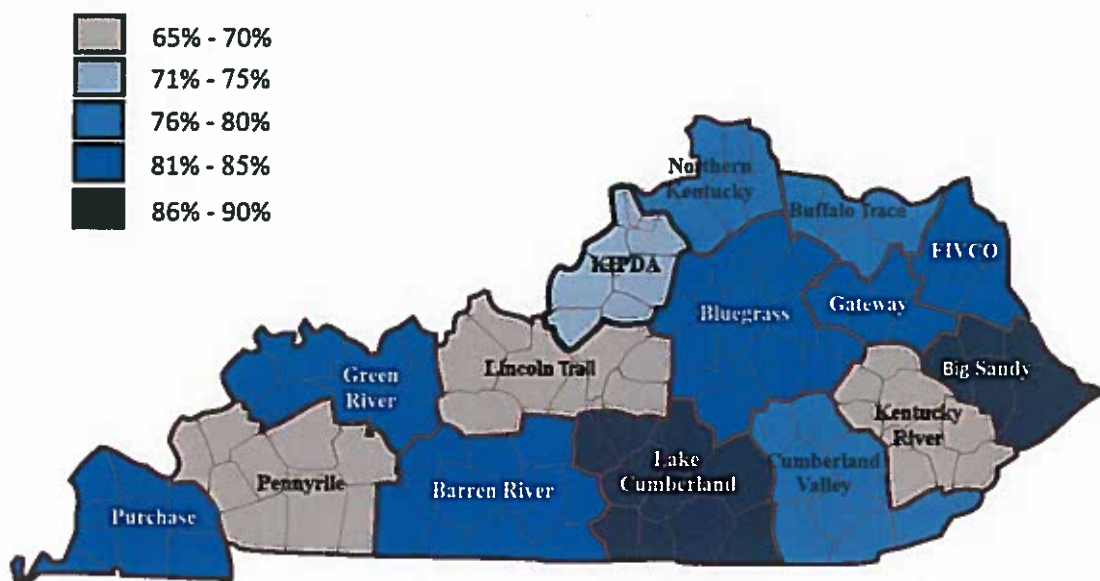


The distribution of the continuum indicators among diagnosed Kentuckians by mode of transmission is shown below. There is considerable variation by risk factors but heterosexuals had the highest levels of retention in HIV-related care and viral suppression, followed by men having sex with men (MSM). Almost half (45%) of injection drug users (IDU) were virally suppressed and about a third each of MSM/IDU and persons without a risk factor reported achieved viral suppression.



The distribution of Kentuckians diagnosed with HIV within each Area Development District (ADD) who achieved viral suppression is shown in the map below. Residence reflects time of initial HIV diagnosis, not current residence. Residents of Big Sandy ADD at time of diagnosis had the highest proportion achieving viral suppression (89%). Pennyrile ADD residents on the other hand had the lowest levels of viral suppression (67%).

Percentage of Kentuckians Living with HIV as of December 31, 2014 Who were Virally Suppressed in 2014 in each Area Development District*



*Area Development District at Time of HIV diagnosis

Limitations:

The analysis presented uses a diagnosis-based continuum, therefore its noteworthy that a proportion of Kentuckians living with HIV who have not been diagnosed and reported to the Surveillance Program were not included. Additionally, the operationalization of continuum terms creates an underestimation of persons living with HIV in the jurisdiction, which is the overall denominator.

Residence at time of initial HIV diagnosis was used and it does not account for changes in residence. It also does not account for in-and-out migration to/from the jurisdiction. This means the estimate may exclude those who have moved into the area and may also include those who have moved out of the area. The Surveillance Program participates in the routine interstate duplication resolution (RIDR) which helps to account for some of the information from jurisdictions that people may have migrated to, but isn't always complete or timely.

The current continuum only used HIV surveillance data, therefore any laboratory reports that may not be reported therein but in other data sources such as the care coordinator and drug assistance programs have not been utilized.

Lastly, Kentucky laws did not require laboratories to report all viral loads until early 2016. Although laboratories were not required to report undetectable viral loads, the surveillance office believes it received most of these results. However, it's worth noting that some reports collected in 2014 may not have been furnished for this reason.

Conclusion:

The beginning of the continuum of care - which is the nation's road map to an AIDS free generation, is getting informed and knowledgeable about HIV testing and prevention efforts. Kentucky has almost one-quarter (23%) of HIV infected individuals unaware of their sero-status. Only after people are informed of their status can they then enter into the continuum of care. However, a holistic approach including all other social determinants of health is necessary to keep people engaged and retained in care after they are first linked. A large majority of Kentuckians were linked into care for the first time in a timely fashion (87%), but over a third (36%) of diagnosed cases were not engaged in care in 2014 and only half of diagnosed cases attained viral suppression. Studies show that beyond individual health benefits, viral suppression has implications for HIV prevention efforts, particularly in the context of reduced HIV transmissibility.¹ Therefore, improvements along each stage of the continuum are critical in the fight against HIV-related morbidity and mortality.

¹Mugavero, M. J., Amico, K. R., Westfall, A. O., Crane, H. M., Zinski, A., Willig, J. H., ... Saag, M. S. (2012). Early Retention in HIV Care and Viral Load Suppression: Implications for a Test and Treat Approach to HIV Prevention. *Journal of Acquired Immune Deficiency Syndromes (1999)*, 59(1), 86-93. <http://doi.org/10.1097/QAI.0b013e318236f7d2>

C. Financial and Human Resources Inventory

Financial and Human Resources Inventory

- a. Below is a table of the HIV available resources and services that are paid for with federal or other funding sources. The primary sources of federal funds are the Centers for Disease Control and Prevention (CDC); the Health Resources and Services Administration (HRSA), including the HIV/AIDS Bureau (HAB) and the Bureau of Primary Care (BPHC); and the Department of Housing and Urban Development (HUD).

HIV Care Continuum

1. HIV Infected
2. HIV Diagnosed
3. Linked to Care
4. Prescribed ART
5. Undetectable Viral Load

Name of Organization	Amount of Funding	Percent of Funds	Services Provided	Prevention and/or HIV Care Continuum
HIV Prevention Services (CDC) Kentucky Cabinet for Health and Family Services, Division of Epidemiology, HIV/AIDS Branch, 275 E Main Street, Frankfort, KY 40601-2321	\$1,536,900	100%	Community outreach, HIV education and training. HIV testing supplies, controls, condoms and educational materials. Assistance at testing events. Technical assistance for providers.	HIV Infected HIV Diagnosed Linked to Care
Volunteers of America (VOA), 570 S. 4 th Street, Louisville, KY 40202	\$200,212	100%	Community outreach, HIV education and training. HIV testing and condom distribution. Prevention with Positives Program.	HIV Infected HIV Diagnosed Linked to Care
AVOL, 225 Walton Avenue, Lexington, KY 40502	\$52,194	100%	Community outreach, HIV education and training. HIV testing and condom distribution.	HIV Infected HIV Diagnosed Linked to Care

Northern Kentucky Independent District Health Department, 2388 Grandview Drive, Fort Mitchell, KY 41017	\$27,286	100%	Community outreach, HIV education and training. HIV testing and condom distribution.	HIV Infected HIV Diagnosed Linked to Care
Louisville Metro Health Department, 400 E. Gray Street, Louisville, KY 40202	\$13,914	100%	Community outreach, HIV education and training. HIV testing and condom distribution.	HIV Infected HIV Diagnosed Linked to Care
Lexington-Fayette County Health Department, 650 Newtown Pike Lexington, KY 40508	\$19,015	100%	Community outreach, HIV education and training. HIV testing and condom distribution.	HIV Infected HIV Diagnosed Linked to Care
Matthew 25 AIDS Services 452 Old Corydon Rd., Henderson, KY 42420	\$15,000	100%	Community outreach, HIV education and training. HIV testing and condom distribution.	HIV Infected HIV Diagnosed Linked to Care
Kentucky Local Health Departments - 61 county health departments located throughout Kentucky with additional offices located regionally.			Provide condoms, HIV rapid test kits and controls.	HIV Infected HIV Diagnosed Linked to Care
Ryan White Part B HIV Care Grant Program (HRSA)				
Kentucky Cabinet for Health and Family Services, Division of Epidemiology, HIV/AIDS Branch, 275 E Main Street, Frankfort, KY 40601-2321	\$15,371,378	100%	AIDS Drug Assistance Program, Part B Core Medical and Support Services	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
Ryan White Part B Subrecipients				
Bluegrass Care Clinic, University of Kentucky, 500 S. Limestone Street, Lexington KY 40536-0284	\$1,162,601	100%	Core Medical Services – medical Case management; ambulatory care; laboratory services; mental health and substance abuse services; nutrition; and support services.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
550 Clinic, University of Louisville, 550 South Jackson Street,	\$1,172,079	100%	Core Medical Services – medical case management; mental Health and	HIV Diagnosed Linked to Care

Louisville, Kentucky 40202				substance abuse services; nutrition; and support services.	Prescribed ART Undetectable Viral Load
Heartland CARES, Inc., 619 N. 30 th Street, Paducah, KY 42001	\$498,076	100%		Core Medical Services – medical case management; ambulatory care; laboratory services; mental health and substance abuse services; nutrition; and support services.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
Matthew 25 AIDS Services 452 Old Corydon Rd., Henderson, KY 42420	\$1,114,485	100%		Core Medical Services – medical case management; ambulatory care; laboratory services; mental health and substance abuse services; nutrition; and support services.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
Northern Kentucky Independent District Health Department, 2388 Grandview Drive, Fort Mitchell, KY 41017	\$845,529	100%		Core Medical Services – medical case management; ambulatory care; Laboratory; mental health and substance abuse services; nutrition; and support services.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
Lake Cumberland District Health Department, 500 Bourne Ave. Somerset, KY 42501	\$189,189	100%		Core Medical Services – medical case management; ambulatory care; laboratory services; mental health and substance abuse services; nutrition; and support services.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
Lexington-Fayette County Health Department, 650 Newtown Pike Lexington, KY 40508	\$466,688	100%		Ryan White Part B Support Services: Food, transportation, housing, emergency financial assistance, etc.	HIV Infected HIV Diagnosed Linked To Care
University of Kentucky Clinic Pharmacy, 740 S. Limestone Street, Lexington, KY 40536-0284	\$7,632,846	100%		AIDS Drug Assistance Program ARV and other approved medications. Health Insurance Premium and Cost- Sharing Assistance	Linked to Care Prescribed ART Undetectable Viral Load
University of Louisville School of Dentistry, 120 Homewood Plaza,	\$729,489	100%		Ryan White Part B Dental Services – preventative, restorative, and	HIV Diagnosed Undetectable Viral

Elizabethtown, KY 42701				specialty care.	Load
Ryan White Part C Recipients (HRSA)					
Bluegrass Care Clinic, University of Kentucky, 500 S. Limestone Street, Lexington, KY 40536-0284	\$570,178	100%	Ryan White Part C Services: Ambulatory care, laboratory services, medical case management, etc.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load	
Matthew 25 AIDS Services, 452 Old Corydon Rd, Henderson, KY 42420	\$433,610	100%	Ryan White Part C Services: Ambulatory care, laboratory services, medical case management, etc.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load	
Heartland CARES, Inc. 619 N. 30 th Street, Paducah, KY 42001	\$635,963	100%	Ryan White Part C Services: Ambulatory care, laboratory services, medical case management, etc.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load	
550 Clinic, University of Louisville, 550 South Jackson Street, Louisville, Kentucky 40202	\$668,865	100%	Ryan White Part C Services: Ambulatory care, laboratory services, medical case management, etc.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load	
Community Based Dental Program (HRSA)					
University of Louisville School of Dentistry, 2301 S. 3 rd Street, Louisville, KY 40208	\$335,801	100%	Ryan White Part B Dental Services – Training of dental students and post graduate students. Dental Services: preventative, restorative, and specialty care.	HIV Diagnosed Undetectable Viral Load	
Dental Reimbursement Program (HRSA)					

University of Kentucky Dental School, 500 S. Limestone Street, Lexington, Kentucky 40526	\$160,050	100%	Ryan White Part B Dental Services – Training of dental students and post grad students. Dental Services: preventative, restorative, and specialty care.	HIV Diagnosed Undetectable Viral Load
Ryan White Part C – Capacity Dev. and Planning Grant (HRSA)				
Bluegrass Care Clinic, University of Kentucky, 500 S. Limestone Street, Lexington, KY 40536-0284	\$100,000	100%	Staff training to perform motivational interviewing of HIV clients to focus on their health care needs and compliance with treatment plan.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
Ryan White Part D – Women, Infants, Children and Youth (HRSA)				
Bluegrass Care Clinic, University of Kentucky, 500 S. Limestone Street, Lexington, KY 40536-0284	\$357,818	100%	Ryan White Part D Services for women and children: ambulatory care, laboratory medical case management, etc.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
Matthew 25 AIDS Services 452 Old Corydon Rd., Henderson, KY 42420	\$387,360	100%	Ryan White Part D Services for women and children: ambulatory care, laboratory medical case management, etc.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
550 Clinic, University of Louisville, 550 South Jackson Street, Lexington, Kentucky 40202out	\$428,273	100%	Ryan White Part D Services for women and children: ambulatory care, laboratory medical case management, etc.	HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
AIDS Education and Training Programs (HRSA)				
Vanderbilt University Nashville Tenn. Southeast Regional AETC	\$4,330,219	Unknown	Goals of the Southeastern AETC will be to develop a comprehensive needs	HIV Infected HIV Diagnosed

University of Kentucky – Subrecipient under the Vanderbilt Grant				assessment to determine effective training goals; perform base training that will utilize multiple training modalities including didactic, interactive, preceptorships, web based distance learning.	Linked to Care Prescribed ART Undetectable Viral Load
HOPWA Housing Opportunities for Persons Living with AIDS (HUD)					
Kentucky Housing Corporation, 1231 Louisville Road, Frankfort, KY 40601-6191	\$530,584	100%		HIV housing services provided in 48 KY counties. Agencies – AVOL, Lexington, Bluegrass Community Action Program, Heartland CARES, Inc.	Linked to Care Prescribed ART Undetectable Viral Load
Community Services and Revitalization, 701 W Ormsby Avenue, Louisville, KY 40203	\$576,546	100%		Provide housing assistance through these agencies: AIDS Interfaith Ministries, Hoosier Hills AIDS Coalition, House of Ruth, Legal Aid Society, VOA, and Matthew 25 AIDS Services.	Linked to Care Prescribed ART Undetectable Viral Load
Federally Funded Community Health Center, Section 330e. (HRSA)					
There are 23 federally funded Community Health Centers (CHCs) in Kentucky. To date, none of the federally funded CHCs are subrecipients of Ryan White funds.	\$66,547,007	Unknown		Preform HIV testing, providing HIV primary care, and in some cases providing medical case management and other social services.	HIV Infected HIV Diagnosed Linked to Care Prescribed ART Undetectable Viral Load
Mountain Comprehensive Care, 266 Medical Plaza Lane, Whitesburg, KY 41858		Unknown		Currently the Ryan White Part B Program and Mountain Comprehensive Care are in discussions related to contracting for services to begin in 2017.	
Rural Health Services	Unknown	Unknown		The Office of Rural Health funds a	

			<p>variety of organizations in Kentucky. It is unknown if they are involved in the testing of persons that may have HIV or whether they provide clinical care or services.</p>	
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b. State of Kentucky HIV Workforce Capacity

The network of services for persons with HIV in Kentucky consists of a major network of providers that are coordinated through the Kentucky HIV/AIDS Branch and a group of social service agencies, community health centers and ASOs that operate independently and may or may not interact with the statewide network as circumstances and patient care require. The Ryan White Part B Program as the provider of Kentucky AIDS Drug Assistance Program (KADAP) is often the only resource available to provide anti-retroviral medications to HIV positive Kentucky residents. As such it is most likely that anyone with HIV within the State will be referred to the KADAP Program and therefore be linked to medications and services.

The HIV/AIDS Branch has been reaching out to existing community health departments, local health department and social service agencies to collaborate in the areas of HIV Prevention and Testing. In addition the Ryan White Part B Program has been actively nurturing and recruiting clinical partners, providers of support services and outreach in urban communities and in very rural portions of Eastern and Western Kentucky.

i. HIV Prevention Resources

Kentucky HIV Prevention Section Employees

- 2 Program Coordinators (1 position vacant)
- 1 Director of Continuing Education
- 1 Grant Administrator/Section Supervisor
- 1 Data Entry Operator
- 7 Disease Intervention Specialists (costs shared with the Kentucky STD Program)
- 5 Prevention Specialists Located - Jefferson and Fayette County

Formerly 3 Outreach prevention specialists located throughout state – lost through funding cuts.

120 - Local Health Department Nurses – provide HIV & STD testing through funding from the HIV Prevention Section. The local health department nurses are still providing testing and education without compensation. The HIV Prevention Section provides training, HIV test kits, controls, condoms, educational materials. A small percentage of local health department staff provide the HIV testing.

17 - Local Health Departments with Syringe Exchange Programs – The HIV Prevention Section is responsible for managing Kentucky syringe exchange programs. Jefferson County has approximately three Full Time Equivalent (FTE) staff.

Additionally the HIV Prevention Section offers a training course called, “Fundamentals of HIV Prevention Counseling.” The HIV Prevention Section sponsors the training of HIV testers through a Capacity Building Grant from the CDC.

ii. Core Medical and Support Services for Persons Living with HIV.

Ryan White Part B, C and D Staffing

- 7 Ryan White Part B Staff
 - HIV/AIDS Branch Manager
 - Part B Program Administrator
 - KHCCP Program Administrator
 - KADAP Administrator
 - KADAP Coordinator
 - Kentucky Health Insurance Continuation Program Coordinator
 - Data Entry Assistant

Statewide Network of Core Medical Services and Support Service Providers

- 26 Physicians and Physician Residents and Nurse Practitioners (approximately 12 FTEs)
- 23 Nurses and Medical Assisting Staff (approximately 12 FTEs)
 - 9 Mental Health/Substance Abuse Counselors (approximately 4.6 FTEs)
 - 60 Medical Case Manager/Social Workers
 - 3 Non-Medical Case Managers
 - 4 Outreach/Early Intervention Services Staff

KADAP Pharmacy – University of Kentucky Clinic Pharmacy

1 Pharmacist/Adherence Specialist

iii. HIV Surveillance Staff

2 Epidemiologists

1 Data Entry Specialist

1 Out-stationed Epidemiologists

iv. Federally Funded Community Health Centers (CHCs) – Calls were made to every CHC in the Commonwealth of Kentucky to discuss HIV Services. Responses varied greatly. Some community health centers are very actively involved in the care and treatment of persons with HIV and/or HCV. These CHCs dedicate portions of clinical providers and case managers that support persons living with HIV. The outcome of the phone surveys is that the HIV/AIDS Branch will continue to pursue stronger partnerships with two CHCs located in Eastern Kentucky. It is not possible to quantify the time and effort that the 23 federally funded CHCs are committing to care of persons with HIV.

v. Local Public Health Departments – In the last year, the Ryan White Part B Program has opened a new service site with the Lake Cumberland District Health Department, located in Southeastern Kentucky. The personnel that are utilized for HIV Services are included under the Ryan White Part B Network. Additional discussions have taken place with the Kentucky River District Health Department located in Hazard, Kentucky. It is anticipated that HIV services provided by the Kentucky River District health Department will begin in January of 2017.

c. Interaction of different funding sources – Payor of Last Resort

All HIV/AIDS Branch employees and contractors are acutely aware of the need to collaborate and use other resources to ensure that the CDC/HRSA funds are used wisely to ensure that every individual has access to HIV Prevention/Testing Services and Ryan White Part B Services. All participants are also aware of the requirement to determine whether other funding sources are available to pay for services and that CDC/Ryan White Part B funds are payor of last resort funding. All other resources should be used before the federal funds.

i. HIV Surveillance – Funding for HIV Surveillance Staff is split between CDC funding and Ryan White Part B Funds. No other funds are available.

- ii. HIV Prevention – HIV Prevention has struggled to maintain prevention, education and testing services are at a level that is needed due to funding reductions in their CDC Prevention grants. In the meantime, a portion of Department for Public Health funds have been redirected to cover the lost CDC funds. The funding shortfall has caused the HIV Prevention Section to strengthen collaborative arrangements with local health departments. Currently, the local health departments are paying for staff throughout the state. The staff provide HIV and STD testing. HIV Prevention pays for the test kits and other prevention materials. Without this level of collaboration, HIV testing would not be available in most of the rural portions of Kentucky.
- iii. Ryan White Part B KADAP Program and Services – The Ryan White Program is the section that is most affected by payer of last resort issues. Ryan White Part B pays for services for clients who may not have other resources.
 - a. Ambulatory Care – Bi-annual certification of clients allows for the checking of health insurance coverage or Medicaid or Medicare. Clients with their own insurance must use that coverage to pay for services unless the service is not authorized by the insurance company.
 - b. KADAP & KHICP – The Kentucky AIDS Drug Assistance Program and the Kentucky Health Insurance Premium Cost-Sharing Assistance Program check through the use of a Pharmacy Benefit Management (PBM) system to see if a client is eligible for another form of insurance. In addition, if the KHICP program purchases insurance or pays co-pays or deductibles the PBM checks to verify that their client does not have other coverages and that the co-pays and deductibles are being charged correctly.
 - c. Other Services – Housing, utilities and emergency financial assistance. If the Ryan White Part B Program receives a request for housing, the case managers will check with HOPWA to determine whether Section 8 housing or housing assistance is available before using Part B housing funds. United Way and other charities are also approached for assistance for utilities, or other needs.
 - d. Food Assistance – Case Managers provide a list of food pantries and meal sites where clients may go to receive additional help with groceries and food. Food cards are provided when other resources are not available. Two Ryan White Part B subrecipients have established food pantries in response to the need to ensure that the HIV positive clients have access to quality food and groceries. These agencies work with outside providers to donate food or buy from other non-profit agencies that sell food at a greatly reduced price. In many cases, Part B funds are only used for meat, eggs, fresh vegetables, and milk.

The HIV/AIDS Branch will continue to collaborate with local agencies to provide the greatest array of services to clients while being strong stewards of the funds that are received from the CDC and HRSA.

d. Needed Resources.

Questions related to needed program resources and or services were discussed with consumers, community representatives and HIV service providers during the needs assessment focus groups and stakeholder meetings. The recommendations have been included in the Kentucky Integrated HIV Prevention and Care Plan. The following needs were identified by the focus groups, stakeholder meetings, and client surveys.

- i. Education – Schools/school boards, medical providers, public health employees, consumers, persons at risk for HIV. Both the HIV Prevention Section and the Ryan White Part B Program funds outreach and education activities. In addition, medical case managers and clinical staff are very focused on educational activities, especially medication adherence.
- ii. Education - Perceptions within churches - Thoughts about birth control within church shapes people’s perceptions. There are not a lot of churches that want to talk about HIV or their members that are HIV positive. The HIV Prevention program has initiated a program to work with African American churches in Louisville. This program includes sponsoring HIV testing activities and providing grant funds to churches to sponsor HIV testing events. The HIV Prevention Program is also working with a church in Hazard, Kentucky that is located in the HCV hotspot. Establishing partnerships with both urban and rural based churches will continue to be a priority.
- iii. Cultural Competency Training – Prevention and Services Staff – public health staff, clinical staff. – The HIV Prevention program works with all of the local health departments providing education. The Part B Program provides HIV educational quarterly meetings for the Part B providers. The need for education related to cultural competency has not been addressed throughout the entire Prevention and Care System. This issue has been identified in the new Prevention and Care Plan.
- iv. HIV Care in the jails and prisons. The Kentucky HIV/AIDS Branch has not been successful in initiating a strategy to work with the prisons and jails in Kentucky. The Prevention and Care Plan has identified this as a priority for the new SCSN.
- v. Development of a statewide Linkage to Care Program to link newly HIV diagnosed clients to care and services as well as to connect with clients that have been lost to care and bring them back to care and services. The Linkage to Care Program should be fully operational by the beginning of 2017.

- vi. Reductions in the HIV Prevention grant from the CDC are beginning to affect the ability the program to provide a comprehensive statewide network of prevention and HIV testing. The HIV Prevention staff is continuously searching for additional funding opportunities for the education and testing staff that was lost to budget cuts.
- vii. HIV Surveillance is using an antiquated HIV tracking system to report and track new cases of HIV and for the tracking of pertinent laboratory values. The HIV Surveillance Program is in the process of evaluating bids for two software programs to replace the old software. Once a bidder has been approved, the contracting and installation process will be initiated.
- viii. Lack of advertising related to HIV prevention and care. There were many comments during the focus groups suggesting that HIV is not a public priority any more. Participants stated that the PSAs, billboards and other public advertising activities seem to have disappeared. Persons who are at-risk do not know where to go for testing and services both in urban and rural areas. The HIV/AIDS Branch is developing the following programs to make sure that persons that are at-risk for HIV are able to reach HIV testing and care sites: 1) The Kentucky HIV "Helpline," which has already been started; 2) Advertising for the HIV Helpline via television and radio PSAs, billboards and bus placards, which will begin in 2017; and 3) an initiative to reach persons that are at-risk for HIV on social media sites including: Twitter, Instagram, Facebook, and dating sites, which are planned for 2017.
- ix. Both clients and staff noted the need for the following additional services: Mental health care, including psychiatrists that prescribe mental health medications, substance abuse treatment, client financial assistance, transportation, housing, and food. All of these recommendations have been included in the new Prevention and Care Plan.

D. Assessing Needs, Gaps, and Barriers

- 1. Goal of the Kentucky SCSN Focus Groups** - Kentucky SCSN focus groups were held to obtain feedback from persons throughout the State of Kentucky who are at-risk for HIV, persons who are HIV positive, and persons knowledgeable about HIV. Information collected during the focus groups will be included in the development of the Kentucky SCSN Work Plan to be used as a guide for HIV Prevention and Service activities for the next four years.
- 2. Focus Group Design**
 - A. Geographic Representation.** The focus groups were held in six regions throughout the state to allow for a very diverse participation in the information gathering process. The goal of the focus groups was to obtain participation and feedback from both HIV positive individuals and individuals residing in each of the six regions who are knowledgeable about HIV.
 - B. Agency Representation.** The agencies that were selected to host the focus groups were instructed to invite participants from the following social, ethnic and demographic populations.
 - a. Populations of color, especially those from African American and Hispanic backgrounds
 - b. Gender - male, female and transgender individuals
 - c. Urban and rural residents of the Commonwealth of Kentucky
 - d. Representatives from the six regional service areas. One focus group was held in each region:
 - i. Louisville Area – Area A – University of Louisville 550 Clinic, Louisville, Kentucky
 - ii. Lexington Area – Area B – AVOL, Lexington, Kentucky
 - iii. Western Kentucky – Area C – Matthew 25, Inc., Henderson, Kentucky
 - iv. Northern Kentucky – Area D – Trinity Episcopal Church, Covington, Kentucky
 - v. South Eastern Kentucky – Area E – Lake Cumberland District Health Department, Somerset, Kentucky
 - vi. Northeastern/Eastern Kentucky, Area F – New Hope Christian Center, Hazard, Kentucky
 - C. Guidelines to ensure standardization of the six focus group sessions.** The SCSN Planning Committee implemented several controls to ensure uniformity in the manner the focus groups were conducted, including the meeting agendas, focus group questions, facilitator training, and focus group write-up/documentation.
 - i. All focus groups utilized the same agenda. All participants received the same instructions at the beginning of the each focus group session related to how the meetings would be run, as well as the rules of participation, and participant confidentiality.

- ii. Identical questions were used with all focus groups. The facilitator asked ten questions with additional follow-up questions that were developed by the SCSN Committee.
 - iii. The questions focused on both HIV Prevention and HIV Services. The questions addressed: perceptions of HIV as a disease, living with HIV, high-risk behaviors with an emphasis on IV drug use due to the high incidence of HCV in Kentucky. In addition, the facilitator asked for suggestions related to prevention and services that would work with specific populations.
- D. **Focus Group Facilitator.** The facilitator for the focus groups was chosen based on experience working with HIV and his knowledge of the Kentucky HIV community, as well as the need to have experience presenting to community based organizations. Mr. Mark Johnson has a Master's Degree in social work and experience in the following areas: HIV Outreach Coordinator, trained health educator, health equity team leader, and has community health planner experience in the African American community.
- A. **Overview of Regional Focus Groups.** Focus Group Reporting Methodology – The focus group leader and the recorder keep notes of the participant responses to each question and scored the questions on a scale of 1 to 5. A score of 1 indicated mild or limited interest in the topic, while a score of 5 indicated very strong interest from the group.

FOCUS GROUP SUMMARY

1. Louisville, Kentucky – 550 Clinic at the University of Louisville

Group Demographics: 15 participants: 10 White males, 2 African American males, 1 African American female, 1 White female, 1 White transgender female. Age range: 28 – 70.

The Louisville focus group was comprised of members of a local standing support group for individuals with HIV. A few new people showed up – 2 were parents of one of the attendees.

Discussion Themes: Mental health issues (depression, low self-esteem, etc.); fear, stigma and religious concerns; and lack of education, awareness and visibility. The consensus of the focus group was that “the State really has to take hold of this.”

2. Lexington Kentucky - AVOL

Group Demographics: 7 participants – 1 African American female, 1 White female, 5 White males. Mix of heterosexual and LGBT. 2 self-identified injecting drug users. Age range: 22 – 60.

Discussion Themes: Stigma and misinformation; lack of education for everybody - “HIV information is nowhere to be found in general community;” needle exchange has been a good thing; and low self-esteem (personal stories).

3. Henderson, Kentucky – Western Kentucky - Matthew 25

Group Demographics: 8 participants - 1 African American female, 1 African American male, 6 white males. Mix of heterosexual and gay. Age range: 35 – 65.

Discussion Themes: Fear of people finding out their status (Disclosure); concerned about the community's stigma of HIV; lack of education throughout region (youth, adults and health care providers); lack of information – “We don't hear or see anything about HIV anymore;” aging individuals with HIV (Social Security versus Ryan White benefits and KADAP, loneliness and depression); heterosexual concerns versus gay concerns (identity assumptions, services for women, etc.); Matthew 25 has been a lifesaver for many of us.

4. Covington, Kentucky – Northern Kentucky - Trinity Episcopal Church

Group Demographics: 14 participants – (2 African American females, 2 African American males, 10 White males). Mix of heterosexual and LGBT. 1 self-identified injecting drug user. Age range: 28 – 67.

Discussion Themes: Lack of general education, particularly for African Americans and youth. Religion is a barrier. Social media – major concerns about anonymous hook-ups and dishonesty. Patients need more education about HIV and treatments – “It's like we have these great drugs now but everything about HIV has been forgotten” (mental health, suicide, coming out, nutrition, etc.). Fear and stigma; injecting drug use a major problem in the area – “needle exchange has been a great thing for our state....long time coming but glad it's here.”

5. Southeastern Kentucky – Somerset, Kentucky - Somerset Recreation Center

Group Demographics: 6 participants (All White gay males). Age range: 40 - 61.

Discussion Themes: Inconsistency of services and access; lack of education for everybody; mental health issues; fear, religion and stigma; and insensitivity of healthcare providers.

6. Northeastern/Eastern Kentucky – Hazard, KY - New Hope Christian Center, Hazard, KY

Group Demographics: 21 participants – (12 White females, 9 White males). Mix of heterosexual and LGBT. A few self-identified substance users. Age range: 35 - 75. This was a unique group, most were general community members with minimal to no HIV knowledge. For several others this discussion group served as the weekly substance abuse support group meeting. Spent good amount of time educating group about HIV.

Discussion Themes: HIV is not a priority in this area because of poverty, unemployment and other life issues; area has big substance abuse problem; and a lack of general education for everybody including healthcare personnel.

B. Responses to the Focus Group Questions – Includes responses from all six focus groups in order to fairly show the responses from all six regions of Kentucky.

1. Is HIV common or problematic in your area?

Louisville (5) - has the highest population of persons living with HIV in the State of Kentucky it has the largest population and the greatest need. There are not enough case managers to work with all the clients, many case managers have caseloads of as many as 140 clients. HIV as a disease is really affecting our young people.

Lexington (4) - People aren't educated – Still at risk. Lots of homophobia. People from other places say there is so much more stigma here than other places...because of this there is more needle use, drug use and shameful sex. HIV is rising among minorities and young people. Young people aren't wearing condoms because they don't think it's a big deal. We do not see HIV information like we did years ago. The new needle exchange programs could indicate that there is a problem in our community. Social media is a problem with a lot of anonymous sex. People are still meeting and having sex in public places like parks, bookstores, etc.

Western Kentucky (3) - Yes, but most people are very guarded about it. People talk about it at work saying bad things and don't know that I am (positive). People are misdirected – my pastor has her own belief system about AIDS – false and misinformed. (I am) too intimidated to talk with pastor about it. In Beaver Dam, there are issues with the medical field and lack of information. If people find out, we have a fear of our house being burned down. Primary care physicians do not deal with it. Most people with HIV in the area are closeted about it.

Northern Kentucky (5) - Seems like 10 new cases a week in clinic (research clinic) – More women, a lot of youth. People not coming to clinic or health department until they're dying (18 yr old with Kaposi's and wasting). Northern Kentucky has highest rate of heroin use in country (HCV). Education is terrible if people are coming in dying. Women getting infected primarily because of men on the down low (DL). Social media and stigma are still really bad here – people are not telling the truth on social media apps. People that are HIV negatives think they can depend on PrEP or if they get it they can just take medication. People with HIV need to know about adherence and resistance.

Southeastern, KY (4) - I don't know any other positives in Albany. Here in Somerset we don't hear about HIV. In London, we don't hear about anything but the increase in drug population. People are scared to admit they are HIV positive and being "outed." Hard to find a job because of it...I was fired from 7 jobs. Small town rumors keeps people from coming out. There's a support group in London...maybe 20 different people attend.

Northeastern/Eastern Kentucky (3) - I'm a nurse and I know it's on the rise in our area. Can HIV be transmitted casually? I saw an article in the local newspaper that said it could be a problem in Perry County. Seems like some of our neighboring counties are starting to do a little more educating. Maybe we need to have an awareness night where people

can talk about it. Heroin is a big problem here. I was a nurse (for 5 counties) that only worked with HIV positives and I had a full case load.

2. What are people's perceptions about people with HIV?

Louisville (5) People are still really confused regarding the disease. Religion and social perceptions create a focus on a specific group of people, they think that it is a homosexual disease. We're the lepers. Culturally, people aren't open to it – in the African American community, it's taboo to talk about, it's difficult to get people to even think about testing in the Black community.

More information is needed then there would be less stigma. Society needs to be more educated. There's a lot of younger people in the clinic now.

Perceptions within churches - Thoughts about birth control within church shapes people's perceptions. There are not a lot of churches that want to talk about HIV or their members that are HIV positive.

Family Stigma - People always ask "How did you get it?"- My mom tells people I have cancer to avoid the stigma. "He has the flu" – that's the denial in my family. "My family threw out the dishes I ate off of".

Lexington (5) - People with HIV deserved it because of drugs and sex. People on social media apps always asking "Are you clean?" My mom refers to me as "sick" – there was a time she was afraid of me being around my nieces.

People need to be educated....get over the hysteria. People including some individuals that are positive, do not understand being undetectable. I didn't get good STD information in school....no sex education. If you aren't doing "abstinence only," then you deserve what you get. People forget that there are people with HIV who were not promiscuous. I got it at 16 years old, why didn't someone come in and give us sex education – I thought only older people got it.

Need to focus back on drug use (PNP – Party N Play), Meth and needle use are problems also.

Western Kentucky (4) - It's different in different communities (Henderson versus New York, urban versus rural). "We can't get the same information they get, it's totally different here."

Scared names of HIV positive individuals may go on some kind of list. Worried about confidentiality – who might be at this discussion, who will know me, etc. Don't have a healthy lifestyle.

Northern Kentucky (4) - Social media makes everything a nightmare – if I get tested or if someone finds out, they may spread it on social media. Fear of the unknown, still fear of people with HIV, fear to come out. Stigma is worse now. I'm afraid to tell anyone that my husband has it because they will think I have it too. The Black church is putting a cover over the problem. I tried to reach out to my minister but they didn't want to respond or support people with HIV. The State needs to do a better job of educating people.

Southeastern, KY (4) - Limited Life, keep your kids away, unclean/like leprosy. Gossip – people saw me at my doc's office in Lexington and went back and told people at home. I feel guilty about having HIV – my religion keeps me confused. People get ostracized and outed in church. It's a gay disease.

Northeastern/Eastern Kentucky (3) – Nasty, Needle sharing. Afraid of them. School kids would pick on gay people. It's a gay disease. People around here wouldn't understand.

3. Describe your experiences about people living with HIV.

Louisville (5) Barriers to care - Friends are afraid of getting tested. Many won't stick to their treatment regimen. Many miss and skip out on appointments. Look how long it took to get needle exchange...it took white people across the river to get it out in Kentucky.

Public schools should address HIV – Teachers, principals, etc. We have to let the shame and stigma go. Need more educators specifically for HIV. HIV information is not out there like it used to be. Workers tend to forget that we have other issues besides HIV, many of us have mental health issues (depression, loneliness, fear, isolation, etc.).

State doesn't do enough to advertise – Have to invest and talk about HIV in communities like we're doing tonight. (Helpline). We don't see banners, TV ads, or hear anything on the radio about HIV. TARC (Transit Authority of River City) didn't give free bus rides last year on World AIDS Day like they've done for years...it's like HIV isn't here anymore.

Lexington (5) Experiences - People think it's God's punishment. It's a sin. I was let go from a job because they found out I was HIV positive. I had a negative experience from my sister. An old employee of **** was spreading names of positives – issues with

confidentiality. People (at a 12-step program) who had been positive for a while were welcoming and helpful.

Western Kentucky (3) - I live a healthier life since I know. Still deal with the idea that I am not a whole person and something is wrong with me. Too many younger people think that HIV is not a big deal. Younger people think you die from it. I hear people say they have a hard time taking their medicine.

Western Kentucky (4) – People are afraid to come out and/or disclose their status Can't lump HIV into one basket. Having HIV has taught me to do more – I learned how to reach out. I'm a veteran and get really good care from the VA hospital – they have great education. Patients not getting adequate information from providers about services Our community still has a lot of stigma and misinformation. It's a sin. Nobody wants to talk about HIV – not even our state government - it's still a problem.

Southeastern Kentucky (5) - Depression – Nervous about people finding out. Burned out. People don't understand it. Some positives are open about it – I'm not one of those. Better not to disclose here because of stigma. The positive community is invisible. My brother's death of AIDS carried over to me.

People automatically think you are gay. If you're gay, people think you have it. People get married to cover up being gay. A lot of men [are] on the down low in this area. Religion says being gay is wrong, so having HIV wrong.

Northeastern/Eastern Kentucky (2) – Some are living normal lives. A baby in Perry County was born with it. People in their 40s know nothing about HIV. I only know one client open about it.

4. What behaviors can increase the risk for getting HIV? Rank 4

Louisville (4) - Unsafe sex, drugs and rock n roll, not using on condoms, not getting tested, multiple partners, not talking about HIV, secrecy/on the down low. Mental health - depression, low self-esteem, fear, discrimination.

Social media apps - create a way to meet people anonymously and even block them from a particular conversation, "Sero-sorting" can be a destructive result.

Lexington (4) – Unprotected sex, alcoholism, drug abuse, multiple partners, not giving a damn, lack of education, lack of information about proper use of condoms and lube, stigma/fear, self-esteem, being told sex is not ok, being told gay is not okay, no education in my school.

Western Kentucky (4) - Drugs, bare backing, not abstaining, lack of education, social media, a lot of bug chasers out there, religious beliefs, non-disclosure.

Northern Kentucky (4) - Drugs, drinking, injecting drugs, unprotected sex, needles, feeling like it can't happen to me, lack of education, social media, promiscuous behavior, religious beliefs, fear of testing, non-disclosure, resistant virus, people feel like no one cares about them especially youth, sex workers.

Southeastern Kentucky (4) - Unsafe sex, on-line chat rooms, sharing needles, drugs and alcohol, Meth is a big problem in our area, fear, having a partner that does not disclose his status, prostitution, self-esteem.

Northeastern/Eastern Kentucky (2) - Unprotected sex, sharing needles, being careless – not getting treatment.

5. What are people's perceptions about people who inject drugs? Rank 5

Louisville (5) Perceptions – crazy, crack whores, they can stop if they want too, low-income. Not educated. Drugs were overprescribed now people are addicted to them – Turn to heroin. Are not innocent victims of HIV. If you get HIV, you deserve it.

Public Misconceptions - Epidemic in Indiana because of Opana not heroin, there were whole families in Indiana sharing needles, some of the people were middle class, middle and upper classes use drugs just like everybody else.

Lexington (4) – Perceptions – dirty, sad, junkies, losers, criminals and thieves. Are not educated. Come from a poor family. Assume you got HIV from drug addiction or prostitution.

Western Kentucky (3) - Addicts, low life's, at risk for HIV/AIDS, lack of understanding, having HIV worse than being a drug user.

Northern Kentucky (3) – Losers, everyone's doing it here – affects all of us. Doesn't have the same stigma as HIV especially to young people. Quick fix to cover their problems. Major problem in this area.

Southeastern Kentucky (5) - Low enough to do this to yourself. Feel sorry for them. No respect for them. Not educated about what's in the drugs (street). Poor. Liars and thieves. London has a needle exchange. Churches run everything here – makes people afraid.

Northeastern/Eastern Kentucky (5) - Low life. Should know better. Poor. They're sick. Pike County has needle exchange, I believe Letcher County has a needle exchange program also. There's no money for rehab/treatment.

6. In your opinion, what are the best approaches to prevention or reducing HIV in your community? Rank 4.

Louisville (4) - Include a POZ magazine in the local newspaper and see what happens – that magazine has a lot of good information. Make HIV visible again. Awareness (banners, TV and radio ads, things on the sides of city bus, bill boards, etc. Lots of education for the entire state.

Use of PrEP - Use Federal funding for PrEP, Need more PrEP clinics. The state really isn't doing anything about PrEP. If condoms save lives, when will PrEP be as readily available?

More mental health services would be helpful to many.

Cultural sensitivity workshops for everybody. Getting churches on board with good factual information would be nice.

Lexington (5) - Education – provide early (HIV) education. Use people with HIV as mentors and role models. Educate people about the cost of HIV. Need balance between “scared” and “no big deal”.....education is key. Educate that HIV is not a gay disease, not a death sentence. Update the literature – it's boring.....it's dated and often about things in larger cities. Get some education on social media. Let high school kids know about testing and where they can go.

Needle exchange. Some providers in Lexington do not test people when they present with symptoms. Train the school nurses on Ora-quick.

Western Kentucky (5) - CDC should target everyone – targeting African Americans let's white people think it's not them. We don't hear anything about HIV anymore, people think HIV has been cured. Educate clients on their rights, include Western Kentucky in State HIV conference.

Northern Kentucky (4) - Need more education and health educators, Need HIV positive role models. Education of some sort is needed on social media badly. We need to get updated information to bug chasers and those practicing bare back sex. The State needs to get more information out about PrEP. We need PrEP education for our area health department and workers. We have to do a better job of educating our religious community and the black community. Have to get more ads on TV, radio and in the newspaper. We need support groups for African Americans, particularly women.

Southeastern Kentucky (4) – Abstain. Condoms – access and when to purchase them. Education throughout community especially in the high school. Educate the young folk,

many in their 20s think it's okay to have unprotected sex with anyone but older people. People not teaching children about sexuality, HIV, STDs. Getting services in the area that stay longer than a year or so....we have care coordinators now but didn't for a while. We need consistent messages about HIV. We need an infectious disease physician in the area.

Northeastern/ Eastern Kentucky (3) - We need education for everybody. We need a program like D.A.R.E. in our schools to talk with young children. Somehow let people know it's not a gay disease. Need a lot more ads in newspapers, on TV and the Internet, radio and social media. I know 2 or 3 girls that really need a test but they won't because of who might see them.

7. Describe your experience in talking with your health care provider about sexual behavior and/or drug use? Rank 4.

Louisville (4) - Positive - My provider at 550 Clinic is very open. I'm comfortable talking to him. Most infectious disease docs are open - If you aren't comfortable, you move on to another. Our case managers make good recommendations based on our needs but this is the Metro area.

Negative - My private provider never talked about sex. I wasn't comfortable with the doctor in Somerset. Docs need more awareness and sensitivity. Some people are still afraid to go to the doctor - denial.

Lexington - (4) - HIV physicians/providers - Some docs in the community are not gay friendly. I had horrible experiences with docs before coming to Bluegrass Care. Health department and student health are judgmental about STD testing.

Need for Help/Assistance - Need social workers or someone to help when you first find out you're positive...it's overwhelming....having someone like that may have gotten me into treatment sooner or kept me in care (Linkage to Care). The STD workers at the health department were aggressive and wouldn't let me call my mom...they gave me my result and immediately wanted to know last people I had slept with.

Western Kentucky (4) - Primary care provider more accepting if I'm honest, comfortable here at Matthew 25, wouldn't be comfortable talking with doctor in other places. Issues with some providers related to confidentiality and sensitivity, medical field needs to be educated, educate pharmacists - HIPAA violations (calling out name of drug in crowd, etc.).

Northern Kentucky (3) - HIV docs are good here, they will talk about anything. My primary care physician is not as comfortable talking about sex and drugs. BET and LOGO do a great of advertising but the local channels are pretty bad. Need more education about medication and side effects. My doc asks about everything (sex, drugs,

smoking). My primary care doc doesn't feel comfortable managing my HIV. VA hospital is so different from other hospitals...they take good care of my needs. People in ERs are treated poorly in Northern Kentucky.

Southeastern Kentucky (5) - I feel uncomfortable talking to my doc about sex. A doctor in Manchester is awful. Doctors around here have abandoned us. I had to move in-state to Lexington....things getting better....we have care coordinators. When I see my infectious disease doc, I'm very comfy talking about everything. No infectious disease doc in Somerset...can't keep them in this area. Our docs are part of the Women's Care Clinic. hospital not sensitive, they won't treat HIV positives, they will send you to Lexington. Providers definitely need more education. Gas/transportation to Lexington is expensive. Dentist here is limited in what he will do for you if you are positive. I heard a doctor telling his receptionist "don't take any Medicaid and Medicare crap...we don't make enough on it. I feel ashamed being on disability. I go to Lexington for counseling – I don't know of social workers or therapists in the area that will see me and be sensitive.

Northeastern/Eastern Kentucky (5) – Not comfortable at all. This is a small community – afraid it will take a while to get comfortable. We do have a few trainings here on HIV for healthcare staff. I would feel comfortable talking with my doctor about anything. The doc I go to would be comfortable with anyone. Some healthcare providers are stand-offish. Most people here don't have a foundation or family doctor. Sex workers are flying under the radar.

8. What barriers are there to reducing risk behaviors? Rank 4.

Louisville (4) - Money, lack of education, discrimination. Mental health services - Only one mental health provider at 550 Clinic. This provider doesn't prescribe medication. State should push University of Louisville to agree to mental health services (staff). Mental health services comes up in every meeting but have to wait eight weeks to get in.

Lexington (3) – Barriers – shame, stigma, lack of education, low self-esteem, money and discrimination. Condoms aren't visible and accessible if you don't go to clubs.

Western Kentucky (4) - Social media/apps like grinder (need to have prevention pop-ups) – it would probably be expensive. Churches have come a long way but still have a long way to go – religion is a big barrier.

Northern Kentucky (3) – Money, depression, religion, stigma, being on the down low.

Southeastern KY (4) – Shame, stigma, religion, insensitivity and fear. Lack of education, especially the youth....they do not know anything about HIV. Adults don't

educate kids. If you're gay, you're going straight to hell. Not being able to recognize your partner as your partner.

Transportation, lack of information, inconsistent services, misinformation.

Northeastern/Eastern Kentucky (5) - We have bigger problems here like unemployment, poverty, food....this area is struggling and there are just bigger problems than getting a test. If the State wants to help make a change, they have to commit to the area. Timothea (AVOL) has been here a short while but her position ends in July. What will we do then? Lack of education – what is HIV? Where to test? Our schools need education about it – kids are having sex at a younger age. Our community needs the very basic information. Religion is pretty strong around here. Politics.

9. Are you aware of a location for HIV testing in your community? Have you experienced any barriers in getting an HIV test?

Louisville (4) - Yes – 550 Clinic, VOA, Health Department, Walgreen's, testing is not hard to find. State needs to address this. We have billboards for everything but HIV.

No– Barriers - Don't think the general population knows where to go. Still a lot of stigma with testing. Being on the down low.

Lexington (3) - Yes - but most people outside the HIV world do not. Most people know the health department or possibly their doctor AVOL, Sometimes at the bars.

No – Barriers – Transportation, People ask me so they really don't know. Fear, Misinformation.

Western Kentucky (5) – Yes - Health Department, Matthew 25, private physician, the local college has an AIDS walk every year, State should be more visible in this area to help out.

No -My old doctor did not want to test me. Some nurses and doctors have refused to touch me. Privacy is a big barrier.

Northern Kentucky (3) - Yes – health department, Walgreens, Lynn Street Church, homeless shelters, St. Elizabeth Healthcare, drug treatment facilities. Would be great to have mobile units for testing like some other cities.

No- Barriers - Facilities constantly changing testing dates and times – they should be consistent. Not knowing where to go.

Southeastern KY (4) - Yes – Health department, women's clinic. Any doctor is supposed to.

No – Barriers - The day after I tested, someone at work said “I heard you have AIDS.” I’d rather go to the health department than my primary doc; I went to Lexington to get tested because I was afraid of people finding out; transportation; money.

Northeastern/Eastern Kentucky (4) – Yes - health department, hospital, any clinic. Rayann and Timothea at church. No- Barriers - I don’t think people know where to go. We do not have an Urgent Treatment Center. Our ER would not be a good place to go because it’s too busy treating people that use it as a primary care doc. No infectious disease doctor in Hazard anymore (we use to have one and he was great...now many Hep A, B, C and HIV clients are going without treatment). There is an infectious disease doctor in Whitesburg. In London, there is a care coordinator. Transportation.

10. What services do people living with HIV currently use? What services should be available for people living with HIV? What barriers do people living with HIV encounter when seeking services?

Louisville (5) - Services being used by HIV Positive persons: food stamps, dental assistance, bus passes, Medical assistance, Housing (if you can find it), some counseling, Same as general public, Ryan White, HOPWA, care coordinators. All services mentioned but we could really use a lot more.

Barriers - Not sick enough to receive them (services), lack of education, lack of provider education - I shouldn’t have to educate my provider on HIV, PrEP, treatment, etc. “Specialty Pharmacies” make it difficult to get medicines timely causing people to miss doses.

Lexington (4) – Lexington service providers - Ryan White, KADAP, God’s Pantry, Moveable Feast, food stamps, HOPWA, Medicaid, utilities, disability, Social Security, support groups, some counseling.

Services Needed - Mentoring, rehab, services for HIV medication related problems. Dialogue for telling your parents or children, something for self-esteem. Transportation, child care, mental health concerns like depression and loneliness. The food stamp office is terrible – no customer service, hard to get healthy foods.

Western Kentucky (5) - Matthew 25 – food, transportation, medical case management, money, housing assistance, dental help, eyes, KADAP, drug assistance programs and lots of other stuff.

Services Needed - Better mentors in health services, Women need more HIV services/resources. Transportation sometimes is a problem, mental health issues, and aging issues. What happens with KADAP when you get social security? Housing issues, loneliness and depression, insensitivity.

Northern Kentucky (3) – Services being used - Food, housing, mental health services, gas cards for travel, health department, VA provides a nutritionist.

Needed Services - support groups for African Americans, more information about men on the down low, more services/resources for women. Transportation, child care, support systems, mental health issues.

Southeastern Kentucky (5) – Current Services - Insurance assistance, utilities, dentist, Ryan White, heating assistance, housing, prevention and services are needed for the whole area.

Barriers - Lexington took away from our area, I'd rather have my teeth pulled than go to ****...they help a select few, but not in this area. Not much access here, I've been forced to go to Lexington if I want good treatment and social services. Care coordinators are doing better here but they have way too many patients they have to see, too much red tape. No education for HIV positives to know what to do and how to get services, doctors at ***** change so often –consistency is a problem, have to tell your story over and over...don't they keep records, lack of services.

Northeastern/Eastern Kentucky (3) – Services - drug assistance, housing (stigma keeps people from asking for housing), social services.

Services Needed - Everything.....more education.

Barriers - Fear, stigma, transportation, finances, discrimination, lack of understanding, lack of access to services.

- C. **Results of Strategic Planning Meeting with Key Stakeholders of the Kentucky Cabinet for Health and Family Services, HIV/AIDS Branch – Held June 23, 2016** – The purpose of the meeting was to obtain input from representatives of the Kentucky Cabinet for Health and Family Services that are knowledgeable with the Ryan White Part B Program as well as state and local health department services and Kentucky Department for Public Health and local health department services and regulations.

Attendees:

HIV/AIDS Branch Administration

Karen Sams	HIV/AIDS Branch Manager
Kay Loftus	Administrative Specialist III

Julie Nakayima, M.S.	Epidemiologist
Julie Kauzlarich, M.P.H.	Research Analyst
Anita Smith	Data Entry Technician

HIV Prevention Section

Gayle Yocum, M.S.W.	Prevention Section Supervisor
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Beverly Mitchell
Greg Lee
Telly Harris

Program Coordinator
Continuing Education Program Administrator
MSM Initiatives Coordinator

Ryan White Part B Services Section

Gloria Dennis
Andrea Fiero
Erin Larmour
Rachael Ravencraft

Ryan White Part B Program Manager
KHCCP Administrator
KHICP Specialist
AIDS Drug Assistance Program Coordinator

The group used the questions included in the: 2017 - 2021 Integrated HIV Prevention and Care Plan. Including the Statewide Coordinated Statement of Need, CDC/HRSA Guidance, June 2015. The Stakeholder Group used the questions from the SCSN Guidance related to describing barriers to HIV prevention and care services, including, but not limited to:

i. Social and structural barriers (e.g., poverty, cultural barriers, stigma, etc.):

Education. Kentucky school curriculum is not focused family planning or birth control. It is based on teaching abstinence. There is no discussion of prevention of HIV or STDs.

Recommendation: Kentucky public schools should begin teaching about HIV/STDS in elementary school and middle school.

Recommendation: Schools could include discussion of HIV/STDs in after school programs.

Stigma: Fear, people do not talk about because others will think that you might have HIV. Many are afraid to be tested or don't want to know. Some people are more afraid to be viewed as gay as opposed to having HIV. Some people test positive three or four, but they do not seek care.

Recommendation: Changing to a system that utilizes two rapid HIV tests, per CDC's guidance. This allows for the confirmation of the first positive at the same time as the first test. Results in having the opportunity to still have the person in a face-to-face setting and initiate the transfer to a care coordinator or an Early Intervention Specialist (EIS). If a direct hand-off of the newly diagnosed persons cannot be facilitated, the program would give out the direct phone numbers of the person performing the test as well as the care coordinator and the EIS.

Failure to reach persons that test positive through self-testing. What happens to the people that self-test?

Recommendation: Ensure that the national 800 telephone number included on the commercial self-test kits is connected to the Kentucky HIV Helpline where all calls are live answered. Could handouts or stickers be displayed with or attached to the HIV test kits that included information on Kentucky HIV Prevention services and the Ryan White Part B Program.

Cost of test kits and controls. Test kits cost– \$30 to \$70 – plus the cost of the controls that must be run to ensure that the tests are accurate.

Recommendation: Linking with Louisville Metro Health Department (LMHD) The LMHD understands that there is a strong need for testing in Louisville and the director is willing to buy the test kits. However there is a lack of trained HIV testers available to do the testing.

Cultural Competency – Agencies do not understand how to reach out to possible HIV infected individuals that come from very diverse racial and ethnic backgrounds. There are so many cultures and subcultures.

Recommendation: Provide cultural competency training to agencies to facilitate understanding and acceptance of other racial and ethnic cultures with a goal of increasing HIV testing in minority communities. Include training of first-line staff including receptionists to accept and understand the persons that are calling for help.

Poverty. If a person’s basic needs are not met, then cannot seek care.

Recommendation: Ensure that all persons with HIV throughout the state that receive Ryan White Part B services are educated on all available services, including: medical care, subspecialty care, medications, mental health, substance abuse, housing, transportation, food programs, etc.

Reaching out to persons in the sex trade. This population that completely flies under the radar.

Recommendation: Develop Outreach and EIS services that are specific to sex trade workers.

ii. **Federal, state, or local legislative/policy barriers (e.g., the changing health care coverage landscape, policies on HIV testing or lab reporting, etc.):**

Kentucky statute only refers one HIV medication. Also, HIV is still referred to as a terminal illness.

Recommendation: Revise state code/laws regarding HIV and allowable treatments and medications.

Criminalization of the sex trade. Keeps persons under the radar and unwilling to seek testing or help.

Recommendation: The state should consider decriminalization of the sex trade.

State Medicaid rules prevent persons in jail (not prison) from receiving help. Jails are a barrier to receiving medications. New governor is going to reduce participation on KYNECT/Medicaid. Current changes in Medicaid rules will result in individuals and families paying a monthly Medicaid premium as well as co-pays and deductibles.

Recommendation: Medicaid should reconsider its rules for HIV infected persons residing in jails.

Recommendation: The Ryan White Part B Program will need to be prepared to assist clients with the changes coming to the State of Kentucky Medicaid program.

iii. Health department barriers (e.g., political landscape, staff capacity, etc.):

Kentucky Department for Public Health - The most significant issues involving staffing of the HIV/AIDS Branch sections. Currently, there are six position vacancies. Positions are being advertised and should be filled before the end of the year.

Recommendation: Continue to aggressively pursue the timely hiring of vacant HIV/AIDS Branch Staff (system is in place to post jobs and interview as quickly as possible).

Start-up of the new state-wide Linkage to Care Program. Hire ten Linkage Navigators to be located throughout the state. Goal of contacting and following up with every new HIV positive individual and those that have been lost to care. Link clients to medical case management, provided intensive non-medical case management, link clients to Ryan White Part B Services. Goal of having clients consistent on ART Therapy (Anti-Retroviral Therapy) and achieve undetectable viral loads.

Recommendation: Complete the contracting, hiring and training phases of the statewide Linkage to Care Program by the end of 2016.

Issues with network of local health departments. Clients seeking HIV tests or services often are treated rudely and there are concerns about client confidentiality.

Recommendation: Provide training to local health department staff on communication with persons seeking HIV testing or care. Also, review with local health departments the federal and state regulations related to confidentiality and the penalties that may be incurred for violating client confidentiality.

iv. Program barriers (e.g., infrastructure capacity, access to data, data sharing, inadequate health information systems, availability of funding, etc.):

The HIV-HCV co-morbidity study being tracked in Hazard, Kentucky, located in Eastern Kentucky, which is experiencing high IV drug usage. This study will run out of funds June 30, 2016. The study was instigated by the increasing numbers of Intravenous Drug Users (IVDUs) that are living in the Northeastern and Eastern regions of Kentucky. This area of the county has exceptionally high incidence of Hepatitis C (HCV) infections on record. The concern is that if the potential for a major outbreak of HIV/HCV co-infection that would potentially extend to other portions of Kentucky and rural Appalachia. The study has enrolled 500 clients that are HCV positive and routinely tests the entire cohort for HIV.

With additional funding, the number of study participants will increase from 500 to 750. The study will continue to be watched by the Kentucky Department for Public Health and the HIV/AIDS Branch.

Access to State of Kentucky income and benefits databases. The ability to access income and benefits databases would assist the program with client enrollment, provide vital information on household income and size and insurance enrollment.

Recommendation: Pursue conversations with the State of Kentucky Medicaid to allow for access to state income and household information.

HIV Prevention Section has received significant reductions in funding from the CDC HIV Prevention Grant (PS12-1201). The CDC funding has decreased by 27.2% over the last three years. The HIV Prevention Section is currently funded for \$1.37 million down from \$1.88 million. The loss of funding has impacted prevention contracts throughout the state as well as the purchase of test kits and testing supplies.

Recommendation: Need to identify new sources of funding to replace the CDC Prevention funds.

The HIV Prevention Section has been hampered by the antiquated data collection systems utilized by the HIV Surveillance Section. The data collection system has negatively affected data entry for new HIV positive test results and statewide HIV viral load laboratory results. In some cases, data entry is in some cases over a year behind. The HIV Prevention Section is unable to track new HIV cases and HIV positive clients that have been lost to care.

Recommendation: The HIV Surveillance Section is in the process of evaluating two software programs that would replace the current out of date system. If a contract is approved to purchase or lease these software programs the Surveillance Section could achieve real-time data collection within six months.

- v. **Service provider barriers. Discuss any stakeholder(s) that are not involved with planning for HIV services that need(s) to be involved in order to address gaps in components of HIV Prevention programming and/or along the HIV Care Continuum more effectively (e.g., lack of specialized resources or specialty care providers.):**

The SCSN Work Group has not been able to find a representative from the jail and prison services to represent HIV positive individuals that are incarcerated or due to be discharged. The Ryan White Part B Services Program has a network of providers that work closely with jail and prison programs to assist clients upon release. However, the work group does not have a representative that works in the industry. This often results in HIV positive individuals being released from prison or jail without advanced notice or without current lab results, medical records or documentation of medications.

The HIV/AIDS Branch will be working to improve its communication and collaboration with representatives from the prison and jail systems with a goal of reducing improper discharges to the street for HIV positive former inmates.

The University of Kentucky Clinic Pharmacy and chain pharmacies are well informed on use of ARV medications and the need for medication adherence. There is a problem with smaller and rural pharmacies with regard to the dispensing of medications, adherence counseling and possible counter indications for mixing ARVs with other medications.

Recommendation: The HIV/AIDS Branch will develop a mailing list of pharmacies and/or their email addresses to provide current information on HIV medications and care. Regular updates will be provided as well as information on the Kentucky HIV Helpline and the how to reach the regional AETC.

- iv. **Client barriers (e.g., transportation, homelessness/housing instability, inability to navigate the system, poverty, stigma, comorbid conditions, etc.).**

Fear/Stigma

Basic Needs and Services

Lack of knowledge

Transportation

Homelessness and housing – need more to be more temporary. Under two years (need more money).

Communication Strategies

Effective communication – learn and explain

Explain – social media – Twitter – Facebook – Instagram –

Competition for a person that creates – Snapchat –

Link it to the hotline.

SCSN – Notes from the January 28, 2016 Stakeholder Meeting

1. Focus on Persons that are Negative with High Risk Behaviors

- i. Misperception of risk, thinking HIV doesn't exist anymore. Youth don't have knowledge about safe sex. Dealing with local school boards. People don't talk about how they stay negative.
- ii. Stigma - substance abuse/mental health issues
- iii. Legislative – federal funding restrictions on syringe access.
- iv. PrEP – low knowledge in community and among medical providers
- v. Need a directory
- vi. Routine testing not being implemented
- vii. Need more marketing

2. HIV Positive not in care

- i. Stigma biggest barrier – religion, health behaviors – denial
- ii. Lack of knowledge about living a long healthy life with HIV
- iii. Lack of transportation
- iv. Past criminal records - going in and out of jail, disrupting care

3. Health Disparities and Underserved

- i. Not knowing what's available
- ii. Social issues – cultural competency – racism - poverty
- iii. Need for communication, hand-outs that will tell newly diagnosed clients where to go for. Where to go for food, clothing, etc.
- iv. More education on sexual health - health literacy
- v. Time restrictions (hard to take off of work to attend appointments)
- vi. Using people from community to deliver services

4. Service Coordination

- i. Fear of being seen in the clinic
- ii. Don't hear much from the faith community, need to get more
- iii. Coordinating care for people who cross state borders
- iv. Abstinence only education in schools

- v. Reimbursement only policies for small agencies that work with HRSA and have small operating budget
- vi. Do some of the smaller county health departments even have the resources?
- vii. Having more interagency meetings
- viii. Difficult to follow clients through all the different agencies and steps
- ix. In rural areas too few providers
- x. Some doctors aren't even giving the patient their results

DISCUSSION – This section does not include all of the discussion points, only the significant comments and suggestions.

What can we do about stigma and other barriers?

Homelessness is a really big problem for Louisville clients.

Legal Aid Society - The agency helps clients with their daily needs as well. These include barriers to employment. They ask clients what their legal needs are, he looks at their situations as a whole. The Staff Attorney for the HIV/AIDS Legal Project helps clients make goals for themselves (e.g. work or work skills, find stable housing, etc.). Also helps clients address discrimination and interface with EEOC. Long-term disability is also an issue that comes up with clients.

Bluegrass Care Clinic - biggest success for them has been adding the Prevention for Positives piece. It focuses on clients who are vulnerable. Focusing on healthy relationships has really helped their client population. They have had a high positivity rate, probably because of the Prevention for Positives initiative.

AETC - Asked if education could be provided on PrEP. The AETC can address Hepatitis, STDs and HIV.

University of Louisville Dental School (ULDS) – Needs more referrals for clients in the Ryan White Part B program who need dental services. Transportation is a barrier to care at the ULDS.

Louisville Metro Government and administers HOPWA. They need housing referrals. For both Ryan White and for the U.S. Department for Housing and Urban Development (HUD).

Walgreens - Does HIV testing on Wednesdays in Louisville.

Northern Kentucky District Independent Health Department - Mentioned the Hepatitis C outbreak, and they are just “waiting” for the first co-infection of Hep and HIV. Problems with getting a needle exchange program started. Even though they have the highest HCV rate in the country.

Prevention Survey

HIV Risk Assessment Survey 2016

The Kentucky SCSN is including for the first time the results of a survey of persons that were tested for HIV and tested HIV negative. The concept behind this survey is to evaluate the risk factors that are causing people to seek out HIV testing, how informed the HIV negative population is regarding HIV, where people obtain their information related to HIV and testing, what other STDs have they been treated for and what are their HIV risk factors.

The responses to the survey were not as good as anticipated. Recommendations for future surveys of persons that have tested HIV negative to obtain vital information regarding risk factors would ask fewer questions and would take place prior to the testing.

Below is a summary of the survey methodology and the results.

HIV Risk Assessment Survey 2016

KENTUCKY DEPARTMENT FOR PUBLIC HEALTH

Prepared by the Applied Statistics Lab

UNIVERSITY OF KENTUCKY
DEPARTMENT OF STATISTICS,
LEXINGTON, KENTUCKY

Survey Distribution Method

A total of 755 surveys were distributed to the local agencies from the Department for Public Health (DPH) for direct distribution to clients receiving HIV prevention services from stakeholders. Surveys were distributed based on the client volumes accessing state-sponsored HIV prevention services. An online version of the survey was also created and made available to the agencies. Here is the link to access this survey: <http://j.mp/2919T4I>

Distribution of Surveys – Surveys and envelopes were given a letter and number that corresponded with the region and agency as noted above. Each envelope included the letter and number that was found on the attached survey. A brief instruction note was included with each survey. Surveys were distributed according to a previous established numbering system.

Confidentiality of Data – The University of Kentucky, Applied Analytics Laboratory (UK Applied Statistics Lab) scanned and stored on a secure drive protected by the UK medical campus firewall. None of the surveys had any personal identifying information. Extreme care

will be taken to ensure that all of the data held on the University of Kentucky servers will be destroyed, and all paper copies of the surveys will be returned to DPH staff.

Survey Responses – A total of 66 HIV High-Risk Surveys were returned to the Kentucky Department for Public Health.

Summary of responses to fifteen of the questions pertaining to respondent demographic and HIV high-risk behaviors. Although there were insufficient responses to represent all regions of the state, some conclusions may be drawn from the responses in the areas of health insurance coverage, high-risk behaviors and how persons that are at-risk for HIV obtain their information related to HIV.

1. Geographic Location of the Survey Respondent

Region of State	Number	%
Lexington Area	44	66.67
Northern KY	4	6.06
South East KY	18	27.27

2. Gender of Respondent

Gender	Number	%
Male	21	37.50
Female	33	58.93
Transgender	1	1.79

3. Race or Ethnicity of Respondent

Race	Number	%
Hispanic	5	7.04
American Indian or Alaska Native	1	1.40
Asian	1	1.40
Black or African American	7	9.86
Mixed Race	3	4.22
White	54	76.05

4. Age of Respondent

Age Group	Number	%
18 – 24	16	24.24
25 – 34	20	30.30
35 – 44	15	22.73
45 – 54	6	9.09
55 – 64	8	12.12
65+	1	1.52

5. Level of Education

Highest Level Education	Number	%
Never attended school	1	1.75
Grades 1 through 8	3	5.26
Grades 9 through 11	7	12.28
Grades 12 or GED	20	35.09
Some college, Associate's degree, or technical degree	13	22.81
Bachelor's degree	4	7.02
Any post graduate studies	9	15.79

6. Health Insurance Coverage

Currently have health coverage	Number	%
No	9	13.85
Yes	56	86.15
Type of Health Insurance Coverage		
Health coverage Private health plan	21	31.82
Health coverage Medicaid	22	33.33
Health coverage Medicare	4	6.06
Health coverage Government plan	3	4.55
Health coverage Other health care plan	9	13.64

Health Insurance Coverage: The survey shows that 86.15% of the respondents have some form of health insurance. It appears that the full implementation of the Affordable Care Act with both the Kentucky Healthcare Exchanges and Medicaid Expansion have reduced the negative effect of being uninsured on persons that may be at-risk for HIV.

7. Use of Condoms

Use condoms	Number	%
Yes, in the past 3 months	7	14.58
Yes, in the past 12 months	3	6.25
Yes, the last time I had sex	4	8.33
No	29	60.42
Refuse to answer	5	10.42

Use of Condoms: Prevention efforts to influence people that are at-risk of being infected do not seem to have worked if 60.42% of the respondents report having unprotected sex.

8. Did you have sex with someone that had HIV or a STD?

Sex with HIV or STD	Number	%
Yes, in the past 3 months	1	1.79
Yes, in the past 12 months	1	1.79
Yes, the last time I had sex	3	5.36

9. Did you discuss HIV with your partner before sex in the last 12 months?

Discuss HIV before sex last 12 months	Number	%
Yes	27	49.09
No	27	49.09
Refuse to answer	1	1.82

Discussion HIV with sex partner: Only half of the respondents have discussed HIV and possible exposure with their sexual partners.

10. Did your partner have sex with other partners in the last 12 months?

Partner had sex with other partners last 12 months	Number	%
Definitely did not	27	49.09
Definitely did	7	12.73
Probably did not	7	12.73
Probably did	4	7.27
Don't know	10	18.18

11. Where do you obtain information related to HIV?

Source of HIV Information	Number
Information from Media	30
Information from Doctor	26
Information from Sex partner	7
Information from Friends and family	8
Information from Church	1
Information from Educational institution	15
Information from Other Source	9
No information	11
Internet– From survey question	24

Information related to HIV: Based on this survey, persons at-risk for HIV obtain their information from many sources. It appears that the sources most often used to obtain information about HIV are: their physician, media and the internet.

12. Have you ever tested for HIV?

Ever tested for HIV	Number	%
No	14	21.88
Yes	47	73.44
Don't know	3	4.69

13. Results of most recent HIV test.

HIV test result	Number	%
Negative	41	83.67
Positive	6	12.24
Never obtained results	1	2.04
Don't know	1	2.04

14. Did you discuss safe sex with your partner?

Discuss with partner about safe sex	Number	%
No	17	35.42
Yes	24	50.00
Don't Know	3	6.25
N/A	4	8.33

15. Did you practice safe sex with your partner?

Practice with partner about safe sex	Number	%
No	22	45.83
Yes	20	41.67
Don't Know	3	6.25
N/A	3	6.25

Practice Safe Sex: Over 45% of the respondents reported that they did not practice safe sex,

Survey of Persons Living with HIV In Kentucky

HIV in Care Survey 2016

The Kentucky SCSN prepared and distributed a statewide survey of persons living with HIV. The survey focused on the demographics of the respondents, access to core medical and support services, confidentiality of patient information, barriers to HIV testing and care.

The responses to the survey were not as good as anticipated. Recommendations for future surveys of persons that have tested HIV negative to obtain vital information regarding risk factors would ask fewer questions and would take place prior to the testing.

Below is a summary of the survey methodology and the results.

HIV in Care Survey 2016

KENTUCKY DEPARTMENT FOR PUBLIC HEALTH

Prepared by the Applied Statistics Lab

University of Kentucky
Department of Statistics
Lexington, Kentucky

Survey Distribution Method

A total of 500 surveys were mailed out to the local agencies from the Department for Public Health (DPH) for direct distribution to clients. Another 500 surveys were directly mailed to Ryan White HIV Positive Clients. A total of 186 responses to the surveys were received.

The local agencies utilized medical case managers to distribute the surveys. Special attention was paid to ensure that the surveys were distributed to a diverse population consisting of gender diversity and race and ethnic diversity. In addition, new agencies located throughout the state were also asked to distribute surveys to persons living with HIV. The list of Non-Ryan White Part B Contractors included: Kentucky River District Health Department/New Hope Church in Hazard; House of Ruth and AIDS Interfaith Ministries in Louisville; and Movable Feast in Lexington (25 per site). An online version of the survey was also created and made available to the agencies. Here is the link to access this survey: <http://j.mp/29l7siN>

Distribution of Surveys - Surveys and envelopes were given a letter and number that corresponded with the region and agency as noted above. Each envelope included the letter and number that was found on the attached survey. A brief instruction note was

included with each survey. Surveys were distributed according to a previous established numbering system.

Confidentiality of Data - The University of Kentucky, Applied Statistics Lab (UK ASL) scanned and stored on a secure drive protected by the UK medical campus firewall. None of the surveys had any personal identifying information. Extreme care will be taken to ensure that all of the data held on the University of Kentucky servers will be destroyed, and all paper copies of the surveys will be returned to DPH staff.

Survey Responses – A total of 66 HIV High-Risk Surveys were returned to the Kentucky Department for Public Health.

This report utilizes a summary of the responses to fifteen of the questions pertaining to respondent demographics and HIV high-risk behaviors. There were insufficient responses to represent all regions of the state, therefore statistical conclusions have not reached for any of the questions.

Geographic Location of the Respondent

Region	Number	%
Louisville Area	91	48.92
Lexington Area	28	15.05
Western KY	35	18.82
Northern KY	19	10.22
South East KY	13	6.99

1. Gender of Respondent

Gender	Number	%
Male	133	71.89
Female	51	27.57
Transgender	1	0.54

2. Race and Ethnicity of Respondents

Race and Ethnicity	Number	%
Hispanic	10	5.23
White	133	69.63
Black or African American	48	25.13

3. Age of Respondent

Age Group	Number	%
Less than 20 years old	1	0.54
20 to 29	7	3.76
30 to 39	28	15.05
40 to 49	51	27.42
50 to 59	67	36.02
60 years or older	32	17.20

Age of Respondents: 80.6% of the respondents were over 40 years of age.

4. Sexual Identification

Identify	Number	%
Heterosexual or straight	70	38.67
Gay or lesbian	93	51.38
Bisexual	12	6.63
Other	6	3.31
Other identify	.	.
Asexual	1	50.00
No interest	1	50.00

5. Level of Education

Highest Level Education	Number	%
Grades 1 through 8	4	2.20

Grades 9 through 11	16	8.79
Grades 12 or GED	52	28.57
Some college, Associate's degree, or technical degree	78	42.86
Bachelor's degree	23	12.64
Any post graduate studies	8	4.40

6. Are you aware of HIV prevention and care services in your community?

Aware of care services	Number	%
No	19	10.33
Yes	165	89.67

Aware of services: Only 10.33% of the HIV positive respondents did not know where to go for services.

7. Do you utilize HIV prevention and cares services in your community?

Utilize care services	Number	%
No	35	19.13
Yes	148	80.87

8. Which of the following services do you believe is the most difficult for an individual with HIV to access?

Services	Highest Unmet Need	Significant Unmet Need	Some Unmet need	Mostly Met
Primary medical care	24	17	25	102
Nutrition Services	23	28	43	73
Medical Case Management	16	23	29	101
Mental Health	30	25	38	76
Substance Abuse	21	22	33	80
Dental Care	36	31	29	75
Medications	28	9	23	108

Housing	39	23	31	70
Transportation	34	23	36	72
Medical specialty care	17	19	27	73

Service needs: Housing, transportation, dental care and mental health services are listed as the highest areas of need.

9. Concern for Patient Confidentiality

Concern HIV status confidential	Number	%
Not at all concerned	51	28.18
Slightly concerned	17	9.39
Somewhat concerned	25	13.81
Moderately concerned	27	14.92
Extremely concerned	61	33.70

E. Data: Access, Sources, and Systems

- a. The following data systems and data reports were used to write the 2017-2021 Integrated HIV Prevention and Care Plan.

HIV Surveillance Section

The data system utilized by the HIV Surveillance Section were used to create the Epidemiologic Overview. The HIV Care Continuum was developed using the Enhanced HIV/AIDS Reporting System (eHARS). EHARS is provided by the Centers for Disease Control and Prevention (CDC) to collect, manage and report on HIV/AIDS surveillance data. The eHARS software is used to collect and report the following information:

- HIV surveillance data
- Follow-up investigation of potential HIV/AIDS cases
- Management of data received from reference and other laboratories
- Preparation of information and reporting data to the CDC

HIV Prevention Section

EvaluationWeb - The HIV Prevention Section uses an online database authorized by the CDC called EvaluationWeb. EvaluationWeb is utilized to collect and report HIV testing information. Kentucky is established as a Direct Data Entry (DDE) site, which means that data is collected and entered from a centralized location, the HIV/AIDS Branch's Prevention Office. The Prevention Office enters data for more than the 180 HIV testing sites located throughout the Commonwealth of Kentucky, except for the contracted agencies from Fayette, Kenton and Jefferson Counties. The counties that are exempted from sending their data to the Prevention Office in Frankfort have direct access to EvaluationWeb to enter their own data.

The EvaluationWeb software includes a menu standard reports that are used for the purpose of tracking testing activity and HIV sero-positivity rates. A recent update to the EvaluationWeb software allows the HIV Prevention Section to include the collection and reporting on non-HIV testing data, including Prevention with Positives (Diffusion of Effective Behavioral Interventions - DEBI information) and Partner Services. The HIV Prevention Section does not have access to the Partner Services data in the system.

Ryan White Part B Program

Data for the Kentucky Health Insurance Continuation Program (KHICP) includes client enrollment and payments for the KHICP and is maintained in an Excel spreadsheet. Clients have already been determined to be eligible for KADAP. The KHICP Specialist confirms that the client is categorized as "eligible" in the KADAP Application Portal.

The medical case manager of a third party contractor prepares and submits the request to initiate insurance payments. The following information is entered in the KHICP spreadsheet:

- Client name address and KADAP Unique Identification Number.
- Insurance information including insurance company, insurance company mailing address, insurance company phone number; employer (if employer-based insurance); individual policy number; and conformation of the monthly or quarterly premium and confirmation of Advanced Premium Tax Credit (APTC) for the client from the Kynect website. The clinic name and medical case manager are also entered into the database to allow for follow-up communication if necessary.

Reports:

- Monthly reports for each MCM agency to request monthly insurance payment requests for each client that is due.
- Quarterly reports for agencies that have clients that receive an APTC credit, or that are on an insurance company list bill.
- Internal cost reports by clinic.
- Monthly premium average
- Client count
- Overall cost report KHICP
- Cumulative and year-to-date financial rebates

Electronic Management and Reporting System (eMARS) - Commonwealth of Kentucky - KHICP utilizes eMARS to create checks to pay the insurance companies and employers for client insurance premiums.

- Insurance companies and employers are registered in eMARS
- Federal Tax ID Number must be entered in the eMARS system
- Create a Vendor Code for each company
- Wherever possible, create a list bill with up to fifty clients that receive their insurance coverage for the same insurance company.
- Create Payment Request Commodity (PRC) to initiate a payment order.
- Batch the PRCs and review the check requests and submit for payment.

Kentucky AIDS Drug Assistance Program (KADAP) Application Portal is the database for the KADAP program in the Commonwealth of Kentucky. Data is collected and entered by the medical case managers. When necessary, a client may fax their own application directly to the KADAP Program. The system assigns a unique client number for every client enrolled. All documentation is monitored by the KADAP staff for accuracy and completeness.

The following information is gathered and stored on the Portal:

- demographic information, age, gender and ethnicity;
- name, address and county of residency;
- client telephone number;
- client health insurance, including the enrollment number, policy number and date of activation, as well as an uploaded copy of the health insurance card
- physician;

- enrolling agency and the medical case manager;
- historic patient medication information;
- medical case manager progress notes;
- lab information at time initial entry and thereafter annual (CD4 count and the percent and viral load);
- eligibility certification documentation;
- proof of Kentucky residency, including scanned and uploaded documents for verification;
- proof of financial income, including scanned and uploaded documents for verification;
- family size; and
- proof of HIV status with confirmatory laboratory test, and/or viral load test result scanned into the Portal.

The data is used to capture reports on the following:

- The clients who are due to recertify each month. This report is used to notify medical case managers, so that they can contact their clients.
- Demographic information, including age, gender, ethnicity of clients according to region
- Eligibility status (e.g. “active,” “deceased,” “inactive,” or “ineligible.”)
- Health insurance enrollment
- Client enrollment.

Data reports listed below are used to prepare the following HIV/AIDS Bureau reports:

- ADAP data report
- Ryan White Services Report
- Annual Part B Application
- Statewide Coordinated Statement of Need
- ADAP cost projections

CAREWare – HRSA’s HIV/AIDS Bureau (HAB) developed and maintained database used to track all Ryan White Part B client services and activities. HRSA allows individual Part B Programs to customize the database to include additional data fields, create custom reports, maintain client eligibility documentation, and track service data for the purposes of showing client utilization and quality management.

Standard Information

- Client personal information, including address and contact information;
- Date of birth;
- Client demographics, including age, gender, ethnicity and language;
- Housing status;
- Health insurance status;
- Client eligibility documentation, including scanned financial, residency and proof of HIV documents;
- Income and family size;
- HIV status;
- Kentucky residency verification; and
- HIPAA authorization forms.

Medical Information

- Year diagnosed;
- Current medication;
- Medication historically;
- Medical drug interactions;
- Significant medical diagnoses, including Hepatitis C and Sexually Transmitted Diseases;
- Medical screenings for contagious diseases;
- Medical history;
- HIV risk factors;
- Ryan White Part B eligibility status;
- Immunization history; and
- Individual Care Plan signed by the client;

Part B Core Medical and Support Services Client Utilization - All KHCCP funded services are reported – each subrecipient agency reports services that are funded under their Part B contract, resulting in a difference between the services available in each region of the state.

Core Medical/Support Services

- Type of service;
- Date of services;
- Service provider;
- Client referral;
- Client follow-up appointment;
- Cost of services, decided by site;
- Service checklist for each services there are a variety of subservices that may or may not be used for each client; and
- Updating clinical data at every visit. Clinical data includes Viral Load and CD4 count.

Quality Management/Performance Measures (HAB Core Measures in Group 1 and Group 2)

- Report Writing** – Standard reports and custom data reports – The Ryan White Part B program reports are standardized. Performance measure reports must be user written and are difficult for a non-programmer to create.
- Describe the policies that facilitated or served as barriers to development of the SCSN**

The SCSN Planning Committee did not encounter significant issues with policies.
- Describe the data or information that was not available to the planning group in conducting the needs assessment and developing the HIV Care Continuum.**

The SCSN Planning Committee encountered barriers in the collection of data from local and state prisons and jails. Data on the prevalence of HIV and the rate of inmates being treated. This issue was identified as a problem and has been included in the Prevention and Care Plan for the next four years.

The SCSN Planning Committee also identified barriers in receiving and recording CD4 and Viral load reports from laboratories, hospitals and clinics located throughout Kentucky. Most of the data must be manually uploaded into the surveillance information system hand entered. There are issues with timely reporting, and subsequent data entry of the laboratory reports. These delays affect the ability of the HIV Prevention Section to “see” where the HIV “hotspots” are. This issue has also been identified in the four year Prevention and Care Plan to purchase and implement new surveillance software data systems in the next two years.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

The Kentucky Integrated HIV Prevention and Care Plan will incorporate the goals of the National HIV/AIDS Strategy for the United States, recently updated to cover from 2015 thru 2020.

1. Reducing the number of people who become infected with HIV:
 - Gay, bisexual, and other men who have sex with men of all races and ethnicities
 - Black women and men
 - Latino men and women
 - People who inject drugs
 - Youth aged 13 to 24 years
 - People in the Southern United States
 - Transgender women
2. Increasing access to care and optimizing health outcomes for people living with HIV
3. Reducing HIV-related health disparities.

2016-2020 NHAS Goal – Reducing New HIV Infections

1. **2016-2020 -SMART Objective – (National)** Increase the percentage of people living with HIV who know their serostatus to at least 90 percent.
2. **2017-2021 – SMART Objective - (Local)** Lower the number of annual new infections by 10 percent (from 352 to 317).
3. **Strategy:** Incorporate community education, a statewide HIV testing program, and expansion of PrEP activities to result in a reduction of new HIV cases.

Education Timeline	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2018	KY HIV Prevention, KY Ryan White Part B Program, KHPAC	<p>Develop and implement a public information program to educate Kentucky residents that are at risk for HIV or have HIV. The program will focus on developing public service announcements, billboards and other media. All education activities will refer at-risk persons to call the HIV "Helpline." All Public Service announcements or through Prevention Funding:</p> <ol style="list-style-type: none"> 1. Targeted advertising in urban areas through billboards and bus placards. 2. Public Service Announcements on television and radio. 3. Education program for locals schools about HIV and testing. 	<p>Individuals that are at-risk for HIV or have HIV and have questions related to their care.</p> <p>MSM & Bisexual Young African Americans Young Hispanics At-Risk Women</p>	<p>Tracking calls to the statewide HIV Helpline (100 plus calls per month from persons that are at-risk or have HIV).</p> <p>Tracking HIV testing data. (Increase of 10% of HIV testing throughout Kentucky).</p> <p>Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per month).</p> <p>Tracking newly diagnosed patients that initiate ART.</p>
Public Awareness Timeline	Responsible Parties	Activity	Target Population	Data Indicators

<p>By the end of 2018</p>	<p>KY HIV Prevention, KY Ryan White Part B Program. KHPAC</p>	<p>Develop and Implement Kentucky HIV "Helpline". Live answered call line for person at risk for HIV or those that have HIV seeking information on the disease and care sites.</p> <ol style="list-style-type: none"> 1. Develop script for answering phone. Train staff to answer phones. 2. Inform testing and service provider agencies to be prepared to receive referrals from the Helpline. 3. Prepare the new Linkage Navigators to receive referrals from the Helpline. 	<p>Individuals that are at-risk for HIV or have HIV and have questions related to their care.</p> <p>Reaching at-risk persons living in rural Eastern and Western Kentucky.</p> <p>MSM & Bisexual Young African Americans Young Hispanics At-Risk Women</p>	<p>Tracking calls to the statewide HIV Helpline (100 plus calls per month from persons that are at-risk or have HIV).</p> <p>Tracking HIV testing data. (Increase of 10% of HIV testing throughout Kentucky).</p> <p>Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per month).</p> <p>Tracking newly diagnosed patients that initiate ART.</p>
<p>By the end or 2018</p>	<p>KY HIV Prevention, KY Ryan White Part B Program KHPAC</p>	<p>Utilize HIV Helpline contract to develop a social media presence for both Prevention and Ryan White Care Services.</p> <ol style="list-style-type: none"> 1. Provide quality HIV prevention Information to persons using popular social media sites including Facebook, Instagram, Twitter and well-known dating sites. 2. Offer information in the form of tweets, updates, and pop-ups to persons utilizing these forms of communication. 3. Provide service director for HIV testing and Ryan White Part B 	<p>Individuals that are at-risk for HIV or have HIV and have questions related to their care.</p> <p>Reaching at-risk persons living in rural Eastern and Western Kentucky.</p> <p>MSM & Bisexual Young African Americans Young Hispanics At-Risk Women</p>	<p>Tracking calls to the statewide HIV Helpline (100 plus calls per month from persons that are at-risk or have HIV).</p> <p>Tracking HIV testing data. (Increase of 10% of HIV testing throughout Kentucky).</p> <p>Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per month).</p> <p>Tracking newly diagnosed</p>

HIV Testing Timeline	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2016	KY HIV Prevention	<p>services throughout Kentucky.</p> <p>HIV Prevention will develop policies, procedures and training to HIV testing staff to implement a new testing system for persons that are not located in clinical settings. The system will allow for utilizing a rapid HIV test and a second (different) rapid HIV test (in compliance with CDC guidelines) to persons that tested HIV positive from the first rapid test. The second rapid test will serve as a confirmative test that will allow HIV Prevention to facilitate a referral to care and/or the linkage navigators. The goal of the program is to reduce the amount of time between a first rapid test and a confirming test as well as to allow the persons providing the test to provide a face-to-face referral to care.</p> <ol style="list-style-type: none"> 1. Implement Rapid Rapid HIV Testing throughout Kentucky. 2. Train HIV testing partners to use Rapid Rapid testing when it will provide the best result without losing the clients. 3. Educate HIV medical providers on the use of Rapid Rapid HIV 	<p>Individuals who are at-risk for HIV.</p> <p>Reaching at-risk persons living in rural Eastern and Western Kentucky.</p> <p>MSM & Bisexual Young African Americans Young Hispanics At-Risk Women</p>	<p>patients that initiate ART</p> <p>Tracking HIV testing data (Increase of 10% of HIV testing throughout Kentucky).</p> <p>Evaluate referrals to HIV navigators (15 referrals to HIV Linkage Navigators per month).</p> <p>Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per month).</p> <p>Tracking newly diagnosed patients that initiate ART.</p>

By the end of 2018	KY HIV Prevention	Testing. Use of a mobile unit to provide HIV testing throughout the state. The recognized epidemic of HCV has resulted in the development of mobile HCV testing program. The HIV Prevention Section will work to include HIV testing on the new HCV mobile testing program. 1. Reach an at-risk population of persons that are sharing needles to inject drugs. 2. Share costs of the program with the Kentucky Preparedness Programs and the HCV Program.	Individuals that are at-risk for HIV. Reaching rural populations in Eastern and Western Kentucky. Reach People who Inject Drugs (PWID) population that is at-risk for HIV.	Tracking HIV testing data (Increase of 10% of HIV testing throughout Kentucky). Evaluate referrals to HIV navigators (15 referrals to HIV Linkage Navigators per month). Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per month). Tracking newly diagnosed patients that initiate ART.
By the end of 2019	KY HIV Prevention	The HIV Prevention Section has been working on developing a HIV opt out testing program at hospitals in Louisville. The program has been delayed by insurance and billing issues for the hospitals. The goal is to have a fully functional opt out testing program in the highest HIV positive incidence area in the state. 1. Provide HIV testing to persons that may be exhibiting symptoms that could be related	Individuals that are at-risk for HIV. IV Drug Users MSM & Bisexual Young African Americans Young Hispanics At-Risk Women	Tracking HIV testing data (Increase of 10% of HIV testing throughout Kentucky). Evaluate referrals to HIV navigators. (15 referrals to HIV Linkage Navigators per month) Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per

		<p>to HIV.</p> <p>2. Link newly diagnosed HIV patients to the linkage navigators or care coordinators.</p>		<p>month).</p> <p>Tracking newly diagnosed patients that initiate ART.</p>
Expansion of Use of PrEP Timeline	Responsible Parties	Activity	Target Population	Data Indicators
<p>By the end of 2018</p>	<p>KY HIV Prevention, KY Ryan White Part B Program</p>	<p>HIV Prevention will educate clients that are HIV at-risk and HIV positive individuals on the benefits of PrEP.</p> <ol style="list-style-type: none"> 1. Develop comprehensive PrEP program focused on assisting at-risk individuals obtaining appropriate ARV medications to prevent transmission of the HIV virus. 2. Focus paying for PrEP through private health insurance, pharmaceutical patient assistance programs, grants. Ryan White Part B will provide educational information to persons interested in PrEP. 	<p>Individuals that are at-risk for HIV or have HIV.</p> <p>MSM & Bisexual</p>	<p>Tracking HIV testing data (Increase of 10% of HIV testing throughout Kentucky)</p> <p>Tracking data on persons that were counseled on the use of PrEP and were able to obtain ARV medications.</p>
Needle Exchange Timeline	Responsible Parties	Activity	Target Population	Data Indicators

<p>By the end of 2018</p>	<p>KY HIV Prevention</p>	<p>The Kentucky Legislature has recently allowed county health departments to develop needle exchanges. Individual counties are developing needle exchanges on a one-by-one basis. The goal is to reach People Who Inject Drugs (PWID) through offering HIV testing with the needle exchange program in each county that develops a needle exchange. The HIV Prevention Section has been assigned responsibility for the needle exchange program.</p> <ol style="list-style-type: none"> 1. Train staff from counties that are initiating needle exchange programs. 2. Provided access to HIV Testing and Ryan White Part B Services throughout Kentucky. 	<p>Individuals who are at-risk for HIV. IV Drug Users</p>	<p>Tracking HIV testing data (Increase of 10% of HIV testing throughout Kentucky).</p>
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1. **2016-2020 NHAS Goal** – Increasing Access to care and improving health outcomes for People Living with HIV.
2. **2016-2020 SMART Objective** – (National) By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85%.
3. **2017-2021 – SMART Objective (Local)** Increase the number of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 300 per year.
4. **Strategy:** Increase Linkage to Care Efforts

Education Timeline	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2020	Ryan White Part B, University of Kentucky AETC	<p>There are a shortage of qualified HIV care providers in Kentucky, especially in Eastern and Western KY. Working with the UK AETC the Ryan White Part B Program will identify providers throughout the stated that have an interest in HIV Care. These providers will be referred to the AETC for training and mentoring.</p> <ol style="list-style-type: none"> 1. Develop training and mentoring program for qualified medical providers. 2. Offer access to expert HIV physicians in the areas of ARV medication management. 3. Offer HIV telemedicine services to rural providers and their patients through the network of local public 	<p>HIV qualified medical providers</p> <p>Patients living in rural portions of Kentucky.</p>	<p>Tracking patients that initiate ART</p> <p>Tracking patients that achieve an undetectable viral load (increase of 10% in total patients with an undetectable viral load).</p>

By the end of 2020	Ryan White Part B, University of Kentucky AETC	<p>health agencies that are already set up for telemedicine.</p> <p>Develop a plan to educate HIV positive patients as to the importance of adhering to medication regimens, preventing resistance to HIV medications, and achieving an undetectable viral load status.</p> <ol style="list-style-type: none"> 1. Train care coordinators and Linkage Navigators on client adherence and medication resistance. 2. Develop handouts to be provided to clients during appointments with care coordinators and linkage navigators. 3. Refer clients that are not in compliance with their ARV regimen to medical providers and pharmacists that are trained in teaching patient adherence. 	<p>Medical providers/pharmacists</p> <p>Care Coordinators</p> <p>Linkage Navigators</p> <p>HIV positive patients</p>	<p>Tracking patients that initiate ART.</p> <p>Tracking patients that achieve an undetectable viral load (increase of 10% in total patients with an undetectable viral load).</p>
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Outreach/ Early Intervention Services Timeline	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2020	KY HIV Prevention, KY Ryan White Part B Program	<p>Develop a statewide Kentucky HIV Navigator Program. Newly diagnosed HIV positive clients and clients that have been lost to care will be linked to specialized linkage navigators to connect clients to care and services. Goal of starting ART therapy and achieving viral load suppression.</p> <ol style="list-style-type: none"> 1. Develop statewide network of 10 linkage navigators. To be located in local health departments. 2. Hire and train new linkage navigators. 3. Develop referral network of HIV positive clients that are either newly diagnosed through the statewide testing and HIV Prevention Program. Also refer clients to the linkage navigators that have been lost to care from the network of Ryan White Part B care coordinators. 	<p>Newly diagnosed and HIV positive clients, clients that have been lost to care.</p> <p>Persons living in rural Eastern and Western Kentucky.</p> <p>MSM & Bisexual Young African Americans Young Hispanics At-Risk Women</p>	<p>Tracking HIV testing data (increase of 10% of HIV testing throughout Kentucky).</p> <p>Evaluate referrals to HIV navigators (15 referrals to HIV Linkage Navigators per month).</p> <p>Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per month).</p> <p>Tracking newly diagnosed patients that initiate ART</p>

Ryan White Part B Services. Timeline	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2018	KY Ryan White Part B Program	<p>Mental health – increase access to mental health services for persons with HIV. Mental health services to include, evaluation, treatment, prescribing medications and follow-up care.</p> <ol style="list-style-type: none"> All regional Ryan White Part B Providers are required to either hire or contract with qualified mental health providers. Mental health services should include prescription of mental health medications, counseling and therapy. 	<p>Ryan White Part B Regional Service Providers</p> <p>Ryan White Part B clients with mental health needs</p>	<p>Tracking clients with mental health issues and adherence to their ARV medications.</p> <p>Tracking patients that achieve an undetectable viral load (increase of 10% in total patients with an undetectable viral load).</p>
By the end of 2018	KY Ryan White Part B Program	<p>Substance Abuse – Increase access to substance abuse services including: detoxification, outpatient residential treatment, and medication therapy.</p> <ol style="list-style-type: none"> All regional Ryan White 	<p>Ryan White Part B Regional Service Providers</p> <p>Ryan White Part B clients with substance abuse needs</p>	<p>Tracking clients with substance abuse issues and adherence to their ARV medications.</p> <p>Tracking patients that achieve an undetectable viral load (increase of 10% in total</p>

			Part B Providers are required to either hire or contract with qualified substance abuse providers.	patients with an undetectable viral load).
			2. Substance abuse services should include individual and group counseling and therapy.	

1. **2016-2020 NHAS Goal** – Reducing HIV related disparities and health inequities.
2. **2016-2020 SMART Objective** – (National) - By 2015, increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.
3. **2017-2021 – SMART Objective (Local)** - Reduce disparities in the rate of new diagnoses by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States.
4. **Strategy:** Education Increase Linkage to Care Efforts

Education Timeline	Responsible Parties	Activity	Target Population	Data Indicators
By end of 2019	KY HIV Prevention, KY Ryan White Part B Program KHPAC	Provide cultural competency training to agencies and community based organizations to facilitate understanding and acceptance of other racial and ethnic cultures. Include first-line staff. Provide trainings on federal and state regulations related to confidentiality. 1. Develop a program to train representatives from local	Local health departments, Community Based Organizations Medical providers as requested.	Review agency client satisfaction surveys. Review of client complaints and grievances. Review changes in client enrollment data for regional testing and care sites.

		<p>health departments, community based organizations and medical providers in working with HIV positive clients of diverse racial and ethnic backgrounds.</p> <p>2. Provide trainings on a regional basis throughout Kentucky.</p>		
<p>Outreach/ Early Intervention Services Timeline</p>	<p>Responsible Parties</p>	<p>Activity</p>	<p>Target Population</p>	<p>Data Indicators</p>

<p>By the end of 2018</p>	<p>KY HIV Prevention, KY Ryan White Part B Program KHPAC</p>	<p>Create an outreach program focused on reaching men and women of color living on the west side of Louisville and Lexington KY. Goal of testing at-risk individuals and linking newly diagnosed clients as well as lost to care clients to HIV services at the 550 Clinic. Utilizing Minority AIDS Initiative (MAI) funding</p> <ol style="list-style-type: none"> 1. Work with community based organizations to contract to hire and train staff to provide outreach and education to persons of color living in urban areas of Kentucky. 2. Train outreach workers to provide HIV testing to at-risk persons. 3. Link newly diagnosed HIV positive clients to Linkage Navigators or Care Coordinators. 	<p>Persons of color that are newly diagnosed HIV positive clients, clients that have been lost to care.</p> <p>Young African Americans Young Hispanics African American Women</p>	<p>Tracking HIV testing data (increase of 10% of HIV testing throughout Kentucky).</p> <p>Evaluate referrals to HIV navigators (15 referrals to HIV Linkage Navigators per month).</p> <p>Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per month).</p> <p>Tracking newly diagnosed patients that initiate ART.</p>
<p>H. Outreach to African Americans Timeline</p>	<p>Responsible Parties</p>	<p>Activity</p>	<p>Target Population</p>	<p>Data Indicators</p>

By the end of 2020	KY HIV Prevention, KY Ryan White Part B Program	<p>Continue and expand the outreach efforts initiated by the HIV Prevention Section has initiated several outreach efforts in Louisville and Lexington to reach the African American faith based community (CDC Prevention Funding):</p> <ol style="list-style-type: none"> 1. Grants and training have been provided for HIV testing. The Ryan White Part B Program has contracted with a African American community based organization to provide Outreach and EIS services on the West Side of Louisville. 	<p>Persons at Risk for HIV and HIV or have HIV.</p> <p>Young African Americans African American Women African American Communities</p>	<p>Tracking HIV testing data (Increase of 10% of HIV testing throughout Kentucky).</p> <p>Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per month).</p> <p>Tracking newly diagnosed patients that initiate ART.</p>
Outreach to Sex Trade Workers Timeline	Responsible Parties	Activity	Target Population	Data Indicators
	KY HIV Prevention	<p>Continue and expand current activities of the HIV Prevention Section. A contract with AVOL to provide outreach and education to sex workers has been initiated. The activities include HIV testing, needle cleaning kits, referral for clinical care.</p> <ol style="list-style-type: none"> 1. Expand current activities with AVOL in Lexington. 2. Partner with an AIDS 	<p>Persons at Risk for HIV and HIV or have HIV.</p> <p>MSM & Bisexual At-Risk Women</p>	<p>Tracking HIV testing data (Increase of 10% of HIV testing throughout Kentucky).</p> <p>Tracking data for newly diagnosed patients entering care (25 newly diagnosed patients documented entering care per month).</p>

		<p>Service Organization in Louisville to initiate a similar program.</p>		<p>Tracking newly diagnosed patients that initiate ART.</p>
<p>Working with HIV Positive Inmates Timeline</p> <p>By the end of 2020</p>	<p>Responsible Parties</p> <p>KY Ryan White Part B Program</p>	<p>Activity</p> <p>Initiate discussions with the representatives of the Kentucky Jailer's association and the Kentucky Department of Corrections to work on a collaboration around discharge planning for HIV positive inmates.</p>	<p>Target Population</p> <p>Persons at Risk for HIV and HIV or have HIV. MSM & Bisexual African Americans Hispanics</p>	<p>Data Indicators</p> <p>Tracking clients that are discharged from Jails and Prisons Tracking data for HIV positive patients Ryan White services network. Tracking HIV positive patients that initiate ART.</p>

B. Collaborations, Partnerships and Stakeholder Involvement

Stakeholder Representation on KHPAC and on the SCSN Planning Committee:

- a. Persons Living with HIV Participation in SCSN – KHPAC has 13 representative from various regions of Kentucky who are HIV Positive. In addition, 900 surveys were distributed by mail or handed out at HIV Clinical Care Programs or AIDS Service Organizations. The majority of the participants in the eight focus groups and stakeholder meetings were HIV positive.
 - b. Kentucky Department for Public Health
 - i. HIV Prevention Section – 3 - 4 staff
 - ii. Ryan White Part B Section – 3 – 4 staff
 - c. Kentucky Division of Medicaid Services – 2 – representatives
 - d. Kentucky Department of Education – 1 representative
 - e. Mental Health – 3 representatives from Ryan White Part B service providers
 - f. Substance Abuse - 2 representatives from Ryan White Part B service providers
 - g. Federally funded Community Health Centers – all 23 community health centers were surveyed for HIV-related services and activities.
 - h. Veteran’s Health Administration – 1 – social worker from the Veteran’s Administration
 - i. Housing and Urban Development (HUD) and Housing Opportunities for Persons with HIV/AIDS – 2 representatives from HUD programs in Louisville and Frankfort
 - j. University of Louisville – School of Public Health and Information Sciences – 1 representative
 - k. University of Kentucky – School of Epidemiology – 1 representative
 - l. Representatives from non-profit agencies located in various regions of Kentucky
 - i. Keeping It Real – Louisville, Kentucky – 1 representative
 - ii. Matthew 25 AIDS Services – Henderson, Kentucky – 1 representative
 - m. Local Health Departments
 - i. Northern Kentucky District Health Department, Fort Mitchell, Kentucky – 1 representative
 - ii. Kentucky River District Health Department - Hazard, Kentucky – 2 representatives
 - n. Ryan White Parts C & D
 - i. Matthew 25 AIDS Services – 1 representative
 - ii. Heartland Cares, Inc. – consultative representation
 - o. Kentucky AIDS Health Education Center (AHEC)
 - i. Lexington, Kentucky – consultative representation
 - p. Kentucky Department of Corrections – no representation
 - q. Kentucky county and local jails – no representation
-
1. Describe contributions of stakeholders and key partners.
 - a. Development of needs assessment - Surveys that were distributed to HIV at-risk populations and People Living with HIV/AIDS (PLWHA) were designed in

collaboration with KHPAC and University of Louisville, School of Public Health and Information Sciences.

- b. Distribution of At-Risk and PLWH Surveys
 - i. At-Risk Surveys - 10 HIV testing agencies and HIV Prevention Partners located throughout Kentucky as well as HIV Prevention Section Staff working at the Pride Festival in Lexington Kentucky.
 - ii. PLWHA Surveys – A total of seven Ryan White Part B service provider agencies located throughout Kentucky, along with four local health departments, distributed 500 PLWHA surveys.
 - c. Needs Assessment – Focus Groups and Stakeholder Meetings – Focus Group Meeting – The eight focus group and stakeholder meetings were held at local health departments and HIV Prevention Partners, AIDS Service Organizations throughout Kentucky. These organizations also assisted in inviting persons at-risk for HIV, PLWH and community representative to participate in the meetings.
 - d. Analysis of Survey Data – The University of Kentucky – Applied Statistics Lab
 - e. Writing of Report/Editing - HIV/AIDS Branch
 - i. HIV Surveillance Section
 - ii. HIV Prevention Section
 - iii. Ryan White Part B Services Section
 - f. Final Review of Integrated HIV Prevention and Care Plan
 - i. KHPAC
 - ii. HIV/AIDS Branch
2. Partners and Stakeholders not involved in the project – The most important void in the 2017-2021 Kentucky Integrated HIV Prevention and Care Plan has been representation from the prisons through the Kentucky Department of Corrections and from local and county jails through the Kentucky Jailors Associations or the Kentucky Sheriffs' Association. The ability to reach persons that are incarcerated or are about to be discharged from incarceration has been an issue for many year. The Prevention and Care Plan has created a goal of recruiting representation from Jails and Prisons in Kentucky.
3. Letter of Concurrence – See Appendix B.

C. People Living With HIV (PLWH) and Community Engagement

Overview of Kentucky Race and Ethnicity Demographics and Funding for Services

The Commonwealth of Kentucky data on race/ethnicity through July 1, 2014 shows that the state is not comprised of a highly diverse racial population. As of July 2014, Blacks account for 8% of the population, Hispanics account for 4% and Whites makeup 85% of the state's population. The Kentucky data for newly diagnosed HIV cases for calendar year 2014 show a very different view of the disproportionate effect of HIV on non-white racial populations. The 2014 data shows that 31% of the new cases were Black, 9% were Hispanic, and 57% of the cases were found in Whites. Historically, since the beginning of the epidemic the cumulative data shows that Blacks have an even greater disproportionate share of the total cases of HIV in the state at 34% while Hispanics represent a smaller percentage of 5%.

The disparity of HIV cases by race and ethnicity has been a focus of the 2017-2021 Kentucky Integrated Prevention and Care Plan. The Kentucky HIV/AIDS Branch has utilized its annual Part B Minority AIDS Initiative (MAI) funding as well as a significant portion of the funding that the state receives under the category of Emerging Community Funding for services in the Louisville communities of color (Emerging Community funds are for metropolitan areas that do not qualify as an EMA or TGA funding, but who over the most recent five years have reported between 500-999 cumulative AIDS cases). The Commonwealth of Kentucky receives Emerging Community funding for the ten county area comprised of the Louisville metro area and the adjacent counties located in Southern Indiana.

Over the last several years, the HIV/AIDS Branch has initiated an outreach effort designed to work with African- American and Hispanic churches and non-profit agencies. The HIV Prevention Program has successfully linked with several African American churches to hold HIV testing events. The Ryan White Part B Program has expanded its current contracts with Louisville-based minority agencies as well as initiated a new contract for outreach, education, non-medical case management, and other support services with Keeping It Real (KIR). KIR is an African American non-profit organization that is located on the west-side of Louisville in a predominately low-income, Black neighborhood. The Part B Program will be holding a competitive procurement process in the spring of 2017 to recruit and help build the capacity of more minority agencies that serve people with HIV throughout Kentucky.

a. Describe how the people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in the jurisdiction.

Over 600 persons living with HIV were involved in the development of the 2017-2021 Kentucky Integrated HIV Prevention and Care Plan. These individuals participated in the surveys and focus groups and reviewed the goals and objectives laid out for the next four years. PLWH who participated in the development of the plan represented all segments of the epidemic in Kentucky including: gay/bisexual men, women with HIV, African Americans and Hispanics. In addition, KHPAC has representation from gay men, women, African Americans and a Hispanic that represent persons with HIV in their communities.

Agencies participating in the development of the HIV Prevention and Care Plan also represent all of the primary communities affected with HIV. The agencies included:

HIV Prevention Partners:

- Volunteers of America of Mid-States
- AIDS Volunteers of Lexington (AVOL)
- African American churches in Louisville.
- Louisville Metro Health Department
- Lexington-Fayette County Health Department
- Matthew 25 AIDS Services
- Heartland Cares, Inc.
- Lake Cumberland District Health Department
- Northern Kentucky Independent District Health Department
- Kentucky River District Health Department

Ryan White Part B AIDS Service Providers

- 550 Clinic at the University of Louisville
- Bluegrass Care Clinic at the University of Kentucky
- Matthew 25 AIDS Services
- Heartland Cares, Inc.
- Lake Cumberland District Health Department
- Northern Kentucky Independent District Health Department

b. Describe how the inclusion of PLWH contributed to the plan development.

The inclusion of PLWH in the development of the Prevention and Care Plan resulted in many significant contributions. As mentioned above, PLWH were involved in the design of the needs assessment, the client surveys as well participated in the gathering of information from persons living with HIV. The participation of PLWH was critical to the

development of the final Prevention and Care Plan based upon their input and recommendations.

There are two contributions that must be provided by PLWH that cannot be obtained from any other source: 1) Clients with HIV who receive services are the only credible source for evaluating existing services. 2) Clients with HIV who receive services are the only source that can provide information into the need to expand existing services or to develop new services.

The following recommendations were included in the Presentation and Care Plan based on input from consumers:

- Statewide education program
 - Use of media and social media to educate persons with HIV or those at-risk for HIV
 - Expansion of HIV testing
 - Expansion of PrEP HIV prevention education
 - Need for syringe exchanges and harm reduction education and outreach
 - Expansion of mental health and substance abuse services
- c. Describe the methods used to engage communities, people living with HIV, those at substantial risk of acquiring HIV infection and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area.

The SCSN Planning Committee with KHCAP developed a comprehensive plan to reach as many at-risk and HIV positive persons living in Kentucky. This was the first time that the SCSN included a survey of persons that are at-risk for HIV. Although the survey was not as successful as hoped, it proved that persons at-risk for HIV will complete surveys. The next attempt will utilize a shorter survey and have persons complete the survey prior to their HIV test.

In addition to the at-risk and HIV positive surveys, the SCSN Planning Committee utilized a series of focus groups and stakeholder meetings that were targeted towards persons that are at risk for HIV, people that HIV positive and persons from the HIV service community.

Both the surveys and the focus groups focused on geographical distribution, reaching minority communities and reaching the gay/bisexual community. Survey distribution was skewed to reach more persons of color, and persons living in rural communities that have little or no access to testing and care services.

The completed survey data was compiled and analyzed by the University of Kentucky, Applied Statistics Lab according to geographical region and urban community. This was

done to ensure that the most underserved communities would have significance in the development of the final Prevention and Care Plan.

- d. Describe how impacted communities are engaged in the planning process to provide critical insight into developing solutions to health problems to assure the availability of necessary resources.

See Section C. above.

Section III: Monitoring and Improvement

A. Describe the process for regularly updating planning bodies and stakeholders on the progress of the plan implementation

The Kentucky HIV/AIDS Branch utilizes the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) to serve as a two-way conduit for information and trends.

1. The KHPAC committee members are representatives of the Kentucky HIV community as such they bring information, policy and service requests to the HIV/AIDS Branch to evaluate and incorporate in planning and policy decisions.
2. Members serve as a sounding/advisory board to discuss new or revised HIV Prevention and Testing policies and procedures, HIV planning, and service development. The KHPAC also participates in the development of the Kentucky HIV Annual Report; HIV Integrated Prevention and Care Plan; the SCSN Letter of Concurrence and the Letter of Review that is submitted each year with the Ryan White Part B Application to HRSA.

Membership of KHPAC – The KHPAC by-laws state that there should be no more than 30 members. Members are recruited to represent the following public and non-profit entities as well as to ensure that there is strong representation of persons who are living with HIV or affected by HIV. Currently, there are 15 voting members of KHPAC. New members are nominated by the Executive Committee and approved by a majority vote of the KHPAC membership. KHPAC approved applicants are forwarded by to the governor or the governor's designee for final approval.

KHPAC membership is drawn from the following:

1. Department for Public Health
2. Department for Medicaid Services
3. Representatives of state agencies and boards who either provide services to clients with HIV or provide education to professionals that come in contact with persons with HIV.
4. Physicians representing different geographic areas of the state.
5. Persons living with HIV.
6. Representatives of community based organizations from different geographic regions of the state.

To the greatest extent, possible the KHPAC membership reflects the different epidemiology of the HIV epidemic in Kentucky.

Schedule of Meetings – KHPAC maintains a quarterly meeting schedule for the KHPAC and active committees during ordinary years. However, special circumstances periodically require KHPAC to meet monthly or as needed to address the special situation. KHPAC has been meeting monthly for the last year to work on the 2017-2021 Kentucky Integrated HIV Prevention and Care Plan.

Continual Process for Updating and Communicating with Planning Bodies and Stakeholders.

The HIV/AIDS Branch will continue to hold quarterly KHPAC meetings. These meetings will continue to focus on two way communication.

1. The KHPAC members will continue to bring forward and report on the successes and problems that take place in the implementation of the Kentucky HIV Prevention and Care Plan.
2. The HIV/AIDS Branch will continue to use KHPAC as a sounding board for the development of HIV preventions and testing services as well as the delivery of the Ryan White Part B KADAP Program and Part B Base Services.

Feedback received from KHPAC over the next four years will be used to evaluate the 2017-2021 HIV Prevention and Care Plan. Changes to the plan will be based upon the successes or problems that are encountered as the Goals and SMART Objectives of the plan are developed and implemented or expanded.

b. Describe plan to monitor and evaluate implementation of the Goals and SMART Objectives.

The HIV/AIDS Branch began a strategic planning process in September of 2015. All Branch staff, including representatives of the HIV Surveillance Section, the HIV Prevention Section and the Ryan White Part B Program, attended the three meetings held to date.

On September 29, 2015, a (SWOT) Strengths, Weaknesses, Opportunities and Threats analysis of the HIV/AIDS Branch was conducted. The analysis helped the branch develop a plan for services that would meet many of the new challenges facing Kentucky in the area of HIV Prevention and Care. An example of the developing challenges includes how to develop a coordinated response to the IV drug problem that has been intensifying in Kentucky. In addition, the strategic planning process was used to obtain feedback from branch employees related to the expansion of HIV Prevention and Testing services and Ryan White Part B services that they would like to see developed over the next four years.

The HIV/AIDS Branch has already begun utilizing a PDSA (Plan Do Study Act) and a Lean/Six Sigma process that requires a continuous review of program services and activities. The branch will expand the PDSA process to include all of the goals and SMART Objectives including in the new Prevention and Care Plan. The implementation of each goal and objective will take place on a quarterly basis. The goals will be evaluated to see if they have been completed, are proceeding appropriately or need to be revised or replaced based on qualitative and quantitative results.

All activities will be documented through the writing of meeting notices, distribution of data reports, and meeting minutes.

- c. Describe the strategy to utilize surveillance and program data and improve the health outcomes along the HIV Care Continuum to be used to impact the quality of HIV service delivery system, including strategic long range planning.**

The Lean/Six Sigma continuous quality improvement project described in section b. above, will utilize data that is collected from the Surveillance, Prevention and Services databases (as described in Section E - the Data Access, Sources and Systems section of this document). The data will be used to evaluate the effectiveness of each goal or service for both HIV Prevention and Ryan White Part B Services. Viral load and CD4 test data may be obtained with through the CAREWare database or through the new laboratory tracking software that will interface with the HIV Surveillance Section.

All newly diagnosed clients will be tracked to ensure that a referral was made to either a medical case manager or to a linkage navigator. Linkage Navigators will be utilized for persons living in rural areas that are not near the HIV/AIDS Branch clinical provider agencies and/or for persons that require intensive case management. All client activity for newly diagnosed and lost to care patients will be followed to ensure that they saw a clinical provider, medications were prescribed, and they begin to see an improvement in their viral load and CD4 counts. All Ryan White Part B patients will have their viral load data tracked by their clinical providers as well as their medical case managers. This information will be shared with each patient. For each patient that has not attained an undetectable viral load, a plan will be created and entered into the patient's electronic medical record as well as in the CAREWare database. This will allow the Ryan White Part B Program to track each patient's progress along the HIV Care Continuum.

Written reports will be provided to the KHPAC as well as to the leadership of the Kentucky Department for Public Health. Lastly, the results of the quarterly evaluations process will be shared with representatives from the Ryan White Part B service providers at their quarterly trainings in order to obtain feedback for additional improvements.

Kentucky HIV/AIDS Planning and Advisory Council (KHPAC)

c/o Gayle Yocum, Co-Chair

HIV/AIDS Branch

275 E. Main Street., HS2E-C

Frankfort, KY 40621

August 29, 2016

Veronica McCants

Public Health Advisor

HIV Prevention Program Branch

Center for Disease Control

Dear Ms. McCants;

I am writing on behalf of the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC), which is the point prevention and care planning body that serves as Kentucky's HIV/AIDS Planning Groups (HPG).

KHPAC has been involved in the development of Kentucky's comprehensive HIV/AIDS Strategic Plan which includes the Jurisdictional HIV Prevention Plan submitted in 2014.

- Members of KHPAC thoroughly revisited the Kentucky HIV/AIDS Strategic Plan to determine the progress of the goals set for prevention in Kentucky. The council submitted a series of questions and concerns to the HIV/AIDS Branch of the Health Department in an open KHPAC meeting on August 2016
- Staff from the HIV/AIDS Branch provided a detailed response to the questions and concerns during the August 12, 2016 meeting.

KHPAC concurs that Kentucky's Jurisdictional HIV Prevention Plan calls for programmatic activities and resources that were allocated to the most disproportionately affected populations and geographically areas that bear the greatest burden of the HIV disease. KHPAC offers our concurrence with one reservation and one concern.

Kentucky in the last two years has moved forward to address the growing epidemic of opioid injectable drug use throughout the Commonwealth. In March of 2015, the Kentucky legislature in a bold and historic vote passed Kentucky Senate Bill 192 paving the way for the establishment of syringe exchange programs by county health departments in Kentucky (see KRS 218A.500/510). The bill also included "Good Samaritan" language that protected people who use drugs from criminal charges if they report an overdose to authorities, expanded access to the overdose-reversing drug naloxone, and expanded state funding and Medicaid support for addiction treatment programs. The passage of this bill represented a significant and commendable step toward improving HIV and hepatitis C (HCV) prevention and addiction treatment in Kentucky and put the Commonwealth on the map as a leader in harm reduction among states in the south. We are grateful to the legislators who championed the bill. Despite this progress, however, very significant challenges remain and require further action by policymakers, health service organizations and providers, the public health community, and individual citizens.

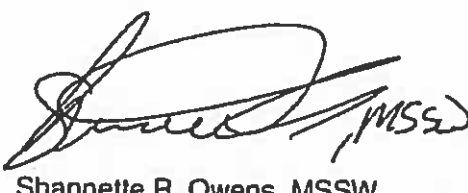
Although this is certainly an improvement for Kentucky, KHPAC has a reservation that there was no funding targeted towards rural counties. In light of recent event in Austin Indian and the recent report issued by The Center of Disease Control, it is imperative that rural counties receive HIV prevention services again. 220 counties, out of more than 3,100 in the U.S. and including Scott County, are most are rural; 56% are in Kentucky, Tennessee and West Virginia, in the Appalachian region hardest-hit by the opioid crisis.

KHPAC advocate that new funding be created to support DPH efforts to address and combat the HIV outbreak that will happen in the rural counties in Kentucky. KHPAC advocates for a budget that is equal to the current budget that the state currently has. KHPAC further recommends that the DPH be granted permission by the CDC to provide funding towards the support of syringe exchanges efforts.

This letter is respectfully submitted the 30th of August in the year 2016.



John Bentley
Community Co-Chair



Shannette R. Owens, MSSW
Community Co-Chair Elect



Gayle L. Yocum
State Co-Chair