

Table of Contents

Contributors i

Acronym List..... ii

Introduction and Executive Summary.....1

I. Where We Are Now: Our Current System of Care.....3

A. Description of Colorado

B. Epidemiological profile of HIV/AIDS in Colorado

C. Emerging epidemiological trends

D. Colorado response to the epidemic

E. Assessment of need

F. Unmet needs estimate

G. Gaps in care

H. Prevention needs

I. Current continuum of care

J. Inventory of Part B funded resources

K. Profile of Ryan White Part B funded providers by category

L. Barriers to care

II. Where We Need to Go: Vision for an Ideal System45

A. Our shared vision that will guide system changes

B. Our shared values that will guide system changes

C. Continuum of care for high quality core services

III. How We Will Get There: System Change47

A. Three year goals and objectives

B. Annual goals and objectives

IV. How We Will Monitor Our Progress53

A. Improving client level data

B. Using data for evaluation

C. Measuring clinical outcomes

CONTRIBUTORS

This Comprehensive Plan was Developed By
The Colorado Department of Public Health and Environment
STI/HIV Section, Care and Treatment Program (Part B)

In Collaboration With:

HIV Care Advisory Committee/ AIDS Drug Assistance Programs (ADAP) Review
Committee
Colorado's Community of People Living with HIV or AIDS
Denver Mayor's Office of HIV Resources (Part A Grantee)
Denver HIV Resources Planning Council
Beacon Center for Infectious Disease (Part C)
Saint Mary's Family Medicine (Part C)
Pueblo Community Health Center (Part C)
Denver HIV Primary Care Clinic (Part C)
Children's Hospital Immunodeficiency Program (Part D)
Community-Based Dental Partnership Program at
University of Colorado School of Dental Medicine (Part F)
Colorado AIDS Education and Training Center (Part F)
And Other Concerned Stakeholders

With Additional Support From:
Mary Kay Myers of Myers Caldwell Planning

Acronym List

ADAP	AIDS Drug Assistance Programs
AIDS	Acquired Immune Deficiency Syndrome
ASO	AIDS Service Agency
BTGC	Bridging the Gap Colorado
CAETC	Colorado AIDS Education and Training Center
CAP	Colorado AIDS Project
CARE Act (Ryan White)	Comprehensive AIDS Resources Emergency Act
CBO	Community Based Organization
CBDPP	Community-Based Dental Partnership Program
CDC	Centers for Disease Control and Prevention
CDPHE	Colorado Department of Public Health and Environment
CHAMP	Colorado Housing Assistance Made Possible
CHIP	Children's Hospital Immunodeficiency Program
CICP	Colorado Indigent Care Program
CLI	Community Level Intervention
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPG	Community Planning Group
CRCS	Comprehensive Risk Counseling and Services
CWT	Coloradans Working Together: Preventing HIV/AIDS
CYP	CHIP Youth Program
DCEED	Disease Control and Environmental Epidemiology Division
FPL	Federal Poverty Level
GLI	Group Level Intervention
HARS	HIV/AIDS Reporting System
HCBS-PLWA	Home and Community Based Services for People Living with AIDS, a Medicaid waiver program
HC/PI	Health Communication/Public Information
HCV	Hepatitis C Virus
HE/RR	Health Education and Risk Reduction
HELIX	HIV Extended Logical Information Exchange
HHS	United States Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HUD	U.S. Department of Housing and Urban Development
IDU	Injection Drug User
ICF/MR	Intermediate Care Facility for the Mentally Retarded

ILI	Individual Level Intervention
MOHR	Mayor's Office of HIV Resources
MSM	Men Who Have Sex With Men
PCC	Primary Care Clinic
PCHC	Pueblo Community Health Center
PCRS	Partner Counseling and Referral Services
PDP	Prescription Drug Plan
PLWA	Persons Living with AIDS
PLWH	Persons Living with HIV
SBIRT	Screening, Brief Intervention, and Referral to Treatment
S-CAP	Southern Colorado AIDS Project
SPNS	Special Projects of National Significance
SSA	Social Security Administration
SSI	Supplemental Security Income
STI	Sexually Transmitted Infection
TGA	Transitional Grant Area
UCSDM	University of Colorado School of Dental Medicine
VA	Veteran's Administration
VAMC	Veterans Administration Medical Center

Introduction and Executive Summary

Colorado is a diverse state of nearly five million people. Colorado's STI/HIV Surveillance Program estimates that 10,609 Coloradans were living with HIV or AIDS as of June 30, 2008. Demographically, persons living with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) (PLWH/A) in Colorado have been predominantly males (89.6 percent) having acquired HIV through sex with other men (73 percent). Although the majority of cases are among Whites, both Blacks and Hispanics have been disproportionately impacted. The proportion of females among newly diagnosed HIV cases continues to increase.

This Comprehensive Plan examines the current system of care available to PLWH/A in Colorado; including the Ryan White Part B funded system and other systems. The AIDS Drug Assistance Program (ADAP) serves approximately 900 people per year, and demand is increasing. In addition, nearly 400 people receive assistance with health insurance, including "wrap around" benefits for those who have a Medicare Part D Prescription Drug Plan. Colorado maintains a network of four HIV regional service providers who deliver medical case management as well as other core and support services. Additional support goes to providers of behavioral health services and primary health care throughout the state, including jail-based programs. Special efforts are extended to those who have been newly diagnosed and those whose care has lapsed.

The Part B needs assessment clearly indicates that PLWH/A most highly prioritize access to medical care, laboratory tests, oral health care, and assistance accessing medications. Case management continues to be very highly prioritized as well. Compared to the general population, respondents to the needs assessment expressed a significant degree of need around mental health and substance use issues. Overall, people are very satisfied with the services that are currently available, but several needed services were reported as not available, particularly alternative care, over the counter medications, dental care, and services related to psychosocial and behavioral health issues.

In response to these identified needs, Colorado plans to continue to support a full continuum of care, with particular emphasis on medical care and medical case management. This is particularly important in light of Colorado's relatively difficult environment for those without health insurance who rely on indigent care and other publicly funded health services.

Colorado's shared vision for HIV care and treatment is a system where clients are able to access a broad continuum of services, leading to improved health outcomes and enhanced quality of life. The Colorado HIV Care and Treatment Program and its community partners invest resources to make progress toward six aspirations: integration, consistency, accessibility, appropriateness, affordability, and sustainability. The Program's long and short-term goals and objectives are built around the Program's intention to improve four key aspects of HIV care and treatment:

- 1) Access to HIV-related medical care, medications, and behavioral health services
- 2) Retention in or adherence to HIV-related medical care, medication regimens, and behavioral health services

- 3) Access to other HIV-related support services
- 4) Quality of all funded services, including improvements in planning and evaluation

To achieve these outcomes, Colorado will rely on a collaborative network of service providers, including local health departments, hospital-based clinics, AIDS service organizations, behavioral health providers, and other community-based agencies. In 2009, this network will include Colorado Department of Public Health and Environment (CDPHE) staff and 14 main contractors together with multiple subcontractors and collaborators. We also rely on a strong and constructive relationship with our fellow Coloradans who are living with HIV or AIDS and who generously participate in planning and quality improvement efforts throughout the year.

I. WHERE WE ARE NOW: OUR CURRENT SYSTEM OF CARE

A. Description of Colorado**General Demographics of Colorado**

The Colorado State Demographer's Office estimated the Colorado population to be 4,813,555 in 2006. Colorado ranks twenty-second in the nation in population, with approximately 1.6 percent of the U.S. population.

The median age in Colorado is 35.4 years old for the year 2006, an increase from 34.9 years old in 2004 (the median age is projected to increase to 36.6 years old by 2029). Over three million people are between the ages of 18 and 65 years old. The elderly population (over 65) has remained stable at approximately 10 percent of the population during the 1990s and early 2000s, and is expected to remain at this level through 2010. Table 1.1 illustrates the distribution of the population by gender and age.

Table 1.1: 2006 Colorado Population by Age and Gender

Age Group	Male	(%)	Female	(%)	Total	(%)
<13	446,643	18.5	425,228	17.8	871,871	18.1
13 – 19	249,028	10.3	236,232	9.9	485,260	10.1
20 – 24	191,105	7.9	173,521	7.3	364,626	7.6
25 – 29	158,078	6.5	145,995	6.1	304,073	6.3
30 – 39	370,864	15.3	342,115	14.3	712,979	14.8
40 – 49	381,234	15.8	374,636	15.7	755,870	15.7
>49	623,047	25.8	695,829	29.1	1,318,876	27.4
Total Population	2,419,999		2,393,556		4,813,555	

Statewide, approximately 70.7 percent of the population classify themselves as White, 3.7 percent classify themselves as Black, 2.8 percent classify themselves as Asian Pacific Islander, 0.9 percent classify themselves as American Indian, 2.5 percent classify themselves as other or mixed race, and 19.4 percent of the population classify themselves as Hispanic. It is noteworthy that according to the U.S. Census Bureau 2006 American Community Survey, 7.1 percent of Colorado's population may be non-citizen immigrants. The following tables show the racial breakdown in Colorado by gender (Table 1.1) and county (Table 1.2). It should also be noted that the population totals presented in Table 1.1 and the totals reported in subsequent tables may vary slightly due to different data sources.

Table 1.2: 2006 Colorado Population by Race and Gender

Race	Male	(%)	Female	(%)	Total	(%)
White (Non-Hispanic)	1,692,198	69.9	1,707,813	71.5	3,400,011	70.7
Hispanic	490,850	20.3	443,560	18.6	934,410	19.4
Black (Non-Hispanic)	93,178	3.8	84,724	3.5	177,902	3.7
Asian/Hawaiian/PI (Non-Hispanic)	62,897	2.6	70,182	2.9	133,079	2.8
American Indian/Alaskan Native (Non-Hispanic)	21,978	0.9	19,183	0.8	41,161	0.9
Two or More Races (Non-Hispanic)	61,216	2.5	63,861	2.7	125,077	2.6
Total Population	2,422,317	100	2,389,323	100	4,811,640	100

Description of Colorado Ryan White Part B Program

The CDPHE Sexually Transmitted Infection (STI)/HIV Section is responsible for the administration of the Ryan White Part B Program. The Part B Program is a work unit within the STI/HIV Section of Disease Control and Environmental Epidemiology Division (DCEED) at CDPHE. This structure improves coordination of STI and HIV related prevention, surveillance, and care services. The Ryan White Part B Care and Treatment Program delivery is divided into four core areas:

The AIDS Drug Assistance Program - The Colorado AIDS Drug Assistance Program (ADAP) is a program to provide AIDS-specific medications at no cost on an outpatient basis to Colorado residents who qualify for the program.

Medicare Part D - In 2008, the State of Colorado Ryan White Part B Program began a new program, *Bridging the Gap, Colorado* (BTGC) to assist Medicare Part D eligible PLWH/A to acquire and pay for medications through a Medicare Prescription Drug Plan (PDP). BTGC “wraps around” Medicare Part D coverage, by paying for participants’ premiums, co-pays, deductibles, and co-insurance, including fees in the so-called “coverage gap.” This allows participants to access the entire formulary of their prescription drug plan at significant cost savings.

Insurance Program - Many of those living with HIV disease are able to continue employment at a business which offers healthcare and medication coverage while they manage their treatment. Others are able to maintain a Consolidated Omnibus Budget Reconciliation Act (COBRA) policy through a former employer while they are transitioning to a new job or to disability. The Ryan White insurance program is intended to assist eligible participants to maintain access to these benefits. The insurance coverage must provide “creditable” pharmaceutical coverage, and be cost-neutral to the ADAP to provide the same coverage. This program has the additional benefit of providing access to medical treatment for its participants.

HIV Care and Case Management - As of April 1, 2009, 14 contractors will be funded to provide HIV care and treatment services, including:

- Assistance in locating and accessing HIV care
- Assistance to remain in HIV care and to stay on medications
- Case management to maintain and improve quality of life

- Mental health therapy
- Substance abuse treatment
- Nutritional assistance
- Medical transportation
- Psychosocial support
- Oral health care
- Referrals to other services

A listing of the major services funded or provided by CDPHE is shown in Table 1.3, with the associated eligibility criteria.

Table 1.3: Service Availability and Eligibility Criteria for Colorado Part B Funded Services

Service	Eligibility criteria
Medical case management	Available to all clients who meet general eligibility criteria
Outpatient/ambulatory care	Clients must provide documentation of one of the following: - A rating from the Colorado Indigent Care Program (CICP), or - Uninsured/underinsured and lacking a CICP rating (e.g., due to very recent diagnosis or undocumented immigrant status), or - Household income at or below 400 percent of Federal Poverty Level (FPL) and at imminent risk of ceasing care due to temporary inability to cover care-related costs.
Emergency financial assistance	Household income at or below 400 percent of FPL. Other criteria vary by provider.
Emergency housing	Household income at or below 400 percent of FPL and must document that the need for housing affects access to medical care.
AIDS Drug Assistance (direct access to medications)	Household income at or below 400 percent of FPL and no creditable pharmaceutical coverage, including Medicaid (unless dually eligible for Medicare and Medicaid).
Insurance assistance for private health insurance	Level I – Household income at or below 200 percent of FPL and creditable pharmaceutical coverage. Level II – household income between 200 percent and 400 percent of FPL and creditable pharmaceutical coverage.
Insurance assistance for clients with Medicare Part D Plans and clients who are dually eligible for Medicare and Medicaid	Income at or below 400 percent of FPL and currently covered by a Centers for Medicare and Medicaid Services (CMS) approved Medicare Prescription Drug Plan that includes all or substantially all of the medications on the CDPHE ADAP Formulary.
Psychosocial support	Available to all clients who meet general eligibility criteria.
Other support services	At or below 400 percent of FPL.
Other core services	At or below 400 percent of FPL.

Additionally, driven by the high rates of PLWH/A who are apparently not in care, CDPHE has undertaken three major initiatives. First, trained disease intervention specialists have contacted people with no reported CD4 or viral load tests in more than one year; nearly one-third of these persons reported a desire to enter into care. Second, CDPHE established a “FirstCare” program, whereby clients newly learning their HIV positive serostatus or who have lapsed in care have an opportunity to have up to \$6,000 of out-of-pocket costs waived, thus reducing financial barriers to care. Third, linkage to care programs were established at Denver Health, in the most heavily impacted urban area of the state.

B. Epidemiological Profile of HIV/AIDS in Colorado

The Surveillance Program at CDPHE estimates 10,619 PLWH/A in Colorado as of June 30, 2008.¹

As of December 31, 2006, a cumulative total of 8,845 cases of AIDS, and an additional 6,184 cases of HIV infection have been reported in Colorado. Significant decreases in AIDS incidence and mortality have been observed both in the United States and in Colorado since the introduction and use of new anti-HIV drug therapies in 1996. In 2006, 321 AIDS cases and 306 HIV cases were diagnosed. There has been a downward trend of newly diagnosed AIDS cases over the last five years, while cases of HIV have increased 26 percent.

As a result of new therapies, fewer PLWH are progressing to AIDS and fewer people are dying from AIDS. AIDS-related mortality has decreased by 18 percent between 2002 and 2006. HIV or AIDS prevalence (number of persons with HIV or AIDS) has increased steadily. By December 2006, an estimated 9,831 persons were living with HIV or AIDS in Colorado, with 41.3 percent of these persons representing persons living with AIDS (PLWA).

The epidemic in Colorado is still overwhelmingly driven by sexual exposure, primarily among men who have sex with men (MSM), which continues to be the most significant risk group and account for 64.8 percent of HIV cases diagnosed in 2006. Among females, heterosexual transmission represents 61.3 percent of reported cases.

People of color are disproportionately affected by HIV/AIDS, especially Blacks, who are over represented in all risk groups. Blacks had an 18.1 percent increase in the number of diagnosed AIDS cases from 2002 to 2006, compared to a 12.5 percent increase among Whites.

Cases of HIV/AIDS continue to be geographically centered along the Front Range population of Colorado, although injection drug user (IDU) cases and cases with no identified risk appear to be reported more frequently from rural/frontier counties.

While the number of women living with HIV in Colorado has increased by 17.2 percent since the beginning of the epidemic, perinatal transmission has decreased dramatically since 1996. The active efforts by Ryan White Funded programs to promote widespread screening of pregnant women for HIV and to make available optimal anti-retroviral drugs and obstetric management during pregnancy and labor/delivery as well as infant prophylaxis as contributed to the decrease in transmission rates. The number of infants born to women living with HIV has increased by 39 percent since 2003. During that period, among over 102 births, four cases of perinatally acquired HIV infection have been reported in infants born to HIV infected mothers in Colorado. Three of the four did not receive treatment to prevent mother to child transmission for the following reasons: no prenatal care, refusal of HIV testing, and acquisition of HIV after initial pregnancy testing.

¹ Based on cases diagnosed and reported in Colorado through June 30, 2008.

Table 1.4: Demographic Characteristics of Persons Living with HIV and AIDS in Colorado Reported Through December 31, 2006

Characteristic	Persons living with HIV		Persons living with AIDS		Total living with either HIV or AIDS	
	Number	(%)	Number	(%)	Number	(%)
Gender						
Male	5142	89.8	3668	89.3	8810	89.6
Female	582	10.2	439	10.7	1021	10.4
Age Group						
<13	30	0.5	8	0.2	38	0.4
13 – 19	141	2.5	20	0.5	161	1.6
20 – 24	828	14.5	132	3.2	960	9.8
25 – 29	1329	23.2	475	11.6	1804	18.4
30 – 39	2332	40.7	1867	45.5	4199	42.7
40 – 49	834	14.6	1180	28.7	2014	20.5
>49	230	4.0	425	10.3	655	6.7
Race						
White (Non-Hispanic)	4024	70.3	2605	63.4	6629	67.4
Black (Non-Hispanic)	754	13.2	608	14.8	1362	13.9
Hispanic	851	14.9	807	19.6	1658	16.9
Asian (Non-Hispanic)	37	0.6	27	0.7	64	0.7
American Indian (Non-Hispanic)	45	0.8	38	0.9	83	0.8
Multiple Race (Non-Hispanic)	9	0.2	16	0.4	25	0.3
Hawaiian/Pacific Islander (Non-Hispanic)	4	0.1	6	0.1	10	0.1
Risk						
MSM	3710	64.8	2587	63.0	6297	64.1
IDU	461	8.1	420	10.2	881	9.0
MSM/IDU	494	8.6	379	9.2	873	8.9
Heterosexual Contact	421	7.4	406	9.9	827	8.4
No Identified Risk	596	10.4	269	6.5	865	8.8
Other	42	0.7	46	1.1	88	0.9

Table 1.5: Regions of Residence of Persons Living with HIV and AIDS in Colorado Reported Through December 31, 2006

Regions ²	Persons living with HIV		Persons living with AIDS		Total living with either HIV or AIDS	
	Number	(%)	Number	(%)	Number	(%)
Denver Transitional Grant Area	4434	79.39	4021	80.21	8455	79.78
North Central	248	4.44	180	3.59	428	4.04
Western	176	3.15	162	3.23	338	3.19
Northeast	172	3.08	159	3.17	331	3.12
Southern	555	9.94	491	9.79	1046	9.87
TOTAL	5585	100	5013	100	10598	100

² See Attachment A for a county breakdown by region.

Persons living with HIV or AIDS who were born outside of the United States

The percent of foreign-born persons has been increasing among Colorado's communities of color. Among HIV cases newly diagnosed in 2006, 34.1 percent of Hispanics were foreign-born; the majority of these persons were born in Mexico. Among Blacks, 27.1 percent were foreign-born; their primary place of origin was the continent of Africa. Cultural and language barriers can make these groups a challenge for prevention and care providers.

Incarcerated persons

According to data from the Colorado Department of Corrections, 21,438 persons were in the custody of Colorado Department of Corrections in 2006 (a six percent increase over 2005); 14,115 were inmates in 24 state correctional facilities in 2006; eight of the Colorado Department of Corrections facilities are located in Fremont County. The remaining 7,323 were housed in contract facilities or county jails. Colorado's incarcerated population is 10.1 percent female and 89.9 percent male. The racial and ethnic characteristics of this population is 47.4 percent White, 19.5 percent Black, 1.9 percent American Indian, 1.0 percent Asian, and 30.2 percent Hispanic. Inmates are universally tested for HIV on entry to the Colorado Department of Corrections, but inmates are not routinely tested while incarcerated nor upon release.

Over the period 2004 – 2006, based on reports from the Colorado Department of Corrections and the Bureau of Justice Statistics, a total of 260 PLWH/A were released from the custody of the penal system in Colorado. Approximately 80 percent, or 208, of these persons are estimated to reside in the Denver Transitional Grant Area (TGA).

Caring for the HIV-infected incarcerated patient is complex and challenging. For many of these patients, the prison health service provides their first opportunity for access to health care. Assuring the continuation of health care started in prison is a major challenge. All male prisoners known to be living with HIV or AIDS are housed at one facility, which also houses uninfected inmates.

Hispanics

The five-year average rate of reported HIV cases among Hispanic males from 2002 to 2006 (12.7 per 100,000 population) is over two times that of White males. Among females, the average rate among Hispanic females (2.1 per 100,000 population) is three times that of White females. From 2002 through 2006, the number of HIV/AIDS cases among Hispanics peaked in 2002 at 130. While the total number of reported HIV/AIDS cases among Hispanics has remained below the reported number in 2002, reported case totals have steadily increased from 2003 (87) to 2006 (118). Among all racial groups, the number of reported AIDS diagnoses increased from 2002 to 2006; Whites showed a 12.5 percent increase, Blacks showed an 18.1 percent increase and Hispanics showed an 8 percent increase during this time. Rates of newly reported HIV cases among Hispanics was greatest in 2002 (8.1 per 100,000), but have begun to increase from the lowest reported rate of 5.2 per 100,000 in 2003 to 7.2 per 100,000 in 2006. In regard to men who have sex with men, Hispanics are over represented (23.9 percent of newly diagnosed HIV cases)

for their proportion of the population (19.4 percent). In regard to injection drug use, the number of reported HIV/AIDS case reported among Hispanics has decreased from 13 cases in 2002 to four cases in 2006. This difference represents a 69.2 percent decrease during this five-year time frame among Hispanic IDU. In regard to heterosexual HIV transmission, Hispanics experienced a substantial increase in the number of reported heterosexually transmitted cases from 2004 (9) to 2005 (20). The number of heterosexually transmitted cases continues to be greater than the lowest number reported in 2004 of nine cases, but has not surpassed the higher number reported in 2005 of 20.

Hepatitis C and HIV Co-Infection

Table 1.6 compares people diagnosed with HIV (n=8,468) since 1993 who are co-infected with hepatitis C virus (HCV) (1,189, 11.8 percent) to people diagnosed with HIV since 1993 who are *not* co-infected with HCV (7,279, 88.2 percent). Risk factors for co-infection include IDU, IDU/MSM, MSM and being White or Hispanic. Co-infection with HCV poses special clinical challenges for the treatment of HIV. Due to shared routes of transmission, there is a wide range of co-infection rates (0.1 – 37) depending on the risk subgroup.

Table 1.6: Hepatitis C and HIV/AIDS in Colorado, Cases Diagnosed Since 1993 and Reported Through 12/31/06

	HIV/AIDS with HCV		HIV/AIDS without HCV	
	Number	Percentage	Number	Percentage
Male	1,003	84.4	6,469	88.9
Female	186	15.6	810	11.1
Current Age				
<13	0	0.0	28	0.4
13 – 14	1	0.1	5	0.1
15 – 19	4	0.3	97	1.3
20 – 24	38	3.2	500	6.9
25 – 29	102	8.6	1,068	14.7
30 – 34	249	20.9	1,616	22.2
35 – 39	292	24.6	1,504	20.7
40 – 44	248	20.9	1,095	15.0
45 – 49	145	12.2	691	9.5
50 – 54	68	5.7	342	4.7
55 – 59	22	1.9	182	2.5
60 – 64	14	1.2	82	1.1
>65	6	0.5	69	0.9
Race				
White	674	56.7	4,650	63.9
Black	200	16.8	1,052	14.5
Hispanic	278	23.4	1,429	19.6
American Indian/Asian and Pacific Islander	29	2.4	123	1.7
Multi-racial, not Hispanic	8	0.7	25	0.3
Risk				
MSM	329	27.7	4,903	67.4
IDU	436	36.7	439	6.0
MSM/IDU	295	24.8	454	6.2
Hemophilia	12	1.0	7	0.1
Heterosexual Contact	58	4.9	768	10.6
Risk not Identified	58	4.9	657	9.0
Transfusion	1	0.1	17	0.2
Pediatric	0	0.0	34	0.5
Total	1,189		7,279	

C. Emerging Epidemiologic Trends

Men Who Have Sex With Men (MSM)

The HIV epidemic in Colorado continues to consist primarily of MSM and MSM/IDU, which represent 73 percent of cumulative cases (total number of cases) of HIV and AIDS. Whites make up the largest racial group of MSM, consisting of 67.4 percent of HIV cases diagnosed in 2006. Blacks and Hispanics are over represented in relation to their percentage of the population. MSM 20 – 49 years old are over represented among recently diagnosed HIV cases in relation to the

percent of males in Colorado. Persons aged 30 – 39 years had the highest percentage of cases. MSM have a much higher rate of recent infection (infected within 170 days of first HIV test) than any other risk group. Increases in early syphilis cases among MSM may indicate increased sexual risk behavior, which increases the possibility of transmission of HIV. Bathhouse contacts or sex arranged over the Internet continues to be a significant source of new HIV and syphilis infections.

Blacks (including both African Americans and persons born outside the United States)

Blacks are over represented in the cumulative epidemic of HIV/AIDS in Colorado among recently infected persons and among all risk groups. The HIV rate per 100,000 population for Black males (27.5) in Colorado in 2006 was nearly five and a half times the rate of White males (5.0). Among Black females the rate per 100,000 is 16.0, which is over 22 times the rate of White females (0.7) in Colorado.

Injecting Drug Users

White males account for the overwhelming majority of IDU cases (1,035 or 73.6 percent). However, Blacks and Hispanics continue to be disproportionately represented in the IDU transmission category in relation to their proportion of the state population. Overall, Blacks account for 143 IDU cases (10.2 percent) and Hispanics for 196 IDU cases (13.9 percent). Among females, the number of IDU-related HIV or AIDS cases (575) is smaller than for males. Three hundred seventy-four cases of HIV or AIDS in females are directly related to IDU. The number of cases of females who acquired their infection as a result of heterosexual contact with an IDU (201 total cases) is substantially higher for females than for males in all racial/ethnic groups.

Females

The proportion of females among newly diagnosed HIV cases is increasing. In 2006, women accounted for 10.4 percent of PLWH/A, an increase from previous years. Black females are over represented, making up 34.2 percent of newly diagnosed female HIV cases. Heterosexual contact (50 percent) was the predominant risk for women diagnosed with HIV in 2006.

D. Colorado Response to the Epidemic

In response to the needs of increasing numbers of people being diagnosed with HIV/AIDS in local communities, the majority of AIDS service providers began as volunteer or non-profit agencies in the mid 1980s. In addition to the Colorado AIDS Project in Denver, regional AIDS Service Organizations (ASOs) were established in northern, southern and western Colorado, as well as in Boulder County. These ASOs, while consulting with each other, have been completely autonomous and self-funded. Upon passage of the Ryan White Comprehensive AIDS Resources Emergency Act (CARE) grant, these entities agreed to become sub-grantees of Colorado's Ryan White funding, which was to be administered by CDPHE. Each sub-grantee was required to form a care consortium, be bound by uniform standards of care, and participate in various collaborative enterprises. They are required to submit annual work plans, submit to annual

audits, and be monitored for CARE Act compliance. The first contracts were implemented in 1992.

The State of Colorado has had a names-based HIV reporting surveillance system since 1985. The law mandates that both laboratories and physicians report any case of HIV and AIDS, within seven days of diagnosis. This names reporting law has provided sound epidemiological data to help make funding decisions, allocate Ryan White funds to the various consortia in an equitable way, track emerging trends, and for program planning.

Through this funding, the following services were made available in the fiscal year that ended March 31, 2008:

- Through ADAP, provided access to 68 medications, including 26 antiretrovirals. 894 ADAP clients were prescribed at least one medication during the year.
- A total of 397 clients with Medicare Part D prescription drug coverage received support through Bridging the Gap, Colorado.
- A total of 141 clients received assistance with the costs of private health insurance, including COBRA and insurance continuation.
- A total of 958 clients received medical case management at four funded community based organizations (CBOs) throughout Colorado. A total of 169 new clients accessed at least one funded service at these providers.
- Four sites implemented enhanced substance abuse services, utilizing the SBIRT (screening, brief intervention, and referral into treatment) model.
- Two new providers of mental health services were funded.
- Linked 60 clients to HIV care and treatment, either with CDPHE staff or at two linkage to care sites in local health departments.
- Provided case management (including ADAP enrollment) for 58 inmates in county jails.
- Maintained an outreach site in Pueblo.
- Supported projects at the infectious disease clinics at Denver Health, University of Colorado Hospital, Kaiser Permanente in Denver, St. Mary's Hospital, Beacon Clinic, and Pueblo Community Health Center that enhanced access to care, retention in care, medication adherence, mental health services, and HIV care in general, including support for 361 laboratory procedures.
- Provided assessment of HIV care for 169 newly diagnosed persons in conjunction with disease investigation services conducted by CDPHE staff.
- For newly diagnosed persons or those whose care has lapsed, established the "FirstCare Program." Through FirstCare, clients are able to avoid nearly all out-of-pocket costs for the first three to six months of care in regard to outpatient care and other Ryan White fundable services. Part B and its funded agencies served 26 clients with FirstCare.
- Funded four ASOs and other community providers to deliver a comprehensive range of services in addition to medical case management, including medical transportation, psychosocial support, food bank, oral health, and housing.
- Provided support for quality improvement, including training courses and consultation services.

As federal funding for HIV services continues to decrease, enhancing the coordination of the prevention and care planning bodies in Colorado is critical to sustaining, as well as improving, the quality of service delivery in the state.

Starting in 2008, the state's HIV/AIDS care and prevention planning groups coordinated by CDPHE began the process of merging together into one statewide HIV/AIDS planning group. The purpose of the Coalition is to serve as an expert resource providing advice and information to CDPHE on issues, trends, needs and resources pertaining to HIV/AIDS in the promotion of effective HIV prevention and care programs. The Coalition will also advise the department on scientific and policy issues, including those related to treatment and access to medical care for persons in Colorado living with HIV/AIDS. The new Coalition structure is intended to integrate the HIV/AIDS planning groups and provide a mechanism to coordinate HIV and AIDS related planning processes and services supported by the department.

Other Ryan White Funded Services in Colorado

Services Supported with Part A Funding

In FY 2008, the Denver HIV Resources Planning Council provided funding to 12 service categories with Part A dollars. Part A funds are used only when no other funds exist to sustain the continuum and fill gaps in service. In FY 2008, the Mayor's office of HIV Resources (MOHR) contracted with 16 separate agencies to provide services in the 12 supported categories. Collectively, these service categories represent a comprehensive continuum of care that provides PLWH/A with the following services:

- Outpatient/Ambulatory Health Services
- AIDS Pharmaceutical Assistance (Local)
- Oral Health Care
- Medical Case Management
- Mental Health Services
- Substance Abuse Services (Outpatient)
- Food Bank/Home-Delivered Meals
- Emergency Financial Assistance
- Housing Services
- Medical Transportation Services
- Case Management (Non-Medical)
- Home and Community-Based Health Services.

In addition to the specified Part A funded service categories, two additional service categories are funded for the TGA through the Ryan White Part B award from CDPHE. These are: ADAP and Health Insurance Premium and Cost Sharing Assistance. PLWH/A within the Part A system of care benefit from these two services with the costs being covered by Part B dollars. Coordination of these Part B-funded categories enhances Part A service delivery by enabling participants to seamlessly access critically needed components of care. The integration of ADAP in particular promotes adherence to medication regimes that are vital for the maintenance of effective primary care and positive health outcomes.

Services Supported with Part C Funding

There are four medical providers supported with Part C funding in Colorado.

St. Mary's Hospital and Medical Center provides comprehensive primary and specialty HIV care to PLWH/A in western Colorado as the HIV primary and specialty care services provider in the 22 county region of western Colorado. Care is delivered in accordance with the most current national treatment guidelines. HIV experts from the Infectious Disease Group at the University of Colorado in Denver travel to Grand Junction twice a month and Durango quarterly to provide HIV specialty care in conjunction with a local primary care physician. In 2008, the Part C Program medical director and an HIV nurse began traveling to Frisco, situated at 9,000 feet elevation in the heart of the Rocky Mountains, to see low-income patients who lack transportation to Grand Junction on a semi-annual basis. The Western Colorado Part C Clinic saw 188 unduplicated patients in 2007, a seven percent increase from 2006. Services provided include oral health care, mental health care, counseling and testing, case management, general and preventive health education, and medication adherence on-site with nutrition consultations, non-HIV specialty care, and substance abuse treatment available off-site through referrals.

The HIV Primary Care Clinic (PCC) at Denver Health provides comprehensive HIV primary care and other services as outlined in the Health and Human Services (HHS) guidelines as their first priority. Addressing maintenance of active patients in care (more focus on following up with patients who do not call or show up for scheduled appointments) is an additional priority. The HIV PCC has begun to incorporate Hepatitis C services into their clinic. Comprehensive mental health assessment and treatment is available in the clinic. Referral to outpatient services for substance abuse is routinely done in the clinic. Primary and secondary prevention is an additional focus of their clinical work. HIV PCC provides some testing and counseling services that have an additional goal of prevention; they also provide free condoms to their patients and other patients at Eastside Health Clinic. Referrals to other service providers are an essential part of the services in the clinic.

The Beacon Center for Infectious Disease at Boulder Community Hospital provides all Ryan White early intervention and core services, including:

- Outpatient/ambulatory care
- Specialty care (dermatology, cardiology, nephrology, endocrinology, urology, neurology, ophthalmology, oral health, nutritional counseling, general surgery, etc.)
- Case management: (on-site, 10 hours weekly)
- Psychiatric services (on-site, one-half-day a week)
- Imaging (magnetic resonance imaging [MRI], computerized tomography [CT], ultra-sounds, etc.)
- Laboratory (CD4/t-cell, viral load; complete blood counts, chemistries, lipids, all appropriate serologic tests, etc.)
- Pharmacy/prescription (340B pricing through the Apothecary)
- Other financial assistance (involving a collaborative financial meeting with local ASOs for patient assistance for Ryan White eligible services)

Pueblo Community Health Center's (PCHC) mission to provide primary health care to those in need, is enhanced with their Ryan White Part C grant. This grant allows PCHC to provide outpatient early intervention and primary health care services for HIV positive persons residing in 17 counties of southeastern Colorado: Pueblo, Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Las Animas, Otero, Prowers, Rio Grande and Saguache. HIV/AIDS Care at PCHC includes: primary health care and services; medical case management; perinatal care; preventive, developmental and diagnostic services for infants and children; diagnostic laboratory and radiology; referrals to specialty care; HIV testing and counseling; pharmaceutical services; oral healthcare; outpatient substance abuse therapy and counseling; outpatient mental health care; nutritional counseling; drug treatment adherence counseling; HIV prevention education with HIV positives; coordination and follow-up after hospital care; 24-hour coverage; and coordination of services with community organizations serving those living with HIV/AIDS.

Services Supported with Part D Funding

Children's Hospital's Immunodeficiency Program (CHIP) provides family-centered supportive services to HIV-positive pregnant women and to children from birth through adolescence and their parents. With Part A, Part D and Children's Hospital support, CHIP provides: outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), medical case management, mental health services, psychosocial support, nutritional counseling, child care, interpreter services, prevention with positives, and medical transportation.

Children's Hospital Immunodeficiency Program is the only comprehensive healthcare program in the Rocky Mountain region focused on serving HIV-infected and at-risk youth (13 to 24 years old). Teenagers recently diagnosed with HIV, as well as those who have lived with it for some time, carry specific challenges unique to their ages. The CHIP Youth Program (CYP) addresses these issues with a medical program developed with the adolescent developmental stages in mind. Peer counselors meet with patients when reporting positive HIV test results and then work with these teens to teach them how to avoid spreading the virus. Peer counselors also provide links to medical care. Youth clinics are designed so youth can meet as a group and support each other in their treatment. More experienced youth provide direction to their less-experienced peers. CYP clients also meet individually with physicians, nurse practitioners, social workers, a psychologist, a psychiatrist, peer counselors, and a nutritionist. CYP offers both formal support groups and informal social events that offer young people a time to share experiences and support each other. Participants in the program also assist CHIP staff in hosting community outreach programs. These events use hip-hop music and pop culture to draw young people to a fun venue that provides confidential HIV testing and prevention information. Participants that receive CYP services become empowered healthcare consumers who are better able to manage their HIV into adulthood. CYP works to provide a smooth transition for youth into adult healthcare systems when they are ready.

In 2007, CHIP provided services to 382 clients, who included 205 HIV positive people, 30 indeterminate, 144 affected, and three unknown. Among these, 88 were youth (18 children aged 2 to 12) and 92 were age 25 to 44.

The following services are top priorities of CHIP:

- 1) Improved mental health and wellness for all populations – this includes systematic assessment and referral, onsite psychiatric services and working with community providers to build capacity to serve CHIP’s unique client base.
- 2) Developing psychosocial programs for perinatally infected children and their families to address issues of aging up into adolescence. This includes support groups and parent education seminars.
- 3) Expanding CHIP partnerships to provide comprehensive and coordinated care to the clients served by Part D. This includes a Part D-funded collaboration with Denver Health to serve adolescents and other clients eligible for CHIP services.
- 4) CHIP providers will receive motivational interviewing training that will help address issues of adherence and prevention with clients.
- 5) Ensuring that rapid HIV testing for obstetrical clients continues statewide and that regardless of where a pregnant HIV-positive patient delivers, she and her baby have access to the necessary antiretroviral protocol.

Services Supported with Part F Funding

The Part F Community-Based Dental Partnership Program (CBDPP) is housed at the University of Colorado School of Dental Medicine (UCSDM) in Denver. On a national level, the CBDPP was first funded in FY 2002 to increase access to oral health care services for HIV positive persons, while providing education and clinical training for dental care providers, especially those located in community-based settings. To achieve its goals, the CBDPP works through multi-partner collaborations between dental and dental hygiene education programs and community-based dentists and dental clinics. Community-based program partners and consumers help design programs and assess their impact.

The Colorado Ryan White Community-Based Dental Partnership Consortium was initially established in August 2002. The program leverages the resources provided by the CBDPP with existing educational collaborations between the University of Colorado School of Dental Medicine, the Colorado AIDS Education and Training Center (CAETC) and the UCSDM network of community-based clinical education sites. This consortium currently consists of UCSDM, CAETC and four community-based dental partners in targeted underserved areas of Colorado (the Marillac Clinic on the Western Slope, the Pueblo Community Health Center in Southern Colorado, Longmont Salud Clinic in Central Colorado, and the Howard Dental Center in Denver). These partnership sites are in areas where Ryan White Parts A and C clinics exist and HIV/AIDS patients have benefited greatly from the increased care and coordination of services provided. Additionally the grant has allowed the UCSDM general practitioner residents based in the Sands House Clinic to become the referral center for tertiary dental care from all of the community-based dental partners. These five clinical training sites have sponsored student and resident experiences in treating over 330 HIV-positive patients during the current year of the CBDPP grant.

Other Publicly-Funded Services for Persons Living with HIV or AIDS in Colorado

Primary and Specialty Health Care Through Medicaid

In Colorado, PLWH/A may be eligible for a special waiver program, called the “Home and Community Based Services Waiver for Persons Living with AIDS” or “HCBS-PLWA” waiver. To qualify for this waiver, PLWH/A must meet the eligibility criteria for one of the Medicaid program categories; the waiver can then expand the benefit available to them. The most common category under which PLWH/A qualify for Medicaid is known as “Aid to the Needy Disabled.”

If the client is under the age of 64 and does not have dependant children, the client must be determined blind or disabled by the Social Security Administration (SSA) standards. Clients deemed eligible for Supplemental Security Income (SSI) from SSA automatically receive Medicaid.

To qualify for a waiver, the applicant's income must be less than \$1,986 (300 percent, or three times, the SSI allowance) per month and countable resources less than \$2,000 for a single person or \$3,000 for a couple. The applicant must also be at risk of placement in a nursing facility, hospital, or intermediate care facility for the mentally retarded (ICF/MR). To utilize waiver benefits, clients must be willing to receive services in their homes or communities. A client who receives services through a waiver is also eligible for all basic Medicaid covered services except nursing facility and long-term hospital care. When a client chooses to receive services under a waiver, the services must be provided by certified Medicaid providers or by a Medicaid contracting managed care organization. The cost of waiver services cannot be more than the cost of placement in a nursing facility, hospital, or ICF/MR.

The primary purpose of the HCBS-PLWA waiver is to provide a home or community based alternative to hospital or specialized nursing facility care. The medical criterion is that the client requires nursing facility or hospital level of care. For those who qualify under HCBS-PLWA, the available services (above and beyond those generally available under Medicaid) are: adult day services, personal emergency response system, homemaker services, non-medical transportation, personal care, and private duty nursing.

Some PLWH/A qualify for an alternative waiver, called the “HCBS Waiver for Persons who are Elderly, Blind, and Disabled.” Many PLWH/A chose this waiver over the HCBS-PLWA waiver because the list of services is more inclusive, including: adult day services, alternative care facilities, community transition services, consumer directed attendant support, personal emergency response system, home modifications, homemaker services, in-home support services, non-medical transportation, personal care, and respite care.

According to the Kaiser Family Foundation, in 2004 (the most recent year for which data is available) 103 PLWH/A participated in the HCBS-PLWA waiver program. The total per-participant cost was \$6,344.³

³ <http://www.statehealthfactsonline.org/>

In terms of access to general health care, Colorado Medicaid does cover a substantial portion of the medical needs of a PLWH including: physician visits, podiatry services, nurse practitioner services, licensed psychologist services, nurse midwife services, outpatient substance abuse treatment, limited inpatient psychiatric services, prescription drugs, telemedicine services, prenatal care services, limited case management, immunizations, hospice services, lab and X-ray, private duty nursing services, inpatient hospital services, outpatient hospital services, emergency services, residential child health care services, family planning services, nursing facilities services, optometrist services, home health services, eyeglasses for adults after eye surgery, durable medical equipment and disposable supplies, physical, occupational and speech therapy, and medical transportation.

Oral Health Care Through Medicaid

Medicaid coverage for adult oral health services is extremely limited in Colorado. To be eligible for coverage, the oral health condition must be demonstrated to be related to a “chronic medical condition in which there is documentation that the medical condition is exacerbated by a condition of the oral cavity.” In some instances, HIV/AIDS could potentially be considered such a chronic medical condition, if the oral health provider is willing and able to assemble the necessary documentation. Colorado Medicaid will also cover adult oral health care if it is “emergency” and is related to “a condition of the oral cavity that would result in acute hospital medical care and or subsequent hospitalization if no immediate treatment is rendered.” The following services/treatments are not a benefit for adult clients under any circumstances: preventive services to include prophylaxis, fluoride treatment and oral hygiene instruction; treatment for dental caries, gingivitis and tooth fractures; restorative and cosmetic procedures; inlay and onlay restorations; crowns; treatment of the oral cavity in preparation for partial or full mouth dentures; and assessment for, delivery of dentures or subsequent adjustments to dentures and bridges.⁴

Medicaid-funded dental coverage for Colorado’s rural PLWH/A is even more problematic. According to a report from the Colorado Rural Health Center⁵, nearly one-third of Colorado counties lacked access to dental services for low income and at-risk (Medicaid, Child Health Plan Plus [CHP+], Medicare) populations in 2000. In 2003, nine Colorado counties had no licensed dentists at all, only 11 percent of Colorado’s dentists participated in Medicaid’s Dental Program, and 40 percent of Colorado counties did not have even one dentist that accepted Medicaid.

Housing Opportunities for Persons Living with AIDS (HOPWA)

Housing Opportunities for Persons with AIDS funding provides housing assistance and related supportive services, working in partnership with communities and neighborhoods in managing Federal funds appropriated to HIV/AIDS programs. HOPWA funds may be used for a wide

⁴ HCPF Rules, 10 CCR 2505-10, available at <http://www.colorado.gov/cs/Satellite?c=Page&cid=1214427706870&pagename=HCPF%2FHCPFLayout>

⁵ http://www.coruralhealth.org/crhc/resources/publications/issuepapers/oral_health12.06.pdf

range of housing, social services, program planning, and development costs. These include, but are not limited to, the acquisition, rehabilitation, or new construction of housing units; costs for facility operations; rental assistance; and short-term payments to prevent homelessness. HOPWA funds also may be used for health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services.

In the Denver TGA, the City and County of Denver's Housing and Neighborhood Development Department administer HOPWA funds for the Eligible Metropolitan Statistical Area. The FY 2008 award for the Denver metropolitan area was \$1,797,040. The funding was used to provide the following services: short term rental assistance, tenant based housing subsidies, subsidized HOPWA units, residential housing with supportive services for the chronically homeless, day shelter and medication adherence services for homeless PLWH/A, housing development, and limited supportive services. The short-term rental assistance funds are used to prevent evictions and assist with deposits. HOPWA rental assistance and Part A emergency housing assistance are closely linked and are administered through the same program. Additionally, U.S. Department of Housing and Urban Development (HUD) has awarded a three-year HOPWA Special Projects of National Significance (SPNS) grant in the amount of \$730,000 to the Colorado AIDS Project (CAP) for the MOSAIC Transitional Housing program. CAP also receives \$400,000 from HUD and McKinney Act funds to support the Juan Diego Project and Dave's Place Supportive Housing programs targeting PLWH/A who are homeless.

For areas of Colorado outside of the Denver TGA, the HOPWA grantee is the Division of Housing in the Colorado Department of Local Affairs. The Colorado fiscal agent for HOPWA is CAP, which has collaborative relationships with the other Colorado ASOs to distribute funds where they are needed statewide. The Colorado HOPWA formulary funds assistance program is known as Colorado Housing Assistance Made Possible (CHAMP).

In Colorado, HOPWA funds are used for three main purposes: 1) Direct rental assistance, 2) Development of permanent housing units dedicated for use by PLWH, and 3) Housing advocacy. Direct rental assistance is the most widely used housing service for PLWH/A. Rental assistance is distributed by CAP, which collaborates with the other ASOs to provide housing support statewide. Clients may apply for these funds through their HIV social worker at area hospitals/clinics or through Ryan White funded service providers.

Direct rental assistance is available to clients who meet federal guidelines for assistance. To be eligible for this program, PLWA must have an annual household income of no more than 80 percent of the median income for comparably sized households in the Denver area. Clients receiving HOPWA rental assistance pay no more than 30 percent of their adjusted household income, 10 percent of their gross income, or a housing allowance as designated by a public welfare agency. A client may receive assistance for up to 21 weeks. Any client receiving rental assistance must be in a housing unit that charges at or below the Fair Market Rent schedule as set forth by HUD.

For the most current funding period, 578 Colorado clients had received some level of support through HOPWA.

Colorado's HIV/AIDS Health Care Providers

The Colorado Department of Regulatory Agencies lists 17,315 licensed physicians in Colorado, across all specialties. The vast majority of PLWH/A in Colorado receive their care from less than 100 physicians and other health care professionals. Table 1.7 shows more detail on these practices as of December 31, 2008. It is the intent of the CDPHE HIV Care and Treatment Program to expand collaborations with these practices, both public and private, to improve access to high quality HIV care statewide.

Table 1.7: Major Medical Practices Serving PLWH/A in Colorado

Practice Name	Provider Names	On-site clinics	Jurisdiction Limits
APEX Family Medicine	Bailey, Mack, Mohr, Scott	Denver	Statewide
Beacon Center for Infectious Disease	King, Pujet, Rogers, Turner	Main clinic in Boulder, with periodic clinics in Fort Collins and Greeley	Residents of Boulder, Broomfield, Clear Creek, Gilpin, Larimer, and Weld Counties
Children's Hospital Immunodeficiency Program	Abzug, Barr, Forsyth, Howard, Kinzie, Levin, Maes, McEvoy, McFarland, Michalek, Pappas, Weinberg, Simons, Scanlon	Main facility is in Aurora; periodic clinics at Denver Health	Statewide
Clinica Tepeyac	Burman, Hansen, Padilla, Parra, Sandoval, Urias, Williams	Denver	Statewide
Colorado Infectious Disease Associates	Gulinson, Karakusis, Kaufman, Kotula, Tillquist	Denver	Statewide
HIV Primary Care Clinic at Denver Community Health	Blum (J), Bolkovatz	Denver	Statewide for those eligible for Medicaid and Children's Health Plan Plus; others must be Denver residents
Denver Health Infectious Disease Clinic	Barber, Burman, Belknap, Cohn, Thrun, Gardner, Gourley, Logan, Caraway, Peterson, Price, Reves, Rietmeijer, Sampson, Wright	Denver	Statewide for those eligible for Medicaid and Children's Health Plan Plus; others must be Denver residents
Denver Infectious Disease Center Consultants	Greenberg, Hammer, Young	Denver	Statewide
Family Centered Medicine	Prutch	Denver	Statewide
Infectious Disease Consultants	Blum (R), Terra	Denver	Denver
Infectious Disease Specialists	Brookmeyer, Hackenberg, Hofflin, Strandberg, Weber, Gates	Colorado Springs	Statewide
Kaiser Permanente Infectious Disease Practice	Bruce, Edell, Kuhns, Mogyoros	Main infectious disease practice is in Downtown Denver, but PLWH may receive primary care in other Kaiser offices	Must reside in specific portions of Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Elbert, El Paso, Gilpin, Jefferson, Larimer, Park or Weld Counties

Practice Name	Provider Names	On-site clinics	Jurisdiction Limits
MCPN (Metropolitan Community Provider Network)	Amador, Arami, Barker, Barter, Creech, Ferrer, Gehred, Martin, Mathad, McLean, Mockler, Munoz, Parmar, Perna, Reddy, Saproo, Schlegel, Tellez	Arapahoe, Jefferson, Adams, and Park Counties and the cities of Lakewood and Aurora	Must reside in Arapahoe, Jefferson, Adams, or Park Counties
National Jewish Health HIV Clinical and Research Program	Huitt, Kasperbauer, Lichtenstein	Denver	Statewide
Peak Vista Community Health Center	Brunmeier, Davenport, Walker-Conner	Colorado Springs	El Paso and Teller County residents only
Private practice	Brandt	Boulder	Statewide
Private practice	Alford	Denver	Statewide
Private practice	Salka, Johnson	Durango	Statewide
Private practice	Gill	Longmont	Statewide
Private practice	Silveria	Colorado Springs	Statewide
Pueblo Community Health Center	Schwartz, Johnson	Pueblo	Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Las Animas, Otero, Prowers, Pueblo, Rio Grande, or Saguache Counties
Rocky Mountain Infectious Disease Consultants	Ong, Peskind, Cobb	Fort Collins	Statewide
Rocky Mountain Infectious Diseases	Clover, Gardner, Harte, Kearns, Neid	Aurora	Statewide
St. Mary's Family Medicine	Davis, Dickenson, Graham	Grand Junction, with periodic clinics in Durango and other mountain communities	Residents of Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, or Summit Counties
South Denver Infectious Disease Specialists	Dias, Messa, Williams	Englewood	Statewide
University of Colorado Infectious Disease Group Practice	Barron, Beckham, Campbell, Carten, Castillo, Connick, Eickoff, Haas, Johnson, Koeppe, Kwong, Levi, Levin, Madinger, McCollister, Nielsen, Shapiro, Weinberg, Wilson	Aurora (with periodic clinics in Grand Junction, Pueblo, and Durango)	Statewide
Veterans Administration (VA)	Bessesen, Redington, Stamper	Denver	Statewide, for those with VA benefits
Western Infectious Disease Consultants	Cullinan, Des Jardin, Fujita, Luck, Mason	Wheat Ridge	Statewide

E. Part B Assessment of Need

During the fall of 2008, CDPHE conducted an assessment to identify levels of need for medical and other supportive services among persons living with HIV/AIDS who resided outside the Denver TGA. Needs assessment data were obtained from PLWH/A through one-on-one interviews, focus groups, and self-administered surveys.^{6 7} These data collection activities were designed to identify patterns of medical (e.g., visits to medical providers, histories of CD4 and viral load testing), dental, and ancillary services utilization, sources of income, costs associated with medical care and prescription/non-prescription medications, access to health insurance, methods of payment for medical care, histories of substance use, self-reported emotional and mental health status, client perceptions of available services, barriers to medical care and other needed services, and PLWH recommendations for improving service delivery. A total of eight PLWH/A participated in one-on-one interviews and 49 in facilitated focus group discussions. A total of 681 persons completed a 2008 survey including 251 PLWH/A living outside the Denver TGA and 390 PLWH/A living in the Denver TGA.

As depicted in Table 1.8, among the 268 respondents reporting a service need in the past 12 months, greater than half reported needing to see a medical provider (60 percent), laboratory testing (58 percent), or dental care (56 percent). The next highest reported service needs included the need for assistance with purchasing prescriptions (48 percent), case management (38 percent), and help with health insurance (32 percent).

Table 1.8: Ranking of Needed Services, From 2008 Part B Survey

Service	Number that reported needing	Percentage that reported needing
Visits to doctors, nurses, and other medical providers	159	60.00
Laboratory tests (CD4, viral load, etc.)	157	58.58
Dental care	149	55.60
Help buying the prescriptions you need	129	48.13
Case management	102	38.06
Help getting or paying for health insurance	87	32.46
Groceries or prepared meals	81	30.22
Emergency financial assistance (utilities, etc.)	60	22.39
Individual or group counseling for mental health	56	20.90
Help getting or staying in housing	54	20.15
Nutritional counseling or supplements	52	19.40
Transportation to and from medical or other services	52	19.40

⁶ The one-on-one interviews involved persons who were not in care (i.e., had no record of a CD4 or viral load performed in the preceding 12 months) or had recent histories of being out-of-care. Such interviews were initiated to explore why PLWH/A might not be receiving medical care and to elicit recommendations for assuring medical follow-up for all PLWH/A.

⁷ Two surveys were utilized in the Part B needs assessment process. A longer survey was used to comprehensively assess the needs of persons living outside the Denver TGA. A second abbreviated survey targeted PLWH/A living in Adams, Arapahoe, Denver, Douglas, and Jefferson counties and focused primarily on their experiences and perceptions related to the Colorado AIDS Drug Assistance, Bridging the Gap Colorado, and health insurance assistance programs. This two-tiered approach was implemented to avoid duplicating information gathered through the Part A needs assessment process. Both surveys were available in Spanish and English in both paper copy and online at the CDPHE website.

Service	Number that reported needing	Percentage that reported needing
Alternative care (acupuncture, herbal remedies, etc.)	45	16.79
Help buying over-the-counter medication	42	15.67
Support groups or peer counseling	36	13.43
Legal assistance	35	13.06
Education-related services	17	6.34
Substance abuse treatment/counseling (out patient)	16	5.97
Home health care or other in-home assistance	13	4.85
Other service	11	4.10
Substance abuse treatment (residential)	7	2.61
Child care while accessing medical or other services	4	1.49

Survey findings indicate that needs related to mental and emotional health are not uncommon among PLWH/A, as shown in Table 1.9. Although a majority of respondents described their emotional health positively, a significant proportion (39 percent) indicated that their emotional health was fair or poor. Approximately 60 percent of respondents reported feelings of sadness, low self-esteem, loneliness, or shame that significantly affected their activities in the past 12 months while half of the respondents reported a need for help dealing with emotional issues in the past 12 months. Additionally, high proportions of respondents reported that a medical or mental health provider had told them that they had a mental health condition such as depression (47 percent), anxiety (34 percent), and bipolar disorder (13 percent).

Among 224 respondents to questions about substance use, 17 percent reported that they felt the need to cut down on their use of alcohol or other drugs while nine percent felt they needed help to decrease their substance use.

Table 1.9: 2008 Part B Survey Responses Regarding Mental Health and Substance Use

Self-described overall emotional health	Number of responses	Percentage of responses
Excellent	48	18.11
Good	114	43.02
Fair	83	31.32
Poor	20	7.55

Self-described feelings of sadness, low self-esteem, loneliness, or shame that significantly affected normal activities	Number of responses	Percentage of responses
Yes	157	59.70
No	106	40.30
Felt a need for help dealing with emotional issues	Number of responses	Percentage of responses
Yes	131	50.38
No	139	49.62

Self-reported mental health diagnoses	Number of responses	Percentage of responses
Depression	126	47.19
Anxiety	91	34.08
Bipolar	36	13.48
Obsessive Compulsive	13	4.87
Schizophrenia	2	0.75

Other	17	7.14
Self-reported characteristics possibly indicative of a substance use problem	Number of responses	Percentage of responses
Felt she/he should cut down on use of alcohol or other drugs	38	16.96
Felt she/he needed help cutting down on use of alcohol or other drugs	21	9.38
Answered "yes" to both questions	20	8.93

In addition to the Part B needs assessment, CDPHE staff reviewed notes from Disease Investigation Specialist interviews with 195 PLWH/A diagnosed between July 2004 and June 2006. Given the nature of disease intervention work, the same data were not available for each of the 195 cases. The information summarized below was drawn from this case review, and, when possible, was supplemented by HIV/AIDS Reporting System (HARS) data.

- Of the 202 people for whom marital status information was available, 30 percent were single, 43 percent were married or had steady partners, 25 percent were divorced or separated, and two percent were widowed.
- Of the 135 people responding to questions about histories of STI, 39 percent reported having an STI in the past.
- Of the 129 people responding to questions about the use of alcohol, 35 percent reported a history of alcohol abuse.
- Of the 170 people responding to questions about drug use, 36 percent reported no history of drug use. A total of 23 percent had used cocaine, 19 percent marijuana, 13 percent methamphetamine, 11 percent crack, and 9 percent heroin. Greater than one-fifth (21 percent) of respondents reported using more than one drug. Another 15 percent reported a history of drug use, but no information was available related to the specific drugs they used.

The 2007 CWT HIV Prevention Needs Assessment report contained primary source information gathered through, focus groups, semi-structured interviews, and Internet surveys. Many of the participants in the focus groups were PLWH and provided insights relevant to care and prevention needs of PLWH/A. In over two-thirds of the interviews and focus groups the issue of discrimination against those who are HIV positive was raised. Coupled with this was the high level of stigma still surrounding the disease, which was attributed to the wider society's lack of knowledge about HIV and how it is transmitted. Several participants mentioned being treated like lepers. Some discussed situations in which people avoided being in their presence or would not allow their children to be around them. One woman described an experience in which people would not ride in the same elevator with her. A number of the participants living with HIV described situations in which family members served them food on paper plates or asked them not to bring food to gatherings. Others mentioned people being concerned about respondents spreading HIV through sneezing and coughing. Participants also spoke of job-related discrimination and especially poor treatment in jails and prisons. Some noted that many people still thought of HIV as a gay disease or something people only got because they deserved it due to their behavior. Because of HIV-related stigma and discrimination, a number of participants discussed their concerns about confidentiality and described instances in which confidentiality had been breached by family members, friends, service providers, and corrections staff.

Participants living with HIV also commonly discussed health-related concerns such as their efforts to improve or maintain their health through better nutrition, exercise, quitting smoking, or taking medications. Several talked of feeling weak and experiencing other HIV-associated health problems and difficulties with HIV medications. Access to health care and health insurance were very important issues for HIV-positive participants, which included difficulties associated with costs and transportation. For those living with HIV who were homeless, appropriately storing and taking HIV medications was especially difficult. Several people mentioned disrespectful treatment by health care and other providers as well as experiences they had with providers who were insufficiently informed about HIV. Mental health issues were also said to be common among those living with HIV. Depression, loneliness, feelings of hopelessness, feeling overwhelmed, feelings of shame, and low self-worth were topics that were frequently discussed.

Additionally, the 2007 HIV prevention needs assessment explored ways to appropriately and effectively meet the needs of people who did not necessarily have clinical diagnoses of serious mental illness, but who still battled with varying levels of depression and associated low self-esteem. Participants in the focus groups and interviews discussed histories of trauma, especially childhood sexual abuse, as very common sources of depression and low self-esteem. According to participants, many people with these experiences were often not allowed to talk about them nor did they receive help dealing with these experiences when they were young. Both men and women living with HIV who participated in one-on-one interviews shared that family members and friends had sexually abused them as children. A number of women participating in the focus groups divulged this as well. In the focus group involving sex workers, all of the women said they had been sexually abused as children, a factor which, in most cases, was cited as leading to substance abuse and prostitution. Histories of abuse and their emotional impact were not only said to influence substance abuse and prostitution, but also domestic violence, an inability to establish sexual boundaries, sex addictions, and risk behaviors for HIV. Substance abuse was also said to then exacerbate poor mental health. Many of the participants living with HIV also spoke of HIV as a source of depression for them. Although a widespread need for mental health services was expressed, several of the participants discussed how difficult it was to access those services by the poor or those without insurance. Also the mental health services some of the participants had accessed in the past were said to be ineffective.

Given that almost all of the participants in the interviews and focus groups identified as heterosexual, several of those who were living with HIV discussed difficulties associated with being “straight” and positive. For those who were single, finding partners was a special concern for them. For those in relationships, maintaining those relationships was often problematic. Several people mentioned that positive couples often blamed each other for their infections. Others discussed difficulties associated with disclosure and concerns about keeping their partners safe. Accessing services more appropriate for heterosexuals was highlighted by a number of participants as they noted that most services were more oriented around meeting the needs of gay men. The desire to be around other straight people who were positive was prevalent. An eagerness to help others and participate in prevention efforts was also commonly expressed.

Finally, participants in the 2007 HIV prevention needs assessment discussed the role of health care providers related to HIV prevention. Many participants thought it was a doctor’s role to provide information about HIV to their patients and talk to patients about their risk behaviors and

how to protect themselves. A few mentioned that providers should talk to their HIV positive clients about prevention and talk to the steady partners of positive patients. One participant also offered that doctors should talk to patients about substance use and histories of trauma and provide appropriate referrals. Several people also expressed that doctors and clinics should make condoms and literature on HIV available to their patients. Several participants noted that many doctors needed to learn more about HIV and how to help people to reduce risk. This would involve doctors making sure that they were comfortable talking to patients about sexual behaviors.

F. Unmet Needs Estimate

The number of PLWH/A who are not accessing care remains a serious problem in Colorado. To estimate the number of PLWH/A statewide who are accessing care, the Surveillance Program at CDPHE regularly analyzes CD4 and viral load test data reported by laboratories.

As stated in the epidemiological profile section of this report, CDPHE estimates that 10,619 people in Colorado were living with HIV or AIDS alive as of June 30, 2008. Of this total, 4,507 were believed to be living with AIDS and 6,112 were believed to be living with HIV. If all of these persons received a level of care consistent with Public Health Service Guidelines, CDPHE would receive at least one laboratory test result (CD4 or viral load) annually for each of these persons. This would assume a perfectly functioning laboratory reporting system, which is known not to be the case, as described below under “limitations on the data.”

During the period July 1, 2007, through June 30, 2008, a total of 17,249 valid CD4 or viral load tests were reported to CDPHE, as required under state regulations. The Surveillance Program matched these tests against the HIV/AIDS Reporting System (HARS) to estimate the extent to which PLWH/A were accessing care during that year. The results of this analysis follows.

Of the estimated 4,507 people living with AIDS only 2,759 persons had a CD4 or viral load test reported to CDPHE between July 1, 2007 and June 30, 2008. This represents only 61 percent of the total AIDS cases, meaning that potentially 1,748 people with AIDS could be out of care. The situation is somewhat better for pediatric cases; of the 16 pediatric AIDS cases, 9 (or 56 percent) had a reported CD4 or viral load test during the year ending June 30, 2008.

In terms of HIV (not AIDS), of the estimated 6,112 people living with HIV, only 1,775 had a CD4 or viral load test reported to CDPHE between July 1, 2007 and June 30, 2008. This represents only 29 percent of the total HIV (not AIDS) cases, meaning that potentially 4,337 people with HIV (not AIDS) could be out of care. The situation is somewhat better for pediatric cases; of the 33 pediatric HIV (not AIDS) cases, 21 (or 64 percent) had a reported CD4 or viral load test during the year ending June 30, 2008.

Newly diagnosed persons appear to be accessing care more consistently. Of the 312 people diagnosed with HIV between July 1, 2007, and June 30, 2008, CDPHE estimates that 71 percent of them (222 persons) had at least one CD4 or viral load test.

There are serious limitations to the CD4 and viral load data that must be considered in estimating

PLWH/A who are out of care, using this methodology. These limitations would tend to make it appear that fewer PLWH/A are in care than is the case. The current Colorado regulation regarding the reporting of tests indicative of HIV or AIDS does not require laboratories to report all CD4 and viral load tests. Only CD4 counts below 500/mm³ or CD4 percentages less than 29 are *required* to be reported. Therefore, a sizeable group of PLWH/A (and particularly PLWH) may not be reported, even though they are in care and receiving regular CD4 tests. In addition, the Veterans Administration Medical Center (VAMC) does not report CD4 or viral load test results to CDPHE. As an indicator of care received, the VAMC reported 255 individual HIV/AIDS patient visits in 2005. Finally, CD4 and viral load tests among patients enrolled in clinical trials are not reported to CDPHE.

G. Gaps in Care

As a component of the 2008 Part B Needs Assessment, respondents were asked about their access to medical services. The average length of time that respondents had gone without being seen by a medical provider or received an HIV related laboratory test was slightly over four months. The average time that respondents reported going without HIV medications was approximately 2.6 months. Approximately 97 percent of respondents reported that they had received a CD4 test in the last year and 98 percent reported receiving a viral load test.

Table 1.10: Data Regarding Access to Care from the 2008 Part B Needs Assessment

Longest time respondents self-reported going without a core medical service	Median Months	Mean Months
Not seeing a medical provider	4.00	4.28
Not getting laboratory tests done for HIV	4.00	4.39
Not receiving medications for HIV	1.00	2.56
Responses		
Length of time since last CD4 test	Number of Responses	Percentage of Responses
0-6 months ago	246	93.18
7 months – one year ago	9	3.41
More than one year ago	3	1.14
Never had a CD4 test	2	0.76
Don't know/Don't remember	4	1.52
Responses		
Length of time since last Viral Load test	Number of Responses	Percentage of Responses
0-6 months ago	243	92.40
7 months – one year ago	10	3.80
More than one year ago	2	0.76
Never had a viral load test	-	-
Don't know/Don't remember	8	3.04

In terms of case management, 83 percent reported meeting with an ASO case manager. Among the 550 persons that reported receiving case management services, 467 (85 percent) received these services in the past year.

Table 1.11: Data Regarding Access to Case Management from the 2008 Part B Needs Assessment

Last time he/she met with a case manager from an AIDS Service Organization	Responses	
	Number of Responses	Percentage of Responses
Less than 3 months ago	144	55.81
3 – 6 months ago	62	24.03
7 months – 1 year ago	14	5.43
More than 1 year ago	24	9.30
Never	7	2.71
Don't know/Don't remember	7	2.71

Part B Needs Assessment respondents were also asked about whether they had failed to receive a service that they needed in the past 12 months.

Table 1.12: Services Needed but Not Received, from the 2008 Part B Needs Assessment

Service	Number that reported needing but not receiving	Percentage of those reporting a needed service that they did not receive
Alternative care (acupuncture, herbal remedies, etc.)	30	66.67
Help buying over-the-counter medication	25	59.52
Legal assistance	20	58.82
Education-related services	10	58.82
Substance abuse treatment (residential)	4	57.14
Support groups or peer counseling	19	52.78
Child care while accessing medical or other services	2	50.00
Nutritional counseling or supplements	24	46.15
Home health care or other in-home assistance	6	46.15
Help getting or paying for health insurance	39	44.83
Individual or group counseling for mental health	22	39.29
Dental care	57	38.51
Emergency financial assistance (utilities, etc.)	22	36.67
Transportation to and from medical or other services	17	32.69
Substance abuse treatment/counseling (out patient)	5	31.25
Help getting or staying in housing	15	27.78
Other services	3	27.27
Groceries or prepared meals	18	22.50
Help buying the prescriptions you need	23	17.97
Case management	11	10.89
Laboratory tests (CD4, viral load, etc.)	12	7.64
Visits to doctors, nurses, and other medical providers	11	6.96

Part B respondents also rated their experience with Colorado's AIDS Drug Assistance Program (ADAP). As indicated in Table 1.13, the vast majority of respondents had positive experiences with the program.

Table 1.13: ADAP Related Responses, from the 2008 Part B Needs Assessment

Responses from <i>within</i> the TGA	Number agreeing or strongly agreeing	Percentage agreeing or strongly agreeing
It was easy to find out about the ADAP services that are available	331	93.24
The process of getting enrolled in the ADAP program was easy.	331	94.57
Once a person is enrolled in ADAP it is easy to continue on the program.	327	99.99
I am satisfied with the help that I receive from the ADAP staff.	345	97.45
I am satisfied with the ADAP pharmacy network where I am able to pick up my medications or have them mailed to me.	344	96.09
Responses from <i>outside</i> the TGA	Number agreeing or strongly agreeing	Percentage agreeing or strongly agreeing
It was easy to find out about the ADAP services that are available	144	94.12
The process of getting enrolled in the ADAP program was easy.	142	93.42
Once a person is enrolled in ADAP it is easy to continue on the program.	144	94.74
I am satisfied with the help that I receive from the ADAP staff.	150	98.04
I am satisfied with the ADAP pharmacy network where I am able to pick up my medications or have them mailed to me.	154	98.09

Similarly, as indicated in the following tables, Part B respondents reported favorable experiences with Colorado’s Insurance Assistance Program for private insurance. Again, client experiences are positive overall.

Table 1.14: Insurance Related Responses, from the 2008 Part B Needs Assessment

Responses from <i>within</i> the TGA	Number agreeing or strongly agreeing	Percentage agreeing or strongly agreeing
It was easy to find out about the insurance support that was available.	117	91.40
The process of getting enrolled for insurance assistance was easy.	112	89.60
Once a person is enrolled in insurance assistance it is easy to continue on the program.	113	95.95
I am satisfied with the help that I receive from the insurance assistance staff.	116	95.87
Responses from <i>outside</i> the TGA	Number agreeing or strongly agreeing	Percentage agreeing or strongly agreeing
It was easy to find out about the insurance support that was available.	62	84.94
The process of getting enrolled for insurance assistance was easy.	61	84.72
Once a person is enrolled in insurance assistance it is easy to continue on the program.	57	82.61
I am satisfied with the help that I receive from the insurance assistance staff.	64	91.43

In terms of Colorado’s “Bridging the Gap” wrap around program for clients with a Medicare Part D prescription drug plan, Table 1.15 provides the percentage of Part B respondents reported agreeing or strongly agreeing on barrier-related questions:

Table 1.15: Medicare Part D Bridging the Gap Colorado (BTGC) Related Responses, from the 2008 Part B Needs Assessment

Responses from <i>within</i> the TGA	Number agreeing or strongly agreeing	Percentage agreeing or strongly agreeing
It was easy to find out about these gap coverage services.	115	92
The process of getting enrolled in this program was easy.	112	94.92
Once a person is enrolled in the gap coverage program it is easy to continue on the program.	109	94.78
I am satisfied with the help that I receive from the staff.	117	95.9
I am satisfied with the gap coverage pharmacy network where I am able to pick up my medications or have them mailed to me.	115	93.49
Responses from <i>outside</i> the TGA	Number agreeing or strongly agreeing	Percentage agreeing or strongly agreeing
It was easy to find out about these gap coverage services.	49	89.09
The process of getting enrolled in this program was easy.	50	92.59
Once a person is enrolled in the gap coverage program it is easy to continue on the program.	49	92.46
I am satisfied with the help that I receive from the staff.	52	96.3
I am satisfied with the gap coverage pharmacy network where I am able to pick up my medications or have them mailed to me.	51	96.23

H. Prevention Needs

Coloradans Working Together: Preventing HIV/AIDS (CWT) is the official HIV community planning group (CPG) for the state of Colorado, as mandated by the Centers for Disease Control and Prevention (CDC). CWT is a collaborative effort between the CDPHE, HIV-infected and affected communities, state and local HIV prevention providers, and other concerned parties, to improve HIV prevention in Colorado. CWT members and participants include AIDS activists, staff of the CDPHE, local health department representatives and service providers, staff and volunteers from statewide community-based organizations, and other concerned and committed citizens.

The CPG, informed by the prevention needs assessment detailed earlier, developed priorities for HIV prevention. The prioritized list of target populations and interventions forms the basis for the Comprehensive Plan that the health department uses when developing its annual application to the CDC for HIV prevention funding. The priority setting process ultimately helps the CPG identify those populations most at risk of HIV infection in Colorado. By identifying and providing services to those target populations, Colorado can reduce the greatest number of new HIV infections. CWT identified persons living with HIV as its top target population for

prevention services. CWT then developed a list of HIV prevention interventions for this target population because of their proven or potential effectiveness, cultural appropriateness, and ability to respond to high-priority, community-validated needs of the target populations. CWT intentionally did not rank the interventions for the target populations. They felt identifying a set of potential strategies and activities for the target populations and implementing those strategies via intervention providers, can prevent the greatest number of new HIV infections.

Table 1.16 – Prevention Needs for People Living with HIV or AIDS, Interventions Recommended

Type of Intervention	Name of Intervention	Comments
<p>Group-Level Intervention (GLI) Interactive health education and risk reduction education delivered to 2 – 20 simultaneous participants.</p>	Healthy Relationships	Providers are aware of community resources and able to refer
	Together Learning Choices	For youth living with HIV
<p>A community level intervention (CLI) identifies and changes the norms, values, and social and environmental factors that facilitate or inhibit risk behaviors within an entire group or community, not simply individual members of the community. The intervention changes the norms, values, etc., incrementally, one step at a time, closer to healthier sexual and substance use behaviors. CLI is based on the concept that certain norms, values, beliefs, and social and environmental factors influence how members of a particular community act. A community is defined as any well-defined or delineated group that distinguishes itself by ethnicity, sexual orientation, gender, age, behavior, geography, or some other self-defining criteria.</p>	Social Marketing Campaign	Specifically about disclosing/discussing status
<p>Health Communication/Public Information (HC/PI) The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services.</p>	Internet, electronic chat rooms, websites	
	Print ads, newspapers	General HIV awareness
<p>Comprehensive Risk Counseling and Services (CRCS) is a client-centered HIV prevention activity for increasing behaviors that reduce risk of transmitting or acquiring HIV by clients with multiple or complex problems such as mental health or substance abuse issues. CRCS provides long term, individualized prevention counseling, support, and service brokerage.</p>	CRCS	.
<p>Outreach An HIV educational intervention designed to reach at-risk populations where they live, work, socialize or congregate.</p>		

Type of Intervention	Name of Intervention	Comments
<p>Partner Counseling and Referral Services (PCRS) The goal of Partner Counseling and Referral Services is to stop the unintentional spread of HIV by notifying persons of possible exposure to HIV and other STIs (e.g., gonorrhea, chlamydia, or syphilis), by facilitating testing and treatment, and by promoting status disclosure and risk reduction. PCRS is a service offered to people infected with HIV, their sex and needle-sharing partners, parents or guardians of perinatally exposed children and other persons at increased risk of acquiring HIV infection. These services help persons and their partners gain earlier access to individualized counseling, HIV testing, STD testing, medical evaluation, treatment, and other prevention and support services. PCRS is a service that combines multiple interventions and prevention strategies, including Counseling, Testing and Referral; Individual Level PCRS excludes interventions where partner counseling is not the focus of the service. Only state and local health departments offer PCRS.</p>	PCRS	
<p>Individual-Level Intervention (ILI) Health education and risk-reduction counseling provided to one individual at a time.</p>	ILI	

In recognition of these prevention needs, the CDPHE STI/HIV Section provide the following prevention services, either directly or through contracts:

- Provide CRCS to persons infected with HIV who are subsequently diagnosed with an STI, named as non-disclosing, unsafe sex partners, or who need additional prevention services beyond those available through a Disease Intervention Specialist. As a result of follow up by a Client Based Prevention Program CRCS provider, clients may be identified as needing more in depth psychiatric services than available through CRCS. To assist such persons, the STI/HIV Section will continue to contract with private practice mental health professionals for the provision of intensive, short term, one-on-one behavioral counseling services.
- Contract with Denver Health and Hospital Authority to provide linkage to care activities. All persons testing HIV positive (or positive for STI if already living with HIV) through Denver Health testing sites will be referred to an in-house prevention counselor for further follow up. These persons will be actively linked to a wide array of services: ongoing medical care, confirmatory testing, viral load/CD4 testing, screening for other STIs, and referral to CBOs, substance abuse treatment centers, mental health providers and HIV primary care clinics. Denver Health’s prevention counselors will work closely with staff to ensure partners of new positives are notified and tested. Prevention counselors will provide brief individual prevention counseling to new positives, persons with long-standing HIV infection, and high-risk partners on a referral basis.
- Continue to contract with organizations to provide CRCS to subpopulations of PLWH: women, African Americans, substance users, and youth. Staff will develop contracts for CRCS with providers capable of integrating mental health, substance abuse treatment, and prevention into a holistic service for their clients.
- Conduct interviews/focus groups with the section’s Medical Advisory Group and physician’s whose practices contain a high number of clients with HIV infection to identify barriers to integrating prevention services into medical practices. Prevention staff will collaborate with the Surveillance Program, which has ongoing relationships with the medical practices. This information will be used to formulate a plan to integrate prevention and care.

I. Current Continuum of Care

As reflected in this plan, the continuum of care, listed in Tables 1.17 and 1.18, and associated goals and objectives have been developed to coordinate Part B services not only with other Ryan White services, but also with services available outside the Ryan White funded system. The Part B Regional Service Provider contractors (which deliver the majority of medical case management) utilize a standard intake and data system. This intake includes a standard financial qualification form that contains all of the necessary information for ADAP, HOPWA, insurance, financial assistance, and other funded programs. The screening includes questions regarding the client’s private health insurance, Medicare, Medicaid, and VA status.

J. Inventory of Resources Funded by Ryan White Part B

Table 1.17: Core Services Funded By Ryan White Part B⁸

Providers	ADAP	Outpatient Medical Care	Drug Assistance (not ADAP)	Oral Health	Early Intervention	Health Insurance	Hospice	Mental Health	Medical Nutrition	Medical Case Management	Sub Abuse Treatment Outpatient
Beacon Center for Infectious Disease		X						X	X	X	X
Boulder County AIDS Project			X	X	X	X		X		X	X
Colorado Department of Public Health and Environment	X				X	X					
Children’s Hospital Immunodeficiency Program		X	X	X				X		X	X
Colorado AIDS Project						X					
Correctional Healthcare Management										X	
Denver Health		X	X		X					X	X
Northern Colorado AIDS Project			X	X	X	X		X		X	X
Peak Vista Community Health Center		X		X							
Pueblo Community Health Center		X									
Southern Colorado AIDS Project			X	X	X	X	X	X	X	X	X
St. Mary’s Hospital		X									X
University of Colorado Hospital ID Clinic								X			X
University of Colorado Health Sciences Center Dental Program				X							
Western Colorado AIDS Project			X	X	X	X		X	X	X	X

⁸ Effective April 1, 2009

Table 1.18: Support Services Funded By Ryan White Part B⁹

Providers	NonMedical Case Management	Emergency Financial Assistance	Food Bank	HE/RR	Housing	Linguistic Services	Transportation	Outreach	Psychosocial Support	Adherence	Referral
Beacon Center for Infectious Disease									X		
Boulder County AIDS Project		X	X				X				
Colorado Department of Public Health and Environment											X
Children’s Hospital Immunodeficiency Program		X					X				
Denver Health							X	X			
Northern Colorado AIDS Project	X	X	X			X	X		X		
Peak Vista Community Health Center							X				
Southern Colorado AIDS Project	X	X	X				X				X
Western Colorado AIDS Project		X	X	X	X	X	X		X		

⁹ Effective April 1, 2009

K. Profile of the Ryan White Program funded providers by service category

Table 1.18: Core Services Funded by Ryan White Part B

AIDS Drug Assistance Program	
Provider	Service Area/Additional information
Colorado Department of Public Health and Environment	All Colorado counties. Medications are distributed by mail order or may be picked up at three pharmacy sites (Denver Health, University of Colorado Hospital, Children's Hospital)

Outpatient/Ambulatory Medical Care	
Provider	Service Area/Additional information
Beacon Center for Infectious Disease	Residents of Boulder, Broomfield, Clear Creek, Gilpin, Larimer, and Weld Counties
Children's Hospital Immunodeficiency Program	All Colorado counties/Part D eligible clients only
Denver Health	Statewide for those eligible for Medicaid and Children's Health Plan Plus; others must be Denver residents
Peak Vista Community Health Center	El Paso and Teller County residents only
Pueblo Community Health Center	Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Las Animas, Otero, Prowers, Pueblo, Rio Grande, or Saguache Counties
St. Mary's Hospital	Residents of Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, or Summit Counties

Drug Assistance (not ADAP)	
Provider	Service Area/Additional information
Boulder County AIDS Project	North Central Region (see Attachment A)
Children's Hospital Immunodeficiency Program	All Colorado counties/Part D eligible clients only
Denver Health	Statewide for those eligible for Medicaid and Children's Health Plan Plus; others must be Denver residents
Northern Colorado AIDS Project	Northeast Region (see Attachment A)
Southern Colorado AIDS Project	Southern Region (see Attachment A)
Western Colorado AIDS Project	Western Region (see Attachment A)

Oral Health	
Provider	Service Area/Additional information
Beacon Center for Infectious Disease	Residents of Boulder, Broomfield, Clear Creek, Gilpin, Larimer, and Weld Counties
Boulder County AIDS Project	North Central Region (see Attachment A); via voucher system
Children's Hospital Immunodeficiency Program	All Colorado counties
Northern Colorado AIDS Project	Northeast Region (see Attachment A); via voucher system
Peak Vista Community Health Center	El Paso and Teller County residents only

Oral Health	
Southern Colorado AIDS Project	Southern Region (see Attachment A); via voucher system
University of Colorado Health Sciences Center Dental Program	Available to residents of all Colorado counties, with on site services at clinic site in Aurora as well as satellite sites in Boulder/Longmont, Grand Junction, and Pueblo.
Western Colorado AIDS Project	Western Region (see Attachment A); via voucher system

Early Intervention	
Provider	Service Area/Additional information
Boulder County AIDS Project	North Central Region (see Attachment A); via voucher system
Colorado Department of Public Health and Environment	All Colorado counties
Denver Health	Statewide for those eligible for Medicaid and Children's Health Plan Plus; others must be Denver residents
Northern Colorado AIDS Project	Northeast Region (see Attachment A); via voucher system
Southern Colorado AIDS Project	Southern Region (see Attachment A); via voucher system
Western Colorado AIDS Project	Western Region (see Attachment A); via voucher system

Health Insurance	
Provider	Service Area/Additional information
Boulder County AIDS Project	North Central Region (see Attachment A); intake site for statewide program
CDPHE	All Colorado counties
Colorado AIDS Project	All Colorado counties; administers statewide program in collaboration with CDPHE and the intake sites
Northern Colorado AIDS Project	Northeast Region (see Attachment A); intake site for statewide program
Southern Colorado AIDS Project	Southern Region (see Attachment A); intake site for statewide program
Western Colorado AIDS Project	Western Region (see Attachment A); intake site for statewide program

Hospice	
Provider	Service Area/Additional information
Southern Colorado AIDS Project	Southern Region (see Attachment A); via voucher system

Mental Health	
Provider	Service Area/Additional information
Beacon Center for Infectious Disease	Residents of Boulder, Broomfield, Clear Creek, Gilpin, Larimer, and Weld Counties
Boulder County AIDS Project	North Central Region (see Attachment A); via voucher system
Children's Hospital Immunodeficiency Program	All Colorado counties
Northern Colorado AIDS Project	Northeast Region (see Attachment A)

Mental Health	
Peak Vista Community Health Center	El Paso and Teller County residents only
Southern Colorado AIDS Project	Southern Region (see Attachment A); via voucher system
Western Colorado AIDS Project	Western Region (see Attachment A); via voucher system

Medical Nutrition	
Provider	Service Area/Additional information
Beacon Center for Infectious Disease	Residents of Boulder, Broomfield, Clear Creek, Gilpin, Larimer, and Weld Counties
Southern Colorado AIDS Project	Southern Region (see Attachment A)
Western Colorado AIDS Project	Western Region (see Attachment A)

Medical Case Management	
Provider	Service Area/Additional information
Beacon Center for Infectious Disease	Residents of Boulder, Broomfield, Clear Creek, Gilpin, Larimer, and Weld Counties
Boulder County AIDS Project	North Central Region (see Attachment A)
Children's Hospital Immunodeficiency Program	All Colorado counties
Correctional Healthcare Management	For inmates in Colorado county jails.
Denver Health	For inmates in Denver jail and clients of Infectious Disease Clinic
Northern Colorado AIDS Project	Northeast Region (see Attachment A)
Southern Colorado AIDS Project	Southern Region (see Attachment A)
Western Colorado AIDS Project	Western Region (see Attachment A)

Substance Abuse Treatment - Outpatient (including Screening, Brief Intervention, and Referral to Treatment)	
Provider	Service Area/Additional information
Beacon Center for Infectious Disease	Residents of Boulder, Broomfield, Clear Creek, Gilpin, Larimer, and Weld counties
Boulder County AIDS Project	North Central Region (see Attachment A)
Children's Hospital Immunodeficiency Program	All Colorado counties
Denver Health	For inmates in Denver jail and clients of Infectious Disease Clinic
Northern Colorado AIDS Project	Northeast Region (see Attachment A)
Southern Colorado AIDS Project	Southern Region (see Attachment A)
University of Colorado Hospital Infectious Disease Clinic	Residents of all Colorado counties may access services at the Aurora clinic site.
Western Colorado AIDS Project	Western Region (see Attachment A)

Support Services Funded by Ryan White Part B

Case Management Nonmedical	
Provider	Service Area/Additional information
Northern Colorado AIDS Project	Northeast Region (see Attachment A)
Southern Colorado AIDS Project	Southern Region (see Attachment A)

Emergency Financial Assist	
Provider	Service Area/Additional information
Boulder County AIDS Project	North Central Region (see Attachment A)
Children's Hospital Immunodeficiency Program	All Colorado counties
Northern Colorado AIDS Project	Northeast Region (see Attachment A)
Southern Colorado AIDS Project	Southern Region (see Attachment A)
Western Colorado AIDS Project	Western Region (see Attachment A)

Food Bank	
Provider	Service Area/Additional information
Boulder County AIDS Project	North Central Region (see Attachment A)
Northern Colorado AIDS Project	Northeast Region (see Attachment A)
Southern Colorado AIDS Project	Southern Region (see Attachment A)
Western Colorado AIDS Project	Western Region (see Attachment A)

Health Education / Risk Reduction	
Provider	Service Area/Additional information
Western Colorado AIDS Project	Western Region (see Attachment A)

Housing	
Provider	Service Area/Additional information
Western Colorado AIDS Project	Western Region (see Attachment A)

Linguistic Services	
Provider	Service Area/Additional information
Northern Colorado AIDS Project	Northeast Region (see Attachment A)
Western Colorado AIDS Project	Western Region (see Attachment A)

Medical Transportation	
Provider	Service Area/Additional information
Boulder County AIDS Project	North Central Region (see Attachment A)

Medical Transportation	
Children's Hospital Immunodeficiency Program	All Colorado counties
Denver Health	For inmates in Denver jail and clients of Infectious Disease Clinic
Northern Colorado AIDS Project	Northeast Region (see Attachment A)
Peak Vista Community Health Center	El Paso and Teller county residents only
Southern Colorado AIDS Project	Southern Region (see Attachment A)
Western Colorado AIDS Project	Western Region (see Attachment A)

Referral	
Provider	Service Area/Additional information
Colorado Department of Public Health and Environment	All Colorado counties
Southern Colorado AIDS Project	Southern Region (see Attachment A)

L. Barriers to care

There are a number of system issues that contribute to access problems for PLWH/A in Colorado.

Per capita spending on Medicaid in Colorado is among the lowest in the United States. Colorado ranks 48 out of 50 states in terms of per capita spending on Medicaid. Only a small portion of Colorado's PLWH/A meet the stringent Colorado Medicaid eligibility criteria. For those who do become eligible for Medicaid, there are significant challenges locating a provider who accepts Medicaid, particularly in the most rural areas of the state. It is also common for Medicaid providers to cap the number of Medicaid slots, resulting in waiting lists. This is true for outpatient services as well as other services, such as nursing homes.

Colorado's high-risk insurance pool, Cover Colorado, is open to PLWH. However, due to the enabling legislation, Cover Colorado is relatively expensive and receipt of premium or other support from state or federal funding disqualifies clients from coverage.

Colorado's laws allow health insurance companies to discriminate against PLWH/A if they seek individual insurance coverage.

Colorado's federally qualified health centers struggle to meet the costs of caring for PLWH/A. Waiting lists are periodically necessary, and access to HIV specialty care can be problematic.

For those who lack health insurance, and for those who are underinsured, Colorado's systems of care require people to exhaust all or nearly all of their assets to gain access to care. Stringent eligibility criteria and requirements to post large deposits make it difficult for many to get into care. Even for those who qualify for the Colorado Indigent Care Program (CICP), access to

specialty care can involve a long waiting period and unaffordable costs. For those who cannot qualify for CICP (such as undocumented immigrants), the situation is even worse.

The level of funding available for mental health and substance abuse services is relatively low in Colorado as compared to other jurisdictions. In a 2001 study commissioned by The National Center on Addiction and Substance Abuse at Columbia University¹⁰, of the 47 jurisdictions responding (including states, the District of Columbia, and Puerto Rico), Colorado ranked number 36 in per capita spending on substance abuse prevention, intervention, treatment, and research. Colorado's per capita funding level (\$217) was 24 percent below the national average (\$287) and 358 percent below the state with the highest per capita level of support (New York at \$777). In a similar 2001 study commissioned by the Colorado Mental Health Funders Collaborative¹¹, Colorado ranked thirty-first nationally for publicly funded mental health care, spending just over \$64 per capita, which was 21 percent below the national average of \$81 per capita.

The health care systems in Colorado's city and county jails are severely under-funded and struggle to meet the Public Health Service guidelines for HIV care as a result. Equipping inmates with HIV medications at discharge is complicated by "late night discharge" practices, which occur after the pharmacies have closed. Access to substance abuse services and mental health care in city and county jails is also inconsistent, particularly outside the larger population centers. In an effort to improve access to care within the county jails, and to facilitate transition to care resources in the community after discharge, Part B has funded projects at Denver Jail and at Correctional Healthcare Management (a private agency that provides health services on a contractual basis to most of the larger county jails outside Denver).

Housing in Colorado has been among the nation's most expensive. As a result, affordable housing is scarce for PLWH/A as it is for most other populations. There is a waiting list of multiple years in several areas of the state for subsidized housing (such as Section Eight). Even with HOPWA, the Fair Market Rent set by HUD is typically far below the rate that landlords could charge other clients. Because of this, PLWH/A face a housing dilemma. If they find an apartment that meets their basic needs, it's often too costly to fall under HOPWA's limits. If they locate an apartment at or below FMR, it may fail to pass the HOPWA "livability" inspection.

Colorado's system of medical care is heavily concentrated in urban areas. For PLWH/A who choose to remain living in their non-urban community of choice, transportation can pose a very serious barrier to care. Public transportation (such as commercial bus service) is only a reliable option in very select areas of the state. Even getting to the nearest bus station can require assistance from friends or relatives. The most devoted support system is stretched to the limits when asked to provide hundreds of miles of costly and time-consuming travel, in precarious weather conditions, often involving an overnight stay. Other options, such as air travel and commercial taxi services, are priced beyond the reach of most PLWH/A and are frequently unreliable.

¹⁰ *Shoveling Up: The Impact of Substance Abuse on State Budgets*, available at <http://www.casacolumbia.org/>

¹¹ *The Status of Mental Health Care in Colorado*, available at <http://www.thecoloradotrue.org/repository/publications/pdfs/MHCC/Executive%20Summary%20Mental%20Health.pdf>

Issues for People Living with HIV but Not Receiving Medical Care

As a component of the 2008 Part B needs assessment, PLWH/A who had not been seen by a medical provider, been given an HIV laboratory tests, or received HIV medications for more than 12 months since their initial diagnosis were asked about their reasons for delaying these services. Among 268 respondents, 20 percent reported being unable to afford care while 17 percent reported having no health insurance.

Table 1.19: Reasons for Delaying Care from the 2008 Part B Needs Assessment

	Number of responses	Percentage of responses
Could not afford it	54	20.15
No health insurance	46	17.16
Other	29	10.82
Fear my privacy would not be respected	21	7.84
Did not qualify for services	18	6.72
Did not know where to go	17	6.34
Lack of transportation	17	6.34
Did not want services	13	4.85
Insufficient insurance	13	4.85
Poor personal treatment by provider	11	4.10
No services available	10	3.73
Low quality of available services	10	3.73
Long wait times for appointments	9	3.36
Too many requirements	7	2.61
Too much paperwork	4	1.49

Provider Perspectives

Part B contracted providers within the Denver TGA were surveyed for the Part A needs assessment. The Part A needs assessment found “both PLWH/As and service providers agreed that there are six main reasons why people are out of care:”

- Struggle meeting basic living needs
- Taking a break from HIV, medications, and the system
- Do not need to see a doctor for their HIV if they feel well
- Do not know where to go to find services or what services are available
- Limited financial resources
- Untreated mental illness and substance abuse

Part B providers outside the Denver TGA were interviewed using the same survey tool. As with the Part A, there was a great deal of agreement between PLWA and providers. While Part B PLWH/As did not list untreated mental illness or substance abuse as a major issue, most of the providers identified it as a barrier. Additionally, most providers listed location of services and transportation as a barrier.

Other systems issues (including Medicaid, Medicare, CICP)

Significant access issues arise from necessary administrative mechanisms maintained by Colorado's largest public health hospitals. The first hospital, Denver Health, is located in the City and County of Denver. To be seen at this site, clients must provide a Denver residential address. Non-Denver County residents are seen at University Hospital, which provides service to indigents through the CICP, a statewide rating system that allows for reimbursement of services for persons who are not eligible for Medicare and Medicaid. Some populations cannot qualify for CICP, including inmates in community corrections and undocumented immigrants.

Per capita spending on Medicaid in Colorado is amongst the lowest in the United States. Only a small portion of Colorado's PLWH/A meet the stringent Colorado Medicaid eligibility criteria.

Colorado's high-risk insurance pool, Cover Colorado, is open to PLWH. However, due to the enabling legislation, Cover Colorado is relatively expensive and receipt of premium or other support from state or federal funding disqualifies clients from coverage.

Colorado's laws allow health insurance companies to discriminate against PLWH/A if they seek individual insurance coverage.

Colorado's federally qualified health centers struggle to meet the costs of caring for PLWH/A. Waiting lists are periodically necessary, and access to HIV specialty care can be problematic.

II. WHERE WE NEED TO GO: Our Vision for an Ideal System

A. Our Shared Vision That Will Guide System Changes

In Colorado's HIV care and treatment system, clients are able to access a broad continuum of services, leading to improved health outcomes and enhanced quality of life.

B. Our Shared Values That Will Guide System Changes

As we design, implement, and support Colorado's HIV care and treatment system, we invest resources to make progress toward the following aspirations:

- **Integration** – Services are client-centered and holistic. Services are linked seamlessly, particularly medical care and supportive services. Clients are empowered to know what is available and how to access what they need.
- **Consistency** – Regardless of their place of residence or personal characteristics, clients have access to services of similar quality and with similar eligibility requirements.
- **Accessibility** – Clients experience a welcoming environment when they seek out services. The services match or exceed client expectations in terms of cultural competence, language, physical location, responsiveness, and compassion.
- **Appropriateness** – Services are evidence-based and meet or exceed standards of care. They are culturally tailored and conducted in the preferred language of the client or with skilled translators. They accommodate the special needs of youth and older adults.
- **Affordability** – Eliminate financial barriers for clients living at or below 100 percent of the federal poverty level and minimize financial barriers to medical care and other funded services for all other clients. Integrate with the system of universal health care as it develops at the state and national levels.
- **Sustainability** – Clients can expect to access a continuum of services over the entire time that they are needed at consistent locations from providers they know and trust. As a chronic condition, HIV manifests different needs over the years that people live with it, and services are adapted accordingly.

C. Continuum of Care for High Quality Services

Like many health problems, HIV disease disproportionately strikes people in poverty, communities of color, and others who are underserved by healthcare and prevention systems. HIV often leads to poverty, due to costly healthcare or an inability to work that is often accompanied by a loss of employer-related health insurance. Utilizing federal and state funds, the Care and Treatment Program attempts to fill gaps in care not covered by other resources. The most likely beneficiaries of funded services include people with no other source of healthcare and those with Medicaid or private insurance whose care needs are not being met.

Through our HIV Continuum of Care, we strive to improve:

- Access to HIV-related medical care, medications, and behavioral health services
- Retention in/adherence to HIV-related medical care, medication regimens, and behavioral health services

- Access to other HIV-related support services
- Quality of all funded services, including improvements in planning and evaluation

The HIV Continuum of Care is made possible through a network of service providers, bridging all parts of the Ryan White Act. The quality-related goals are threefold:

- To leverage the contributions of Part B programs to improve overall care as measured by system wide metrics
- To improve service delivery and efficiencies within Part B funded agencies as demonstrated by organizational metrics
- To build capacity of Part B programs to measure and improve quality

III. HOW WE WILL GET THERE: System Changes Needed To Assure Availability Of And Accessibility To Core Services

Three-Year Goals And Objectives

By March 31, 2012, the network of funded agencies will document improvements in the following four areas:

- 1) Access to HIV-related medical care, medications, and behavioral health services
- 2) Retention in or adherence to HIV-related medical care, medication regimens, and behavioral health services
- 3) Access to other HIV-related support services
- 4) Quality of all funded services, including improvements in planning and evaluation

Annual Goals

Goal 1 – By March 31, 2010, increase the number of PLWH/A in Colorado who are actively engaged in high quality HIV outpatient/ambulatory care.

Goal 2 – By March 31, 2010, improve adherence rates among Colorado’s PLWH/A who have been prescribed an HIV-related medication regimen through a combination of individual counseling, groups, education, and other strategies.

Goal 3 – By March 31, 2010, increase the number of PLWH/A in Colorado who receive comprehensive, coordinated medical case management services.

Goal 4 – By March 31, 2010, increase the percentage of medically case-managed PLWH/A who access at least one of the following high priority services: outpatient/ambulatory health care, oral health, assistance acquiring medications, assistance with insurance costs, early intervention services, medical nutrition therapy, food bank/home-delivered meals, medical transportation, or emergency financial assistance.

Goal 5 – By March 31, 2010, increase the number of PLWH/A in Colorado who are actively screened for mental health and/or substance use issues and, when indicated, are given access to behavioral health services that meet their needs.

Goal 6 – By March 31, 2010, 75 percent of agencies funded to serve clients living with HIV or AIDS will have a Quality Committee and a written Quality Plan.

Annual Objectives

2009 –2010 Plan		
Goals	Objectives	Clients Served
Goal 1: Increase the number of PLWH/A in Colorado who are actively engaged in high quality HIV outpatient/ambulatory care.	A) Support client access to one or more of the following services at clinics, hospitals, and other medical providers: outpatient/ ambulatory care, local pharmaceutical assistance, oral health, early intervention, home health, hospice, or medical nutrition therapy.	200
	B) Support client access to one or more of the following services at or through community-based regional service providers: oral health, early intervention, home health, hospice, or medical nutrition therapy.	150
	C) Utilize state health department staff to identify clients who are not in care and actively link them to care.	50
Goal 2: Improve adherence rates among Colorado’s PLWH/A who have been prescribed an HIV-related medication regimen through a combination of individual counseling, groups, education, and other strategies.	A) Provide access to at least 22 Antiretroviral and at least 65 Non-antiretroviral HIV therapeutic treatments to eligible persons during the fiscal year through the ADAP.	940/month
	B) Utilize federal funding to provide Medicare Part D Prescription Drug Plan premium assistance to ADAP eligible persons.	350 unduplicated
	C) Utilize the Colorado State Pharmaceutical Assistance Program to assist clients with Medicare Part D "wrap around" (deductible, cost sharing, coverage gap, and catastrophic level assistance) utilizing State funding.	600 unduplicated
	D) Maximize the utilization of ADAP funds and the benefits to clients through longer term Health Insurance Premium and Cost Sharing Assistance. Provide financial assistance for eligible PLWH to maintain a continuity of health insurance or to receive medical benefits under a health insurance program.	190 unduplicated
	E) Provide additional local support for medications at Regional Service Provider sites outside the Denver TGA.	150
	F) Provide additional local support for short-term health insurance needs at Regional Service Provider sites outside the Denver TGA.	40

2009 –2010 Plan		
Goals	Objectives	Clients Served
Goal 3: Increase the number of PLWH/A in Colorado who receive comprehensive, coordinated medical case management services.	A) Provide medical case management for PLWH who are currently inmates in county jails, to facilitate transition to community resources.	45
	B) Provide medical case management at or through regional service providers outside the Denver TGA.	950
	C) Provide specialized medical case management in other settings, including medical providers.	30
Goal 4: Increase the percentage of case-managed PLWH/A who access at least one high priority service.	A) Support client access to one or more of the following services at clinics, hospitals, and other medical providers: nonmedical case management, child care, direct emergency financial assistance, food bank, health education/risk reduction, housing, linguistic services, medical transportation, outreach, psychosocial support, or referral.	150
	B) Support client access to one or more of the following services at or through regional service providers: nonmedical case management, child care, direct emergency financial assistance, food bank, health education/risk reduction, housing, linguistic services, medical transportation, outreach, psychosocial support, or referral.	500
	C) Support client access to one or more of the following services through other providers: nonmedical case management, child care, direct emergency financial assistance, food bank, health education/risk reduction, housing, linguistic services, medical transportation, outreach, psychosocial support, or referral.	500
	D) Utilize disease investigation staff (DIS) to identify client needs for care-related services and make active referrals.	300
Goal 5: Increase the number	A) Support client access to specialized mental health services.	25

2009 –2010 Plan		
Goals	Objectives	Clients Served
of PLWH/A in Colorado who are actively screened for mental health and/or substance use issues and, when indicated, are given access to behavioral health services that meet their needs.	B) Support client access to substance abuse services, including screening, brief intervention, brief therapy, and formal drug treatment.	1,000
Goal 6: Increase the number of funded agencies with a Quality Committee and a written Quality Plan.	Clinical Quality Management Activities	
	A) Finalize the Statewide Quality Plan and begin implementation, to include providing technical assistance to all funded contractors to undertake local quality improvement activities.	
	B) Revise the standards for all funded services, based on a broad based process, and utilizing recent data on evidence-based practices.	
	C) Ensure that funded contractors are showing good faith progress implementing the quality expectations written into their 2009 contracts.	
	D) By year-end, evaluate the implementation of the Statewide Quality Plan and make any necessary adjustments for the future.	
	ADAP Clinical Quality Management Activities	
	A) Review and assess the current list of medications on the ADAP formulary regarding appropriateness and potential drug interactions or complications.	
	B) Assess other available medications not currently on Colorado's formulary and new medications as they receive Food and Drug Administration approval for inclusion on Colorado's ADAP formulary.	
	C) Prioritize any changes, reductions, or additions to the formulary.	

IV. HOW WE WILL MONITOR OUR PROGRESS

A. Improving Client Level Data

Beginning in 2009, CDPHE will implement data systems that allow monitoring progress toward long term annual objectives while also meeting client level data requirements. Table 4.1 summarizes the current understanding of the data systems that funded providers will use beginning in April 2009.

Table 4.1: Data Systems of Fiscal Year 2009 Funded Providers

Provider	Data extracted from records, exported to Ryan White CAREWare	Data entered into an online data system by the provider or CDPHE staff	Data compiled through the provider's data system and directly reported to HRSA
Beacon Center for Infectious Disease			X
Boulder County AIDS Project		X	
Colorado Department of Public Health and Environment		X	X
Children's Hospital Immunodeficiency Program	X		X
Colorado AIDS Project	X	X	
Correctional Healthcare Management		X	
Denver Health	X		
Northern Colorado AIDS Project		X	
Peak Vista Community Health Center	X		
Pueblo Community Health Center			X
Southern Colorado AIDS Project		X	
St. Mary's Hospital			X
University of Colorado Hospital ID Clinic	X		
University of Colorado Health Sciences Center Dental Program	X		
Western Colorado AIDS Project		X	

The online data system referenced in Table 4.1 is expected to change in 2009. Colorado AIDS Project developed the current system, HELIX, locally. It is being phased out in favor of one of the HRSA-sanctioned data systems used in another jurisdiction. Colorado is in negotiations with California's AIDS Regional Information and Evaluation System (ARIES) system to be the new data system in 2009.

In some instances, a provider may be using multiple systems. This is either because they use different systems for different services or because they are transitioning from a current system to a new system.

B. Using Data For Evaluation

Colorado Department of Public Health and Environment will compile data from the data systems on at least a quarterly basis and compile year to date progress reports for evaluation purposes. In addition, the Colorado Statewide Quality Committee will review data concerning performance measures (described below) and will utilize this data to identify quality improvement progress and opportunities.

C. Measuring Clinical Outcomes

Colorado's Statewide Quality Committee will take leadership in identifying performance measures regarding clinical services and measuring progress toward quality improvement. By March 31, 2009, Colorado's Quality Plan will identify specific performance measures that will be monitored system-wide, selecting from the Group One Performance Measures published by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau. The Quality Committee will receive reports compiled by CDPHE at their periodic meetings.

Colorado Department of Public Health and Environment is also revising the Part B Standards of Care. The revised standards for clinical services will include specific performance measures, which will be monitored through onsite monitoring and analysis of data.

Attachment A – Regional Service Provider Geographic Areas

Colorado’s 64 counties are allocated into five regions for planning purposes.

North Central

Boulder
Broomfield
Clear Creek
Gilpin

Northeast

Larimer
Morgan
Phillips
Sedgwick
Washington
Weld
Yuma
Logan

Southern

Alamosa
Baca
Bent
Chaffee
Cheyenne
Conejos
Costilla
Crowley
Custer
El Paso
Elbert
Fremont
Huerfano
Kiowa
Kit Carson
Las Animas
Lincoln
Mineral
Otero
Park
Prowers
Pueblo
Rio Grande
Saguache
Teller

Western

Archuleta
Delta
Dolores
Eagle
Garfield
Grand
Gunnison
Hinsdale
Jackson
La Plata
Lake
Mesa
Moffat
Montezuma
Montrose
Ouray
Pitkin
Rio Blanco
Routt
San Juan
San Miguel
Summit

Denver Transitional Grant Area

Adams
Arapahoe
Denver
Douglas
Jefferson