Idaho's HIV and Viral Hepatitis Jurisdictional Comprehensive Plan 2012-2015

Developed by Mountain States Group, Inc., with guidance from the
Idaho Advisory Council on HIV and AIDS for the
Family Planning, STD and HIV Programs of the Idaho Department of Health and Welfare,
this Plan includes the
Jurisdictional HIV Prevention Plan,
Ryan White Care Comprehensive Plan
and
Statewide Coordinated Statement of Need

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Idaho Advisory Council on HIV and AIDS

FAMILY PLANNING STD & HIV PROGRAMS

IDAHO DEPARTMENT OF HEALTH & WELFARE

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Mission Statement

Idaho will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

Introduction

The Idaho HIV and Viral Hepatitis Jurisdictional Comprehensive Plan 2012-2015 provides a collaborative mechanism to identify and address the most significant issues related to the needs of Idahoans living with HIV/AIDS (PLWH/A), and to maximize coordination, integration and effective linkages across HIV Prevention, Ryan White HIV/AIDS Program Parts B and C grantees and other state, federal and private funders. This document addresses the criteria required of the Statewide Coordinated Statement of Need, the HIV Care Comprehensive Plan, the Comprehensive HIV Program Plan and the Jurisdictional HIV Prevention Plan. As such, this document will serve as the basis for HIV planning statewide and will assist in planning resource allocation decisions, measurable objectives, quality management programs and statewide plans, and any other activities that enhance HIV prevention efforts and HIV care and service delivery statewide.

In July 2010, the White House released the National HIV/AIDS Strategy (NHAS) to provide guidance for future HIV care and prevention activities in the United States. The NHAS identifies three primary goals:

1. Reducing HIV incidence
2. Increasing access to care and optimizing health outcomes
3. Reducing HIV-related health disparities

A. HRSA Response

In response to the National HIV/AIDS Strategy, the Human Resources and Services Administration (HRSA) added expanded language to several components of the Ryan White Part B Program responsibilities. The section called Early Identification of Individuals with HIV/AIDS (EIIHA) includes the identification, counseling, testing, informing, and referral of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to care.

B. CDC Response

The Centers for Disease Control and Prevention (CDC) developed a five-year funding opportunity announcement (FOA) aligning with the National HIV/AIDS Strategy. This FOA focuses on addressing the national HIV epidemic by reducing new infections, increasing access to care, improving health outcomes for people living with HIV, and promoting health equity. Consequently, funding has shifted so that jurisdictions most affected by the epidemic will receive additional funds while low-prevalence states will experience a decrease in funding.

C. IACHA Response

The Idaho Advisory Council on HIV and AIDS (IACHA) chose to align the mission statement and goals of its HIV and Viral Hepatitis Jurisdictional Comprehensive Plan with the National HIV/AIDS Strategy.

Section 1: Community Planning Structure in Idaho

The community planning process in Idaho involves a close working relationship between IACHA, the state HIV Care and Prevention programs, and a variety of collaborative partners.

A. Idaho Advisory Council on HIV and AIDS (IACHA)

The purpose of IACHA is to strengthen Idaho's HIV and AIDS care and prevention programs (see Appendix A for a complete description of IACHA's history). IACHA participates in the development of a Comprehensive HIV Care and Prevention Plan that is evidence-based, relevant to Idaho's populations at risk of infection and based on meaningful community input. IACHA bases decisions on several sources of data, including an epidemiological profile of People Living with HIV/AIDS (PLWH/A) in Idaho, population and district-specific needs assessments and studies of which interventions have proven to be successful in reducing HIV and caring for PLWH/A.

IACHA is a community-based group comprising PLWH/A, representatives from public health, HIV Prevention, and HIV medical case management providers and individuals representing communities at risk for HIV. Voting members fill one of 26 specific slots, which are based on the Idaho HIV Epidemiological Profile (Appendix B) and include the following:

- Community Based Organization (HIV Prevention)
- Direct Care
- Corrections/Criminal Justice
- State Health
- Public Health
- Substance Use
- Education
- Behavioral Science
- Medical Care
- Mental Health
- MSM Youth (18-24)
- Low Income
- People of Color
- Hispanic
- MSM (two slots)
- IDU
- HIV positive (three slots)
- HIV positive (55+)
- High Risk Heterosexual
- Transgender
- Viral Hepatitis
- Homeless
- Foreign Born

Three IACHA subcommittees are tasked with various components of the Comprehensive Plan: the Research Committee, Data Committee, and Finance Committee. These committees provide updates via Administrative Committee conference calls and presentations at IACHA meetings. The entire IACHA membership makes all final decisions and recommendations.

B. Idaho HIV/AIDS Programs

The Family Planning, STD and HIV Programs houses the HIV Prevention Program, the Ryan White Part B Program and the AIDS Drug Assistance Program (ADAP).

1. Idaho HIV Prevention Program

CDC created a new five-year funding opportunity for state health departments to provide comprehensive HIV prevention programs. The Idaho HIV Prevention program receives funding from CDC under this grant, which began January 1, 2012. The purpose of this grant is to implement HIV prevention programs that will reduce new infections, increase access to care, improve health outcomes for people living with HIV, and promote health equality.

To achieve these goals, the state health departments receive funding to provide the following:

1) HIV testing
2) Comprehensive prevention for HIV positives
3) Condom distribution
4) Policy initiatives

The Idaho HIV Prevention Program is also required to conduct the following: 1) jurisdictional HIV prevention planning, 2) capacity building and technical assistance including training, and 3) program planning, monitoring and evaluation, and quality assurance.

CDC also included the opportunity for states with the resources and capacity to implement three recommended program components of which the Idaho HIV Prevention Program has chosen to fund activities under evidence-based interventions for HIV negative persons at highest risk for acquiring HIV and social marketing, media, and mobilization. For a list of funded activities and agencies, see Appendix C.

2. Idaho Ryan White Part B Program

In FY2012, the Idaho Ryan White Part B (RWPB) Program funds will provide the following services:

1. Medical case management
2. Ambulatory outpatient care through payment for HIV monitoring labs
3. Medical transportation
4. Emergency financial assistance
5. Pharmaceutical services (ADAP)

Medical case management, medical transportation assistance and emergency financial assistance are administered through contracts with six agencies throughout Idaho.

Funding allocations for the Idaho Ryan White Part B Program are included as Appendix D.

3. Idaho AIDS Drug Assistance Program (ADAP)

ADAP provides eligible Idahoans access to the prescription medication needed to manage and treat HIV. FPSHP contracts with A-S Medication Solutions™ LLC for the provision of HIV-related medications to ADAP eligible clients throughout Idaho.

C. Collaborative Partners

To complete the tasks as defined by CDC and HRSA for the HIV and Viral Hepatitis Jurisdictional Comprehensive Plan, IACHA collaborates with the following partners:

1. Viral Hepatitis

CDC provides funding to Idaho for a .25 FTE Viral Hepatitis Prevention Coordinator (VHPC) position. This part-time position is combined with the HIV Prevention Program Specialist position. The primary role of the VHPC is to manage and coordinate activities directed toward the prevention of viral hepatitis infections. Program activities aim to increase awareness and knowledge about transmission of viral hepatitis, and decrease the incidence of viral hepatitis infections. Including the VHPC position within FPSHP allows for more access to agencies contracted for prevention services. The transmission of viral hepatitis is very similar to HIV; both can occur via contaminated blood, mother-to-child during birth, and sexual contact.

Program collaboration at the state level allows more opportunities to increase viral hepatitis education activities at the local level by encouraging HIV prevention contractors to include hepatitis education as part of their HIV prevention activities. Idaho's local district health departments (DHD) provide Family Planning services, STD testing and treatment, HIV testing, and hepatitis B and hepatitis C testing. Six of the seven health departments also provide adult immunizations including hepatitis A and hepatitis B.

Each of Idaho's District Health Departments screen for hepatitis B virus (HBV) and hepatitis C virus (HCV) based on behavioral risk criteria. The behavioral risk criteria for HBV include:

1. Exposed to HBV
2. Two or more sex partners in 60 days
3. IDU (past or present)
4. Sexual contact with IDU
5. Person with HIV
6. Commercial sex worker or partner of sex worker
7. Sexually active MSM or partner of MSM
8. Household contact of person with HBV
9. Pregnant women

Persons who should be tested routinely for hepatitis C virus (HCV) infection based on their risk for infection:

- Currently injecting drugs
- Ever injected drugs, including those who injected once or a few times many years ago
- Have certain medical conditions, including persons :
    - who received clotting factor concentrates produced before 1987
    - who were ever on long-term hemodialysis
    - with persistently abnormal alanine aminotransferase levels (ALT)
- Were prior recipients of transfusions or organ transplants, including persons who:
    - were notified that they received blood from a donor who later tested positive for HCV infection
    - received a transfusion of blood, blood components or an organ transplant before July 1992

Persons who should be tested routinely for HCV-infection based on a recognized exposure:

- Healthcare, emergency medical, and public safety workers after needle sticks, sharps, or mucosal exposures to HCV-positive blood
- Children born to HCV-positive women

Adults born during 1945 through 1965 should be tested once for hepatitis C virus (HCV) infection without prior ascertainment of HCV risk factors.

The Wellness Center (the Ryan White Part C clinic is located in Boise with satellite offices in Twin Falls and Pocatello) provides screening for hepatitis A, hepatitis B, and hepatitis C for all of their HIV positive clients. Immunizations are offered to all clients who are not already immune or who do not have a positive surface antigen confirmation for hepatitis B. For clients co-infected with HIV and HCV, RW Part C funds can support limited treatment and provide for a genotype and viral load test. For clients without a third party payment, the Wellness Center covers the cost of labs during treatment and helps clients obtain medication through patient assistance programs.

2. Idaho HIV Surveillance Program

The Idaho HIV Surveillance Program receives funding from the CDC for HIV epidemiologic services. The program is on a five-year funding cycle with a new funding cycle expected for 2013-2017. The main surveillance project measures, as guided by CDC, include the following:

1. Death ascertainment to improve accuracy of prevalent HIV/AIDS by matching registry data with vital statistics data
2. Intra-state de-duplication of records to improve accuracy of data
3. Interstate de-duplication of HIV cases to improve accuracy of diagnosis data among persons reported (every 6 months)
4. Ascertainment of cases and case data (≥ 85% of expected number of cases) in a complete and timely manner (≥66% expected diagnoses within 6 months of diagnosis)
5. Ascertainment of risk factors for >85% of cases
6. Security and confidentiality protocols in place and certified to meet CDC criteria

To accomplish these tasks, the Idaho HIV Surveillance Program contracts with the Idaho District Health Departments (DHD) for HIV surveillance activities, which entail investigation and reporting of HIV/AIDS cases in their respective jurisdictions, performing active surveillance where needed (per the DHD discretion), keeping case information secure and confidential, and training (as funding allows). HIV/STD Prevention contracts also provide funding for the Partner Counseling Referral Services portion of the case investigation process. The DHDs provide epidemiologic investigation in accordance with Idaho's Investigative Guidelines.

3. Housing Opportunities for Persons with AIDS (HOPWA)

HOPWA funds support housing assistance as well as supportive services including health care, essential health services and case management. Idaho's Ryan White Part B Medical Case Managers

work (directly or indirectly) with the Idaho HOPWA Program to assist clients in retaining or gaining safe, stable housing.

A representative from the Idaho HOPWA Program serves on IACHA as a technical assistant provider and on the Idaho HIV Quality Management Committee as a member.

4. Regional Planning Groups (RPG)

To support continued efforts of regional planning groups, FPSHP has arranged for Mountain States Group to hold and distribute funds to approved planning groups and act as point of contact for RPGs. Each of the seven Idaho health department jurisdictions may have one recognized and functioning RPG as approved by the IACHA Administrative Committee.

Each RPG is eligible to receive funding through an application process, if they elect to continue as a group and actively meet in 2012. RPGs may apply for funds to support HIV/AIDS planning meetings or special events (e.g., National HIV Testing Day, World AIDS Day or other HIV awareness days). Funding applications must list dates and times of meetings/events, full names of meeting attendees and contact information, and details of how funding will be utilized. Funding for RPG activities is subject to approval by the IACHA Administrative Committee.

5. Northwest AIDS Education Training Center (NWAETC)

The NWAETC Education Coordinator frequently attends IACHA meetings to provide updates about the NWAETC activities. The Coordinator also serves on the Idaho HIV Quality Management Committee. In addition, Idaho's HIV Prevention Program contracts with the NWAETC Education Coordinator to provide the following HIV training:

1. Fundamentals of Waived Rapid Test Training
2. Client-Centered Counselor Training
3. Integration of Viral Hepatitis
4. Social Networks Strategies Training

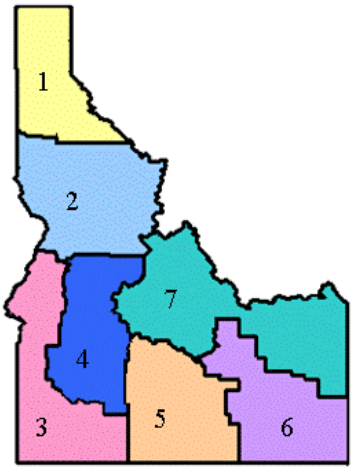
6. Wellness Center (Idaho's Ryan White Part C Clinic)

A representative from the Family Medicine Residency of Idaho's Wellness Center (a Ryan White Part C clinic) serves as technical assistant provider for IACHA. Staff members from the Wellness Center also serve on the Idaho HIV Quality Management Committee. The RWPB QM Coordinator and the RWPC Coordinator work collaboratively to share data and evaluation results with program staff, medical case management providers, and the Statewide QM Committee members and clients.

Section 2: Idaho Demographic Background

A. General Population Information

The U.S. Census Bureau estimated the Idaho population to be 1,545,801 in 2009. Idaho ranks 39 in the nation in population, with less than one percent of the U.S. population.



Idaho has forty-four counties and a land area of 83,557 square miles with agriculture, forestry, manufacturing and tourism the primary industries. Eighty percent of Idaho's land is either range or forest.

Much of the state's central interior is mountain wilderness and national forest. Nineteen of Idaho's forty-four counties are considered "frontier," with averages of less than six persons per square mile.

Being a rural state, transportation in Idaho is limited to two main highways: Highway I-80 running east and west in the southern part of the state and Highway 95 running north and south along the western border of the state. The physical barriers of terrain and distance have consolidated Idaho's population into seven natural regions. Idaho's public health delivery system is organized around the seven population centers, with counties grouped into seven districts (as noted in the map above).

More than one-third of Idaho's population is 24 years of age or younger. Idaho's population ranks 4th youngest in the U.S. with an average age of 34.0 years.

Table 1: **Distribution of Population by Gender and Age— Idaho 2009**

Note: Highlighted sections signify populations of significance

Age Group	Male	%	Female	%	Total	%
≤14	180,037	23%	171,887	22%	351,924	23%
15-19	58,173	7%	56,771	7%	114,944	7%
20-24	59,718	8%	53,991	7%	113,709	7%
25-29	57,133	7%	54,211	7%	111,344	7%
30-39	99,952	13%	95,350	12%	195,302	13%
40-49	99,142	13%	97,931	13%	197,073	13%
>49	221,763	29%	239,742	31%	461,505	30%
Total Population	775,918	100%	769,883	100%	1,545,801	100%

Source: Estimates for 1990-1999 are bridged-race intercensal population estimates of the July 1 resident population. Estimates for 2000-2009 are Vintage 2009 bridged-race postcensal population estimates of the July 1 resident population. These estimates were prepared by the Census Bureau in collaboration with NCHS.

In Idaho, Hispanics comprise 11% of the population. Comparatively, Hispanics comprise 16.3% of the U.S. population (according to the U.S. Census Bureau, 2010 Census).

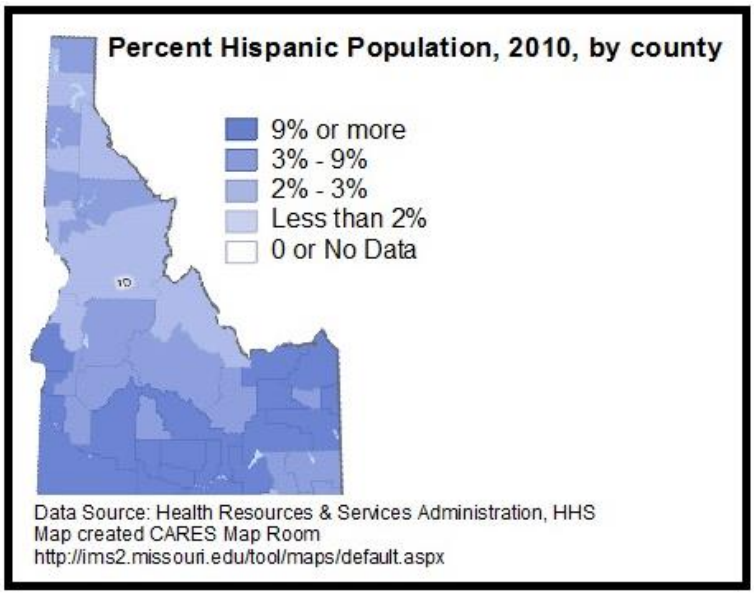
Table 2: **Distribution of Population by Ethnicity— Idaho 2009**

Note: Highlighted sections signify populations of significance

Ethnicity	Male	%	Female	%	Total	%
Hispanic or Latino	87,499	11%	77,786	10%	165,285	11%
Not Hispanic or Latino	688,419	89%	692,097	90%	1,380,516	89%
Total Population	775,918	100%	769,883	100%	1,545,801	100%

Source: Estimates for 1990-1999 are bridged-race intercensal population estimates of the July 1 resident population. Estimates for 2000-2009 are Vintage 2009 bridged-race postcensal population estimates of the July 1 resident population. These estimates were prepared by the Census Bureau in collaboration with NCHS.

The following map shows the more densely Hispanic populated areas of Idaho to be in the southern part of the state.



Among both males and females, the majority of Idahoans are white (95.5%).

Table 3: **Distribution of Population by Race— Idaho 2009**

Note: Highlighted sections signify populations of significance

Race	Male	%	Female	%	Total	%
American Indian/Alaska Native	13,303	2%	13,329	2%	26,632	1.7%
Asian or Pacific Islander	10,766	1%	12,432	2%	23,198	1.5%
Black or African American	9,045	1%	10,193	1%	19,238	1.2%
White	741,656	96%	735,077	95%	1,476,733	95.5%
Total Population	775,918	100%	769,883	100%	1,545,801	100%

Source: Estimates for 1990-1999 are bridged-race intercensal population estimates of the July 1 resident population. Estimates for 2000-2009 are Vintage 2009 bridged-race postcensal population estimates of the July 1 resident population. These estimates were prepared by the Census Bureau in collaboration with NCHS.

The following table illustrates the distribution of Idaho's population by health district. Health District 4, which includes Boise, the state capital, is the most populated district in Idaho.

Table 4: **Distribution of Population by Health District— Idaho 2009**

Note: Highlighted sections signify populations of significance

Health District	Population	Percent
District 1	213,662	13.8%
District 2	104,496	6.8%
District 3	251,013	16.2%
District 4	429,647	27.8%
District 5	179,994	11.6%
District 6	167,290	10.8%
District 7	199,699	12.9%
TOTAL	1,545,801	100%

Source: 2010 HIV/AIDS Epidemiologic Profile

B. The HIV/AIDS Epidemic in Idaho (as summarized in the 2010 Idaho HIV/AIDS Epidemiologic Profile)

The Family Planning, STD, and HIV Programs (FPSHP) and IACHA use HIV/AIDS epidemiologic and surveillance data to provide guidance and funding for programs for persons with, or at risk for, HIV/AIDS. The goals of these programs are to prevent HIV infections and, for those who are infected, to promote testing, care, and treatment. HIV prevention and care planning groups use HIV/AIDS epidemiologic profiles for multiple purposes. This document describes the current impact of the HIV/AIDS epidemic in Idaho in terms of socio-demographic, geographic, behavioral, and clinical characteristics of persons infected with HIV. The profile is intended to be a valuable tool to be used at the state and local levels by those who make recommendations for allocating HIV prevention and care resources, planning programs, and evaluating programs and policies. The Idaho HIV/AIDS Epidemiological Profile is included as Appendix B.

***Table 5*. Characteristics of Cumulative Non-duplicated Idaho Residents HIV and AIDS Diagnosed through 12/31/2009**

Note: Highlighted sections signify populations of significance

	Disease/Condition			
	HIV		AIDS	
Sex	**#**	**%**	**#**	**%**
Male	373	81%	569	85%
Female	86	19%	97	15%
Total	459	100%	666	100%
Race/Ethnicity				
Hispanic	56	12%	69	10%
American Indian/Alaska Native	8	2%	10	2%
Asian/ Pacific Islander	3	1%	3	0%
Black	20	4%	17	3%
White	366	80%	562	84%
Unknown	6	1%	5	1%
Total	459	100%	666	100%
Age group at first diagnosis				
<13	5	1%	3	0%
13-19	13	3%	5	1%
20-29	192	42%	159	24%
30-39	141	31%	269	40%
40-49	81	18%	155	23%
Over 49	27	6%	75	11%
Total	459	100%	666	100%

Source: 2010 HIV/AIDS Epidemiologic Profile

1. Overall Summary

- 1,125 HIV and AIDS cases have been diagnosed in Idaho residents and 1,254 individuals are presumed to be living with HIV or AIDS in Idaho, including individuals first diagnosed out-of-state.
- Males have been diagnosed with HIV/AIDS at a higher two-year aggregate rate than females during 2004–2009. The two-year aggregate rate trend among males increased sharply in 2008– 2009, rising 57% over the rate in 2004–2005. The rate among females stayed relatively level.
- Increases in two-year aggregate case counts occurred in five of six age groups. Age groups with at least 20 cases during 2004–2009 were 20–29 years, 30–39 years, 40–49 years, and 50+ years. In the four age groups with at least 20 cases over the most recent six-year period, the increase was more than 70% in three, indicating increases were spread across age groups.
- Whites accounted for 76% of diagnoses during 2004–2009, and a 76% increase in diagnoses was observed among Whites during 2004–2009. The number of diagnoses among other race/ethnic categories remained relatively level.
- MSM continues to be the most reported mode of exposure (49%) during 2004–2009, and the number of diagnoses among MSMs, MSM/IDUs, and Heterosexuals (including Presumed Heterosexuals) increased. Diagnoses among IDUs decreased by half, although the numbers are so small they are likely statistically insignificant.

2. Populations of Interest

- 109 (49%) of the total 219 individuals diagnosed with HIV/AIDS during 2005–2009 were MSM. The highest proportion (32%) was aged 20-29 years. All but one were either White (87%) or Hispanic (12%).
- 23 MSM/IDU were diagnosed during 2005–2009. Most (57%) were 30-39 years at diagnosis. All but two were White.
- 17 non-MSM IDU were diagnosed during 2005–2009. 65% were male. Female IDUs were younger than male IDUs. In women, the highest proportions were aged 20-29 years at diagnosis, whereas for men, the highest proportion was aged 40-49 years.
- 27 heterosexual and presumed heterosexual mode of exposure diagnoses were reported during 2005–2009. 74% were female. Heterosexual females had twice the proportion of Hispanic race/ethnicity and were distributed toward younger age groups compared with males.

3. Cumulative HIV and AIDS Diagnoses

At 3.7 per 100,000, the Idaho rate is far below the estimated rate of 19.4 for the 37 U.S. states with mature HIV reporting systems in 2008. Rates of HIV infection (including concurrent AIDS diagnosis) have decreased in Idaho since the early 1990s, but appeared to increase substantially in the most recent two years for which data are available. In Idaho, 1,254 reported persons (whether they were diagnosed in Idaho or another state) are presumed to be living with HIV/AIDS.

4. HIV Diagnoses

A total of 459 residents were first diagnosed with HIV in Idaho from 1984–2009 and have not yet received an AIDS diagnosis.

- The majority (81%) of HIV cases were male and White (80%)
- By age, the highest proportion of HIV cases was diagnosed in persons aged 20-29 years (42%), though persons aged 30-39 years accounted for almost one-third of diagnoses
- The most frequently reported exposure category was MSM, although less than half of the total
- Five were pediatric cases

5. AIDS Diagnoses

A total of 666 residents were first diagnosed and reported with AIDS in Idaho from 1984–2009.

- The majority (85%) were male and White (85%)
- Forty percent were aged 30–39 years at their AIDS diagnosis
- Over half of diagnosed cases were among MSM
- Three cases were pediatric

6. Mode of Exposure

Of the 1,254 people who have been diagnosed with HIV or AIDS between 1984 and 2009, the primary modes of exposure are as follows:

- More than half (56%) of males living with HIV/AIDS in Idaho had MSM mode of exposure classification
- Among men, IDUs accounted for 10% and the dual-category MSM/IDUs were an additional 14%
- More than half of females living with HIV/AIDS had heterosexual or presumed heterosexual [1] mode of exposure
- Both males and females had notable proportions of unidentified risk

***Table 6*. Presumed Living HIV/AIDS Cases by Sex and Mode of Exposure—Idaho, 2009**

Note: Highlighted sections signify populations of significance

Exposure Category	Males		Females		Total	
	#	%	#	%	#	%
Adult						
MSM	575	56%	NA	-	575	46%
IDU	103	10%	62	27%	165	13%
MSM/IDU	148	14%	NA	-	148	12%
Hemophiliac	4	0%	1	0%	5	0%
Heterosexual contact	56	5%	94	41%	150	12%
Presumed heterosexual contact	0	0%	30	13%	30	2%
Transfusion/transplant	4	0%	2	1%	6	0%
Risk not specified	129	13%	28	12%	157	13%
Pediatric						
Mother with/at risk HIV	3	0%	8	3%	11	1%
Transfusion/transplant	0	0%	0	0%	0	0%
Other/undetermined	2	0%	5	2%	7	1%
TOTAL	1024	82%	230	18%	1254	100%

Source: 2010 HIV/AIDS Epidemiologic Profile

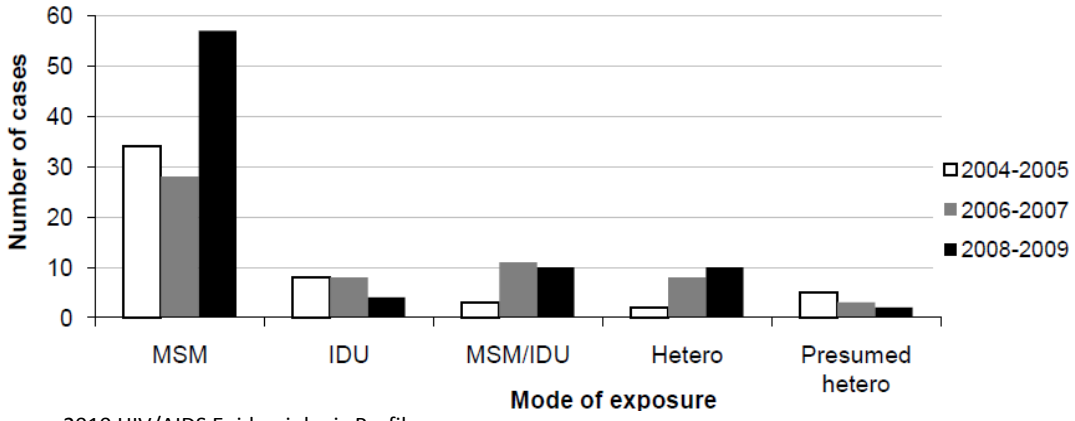
[1] Includes only females who answered "yes" to sex with male and "no" to IDU

Recent trends regarding mode of exposure include the following:

1. The cases among MSM and MSM/IDU appeared to increase from 2007 to 2009
2. Heterosexual mode of exposure increased, but when combined with the presumed heterosexual category, the trend was somewhat flat, with 10 cases in 2004–2005 and 11 cases in 2008–2009

For further details, see Figure 1.

Figure 1. Two-Year Aggregate HIV/AIDS Diagnoses by Selected Mode of Exposure—Idaho, 2004–2009



Source: 2010 HIV/AIDS Epidemiologic Profile

7. HIV/AIDS Distribution by Health District

Health District 4 had the highest percentage of reported persons presumed living with HIV/AIDS (41.5%)

***Table 7*. Presumed Living HIV/AIDS by District of Residence at Report—Idaho, 2008**

Note: Highlighted sections signify populations of significance

Health District	Total	Percentage
District 1	147	11.7%
District 2	81	6.5%
District 3	156	12.4%
District 4	520	41.5%
District 5	117	9.3%
District 6	132	10.5%
District 7	101	8.1%
TOTAL	1,254	100%

Source: 2010 HIV/AIDS Epidemiologic Profile

8. Gender

Overall, both HIV and AIDS in Idaho is much higher numbers in males as exemplified in the following data:

- More males than females were living with HIV/AIDS in Idaho at the end of 2009
- Males outnumbered females at a ratio of 5.5:1 (at the national level, this ratio is 2.7:1, according to the CDC 2008 HIV Surveillance Report
- From 2005-2009, 84% of new HIV and AIDS diagnoses were among males; 16% were among females

For more information, see the following table and Figure 2.

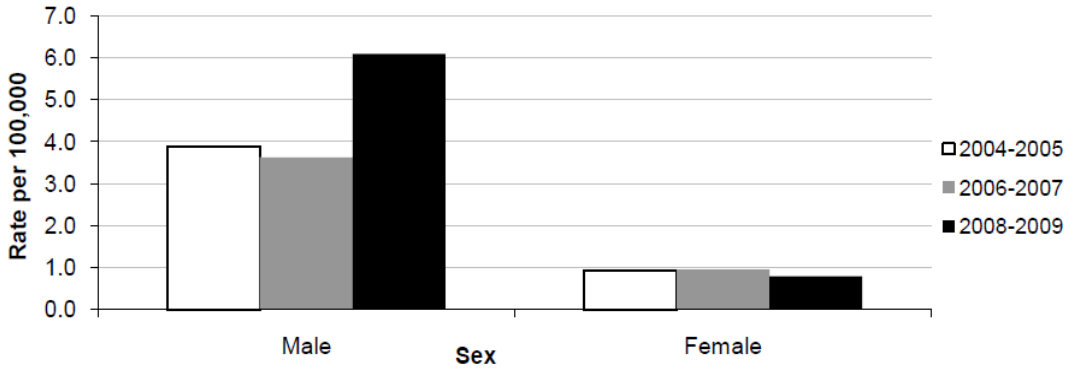
Table 8. **Cumulative HIV and AIDS Diagnoses in Idaho through 12/31/2009**

Note: Highlighted sections signify populations of significance

	HIV		AIDS		HIV/AIDS Combined	
Sex	**#**	**%**	**#**	**%**	**#**	**%**
Male	373	81%	569	85%	942	84%
Female	86	19%	97	15%	183	16%
TOTAL	459	100%	666	100%	1125	100%

Source: 2010 HIV/AIDS Epidemiologic Profile

Figure 2. Two-Year Aggregate Rate of HIV/AIDS Diagnoses by Sex—Idaho, 2004–2009



Source: 2010 HIV/AIDS Epidemiologic Profile

9. Late Testers

In Idaho, the trend of individuals diagnosed with AIDS within 1 year of HIV diagnosis has been variable since the late 1980s. AIDS was diagnosed within 1 year in 36% of individuals diagnosed with HIV during 2005–2009. This is similar to the national proportions of 32% and 38% as reported by the CDC in the 2008 HIV Surveillance Report and the June 2009 Morbidity and Mortality Weekly review article (*Late Testing-34 States, 1996–2005*), respectively.

- In regards to individuals diagnosed with AIDS within one year of HIV diagnosis, there was no appreciable difference in number of cases observed between males and females.
- Hispanics and Whites had similar proportions consistent with the overall total (38% of Hispanics were diagnosed with AIDS within 1 year; 36% of Whites were diagnosed with AIDS within 1 year)
- Of the four American Indians diagnosed between 2005-2009, three-quarters were diagnosed with AIDS within 1 year
- Individuals with Heterosexual or Unspecified modes of exposure were higher proportion late testers than other adult exposure categories
- Districts 4, 6, and 7 had the lowest proportion of late testers by district

10. Age Group

HIV diagnoses increased in three different age groups during 2002– 2007 as described below:

- Cases increased by 80% among 20-29 year olds
- Cases increased 72% among 40-49 year olds
- Cases increased 100% among persons aged 50 and over (although the number in this age group was few compared to 20-29 and 30-39 year olds)

C. The HIV/AIDS Epidemic in Idaho (as updated in the FY2012 Idaho HIV Care Grant Application)

The Health Resources and Services Administration, (HRSA), requires annual updates to the profile of PLWHA in Idaho for inclusion in the RWPB HIV Care Grant Application. The following information was included in the FY2012 Idaho HIV Care Grant Program Part B Grant Application.

From 2008 to 2010, the number of new HIV cases was relatively flat, while there was a notable increase in the number of AIDS diagnoses over the same three-year time period.

Table 9. **HIV (not AIDS) and AIDS Cases by Year of Report— Idaho, 2008–2010**

Note: Highlighted sections signify populations of significance

Year of Report								
	2008		2009		2010		TOTAL (2008-2010)	
	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
TOTAL	37	29	41	33	32	51	110	113
	66		74		83		223	

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update

1. HIV/AIDS Distribution by Health District (updated information)

Overall, in Idaho, the rate of reported persons presumed living with HIV/AIDS is 82.3 per 100,000. Health District 4 had the highest rate of reported persons presumed living with HIV/AIDS as well as the highest actual numbers of persons living with HIV/AIDS (for further details, see table below).

Table 10**. Presumed Living with HIV (not AIDS) and AIDS by District of Residence at Report—Idaho, 12/31/2010**

Note: Highlighted sections signify populations of significance

Health District	Diagnosis Category		Total	Percentage	Rate of Total (per 100,000)
	HIV	AIDS			
District 1	64	85	149	12%	70.0
District 2	40	45	85	7%	80.6
District 3	67	93	160	12%	62.9
District 4	277	261	538	42%	123.0
District 5	55	63	118	9%	63.3
District 6	73	62	135	10%	79.6
District 7	54	55	109	8%	53.1
TOTAL	630	664	1,294	100%	82.3

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update

2. Gender (updated information)

Overall, both HIV and AIDS in Idaho have much higher numbers in males as exemplified in the following data:

- 2010 HIV total number of males reported (28) was 7 times the number of females (4)
- From 2008 to 2010, the number of newly reported AIDS diagnoses among males was greater than those among females by a multiple of 3.9
- The two-year aggregate rates of HIV/AIDS diagnoses increased sharply among males, rising 57% from 3.9 per 100,000 in 2004–2005 to 6.1 per 100,000 in 2008–2009.

Table 11. **HIV (not AIDS) and AIDS Cases by Sex and Year of Report— Idaho, 2008–2010**

Note: Highlighted sections signify populations of significance

Year of Report								
Sex	**2008**		**2009**		**2010**		**TOTAL (2008-2010)**	
	HIV	**AIDS**	**HIV**	**AIDS**	**HIV**	**AIDS**	**HIV**	**AIDS**
Male	31	24	36	24	28	42	95	90
Female	6	5	5	9	4	9	15	23
TOTAL	37	29	41	33	32	51	110	113
	66		74		83		223	

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update

3. Race/Ethnicity (updated information)

1. Hispanic
   - The number of HIV (not AIDS) diagnosis reports among Hispanics was variable between 2008–2010
   - During 2008-2010, Hispanics constituted 35 of the 193 HIV and AIDS cases (18%)
   - During 2008-2010, Hispanics constituted 25 of the 113 AIDS cases (22%)
   - Whether looking at the combined HIV/AIDS figures or the AIDS-only figures, Hispanics represent a significant proportion of the HIV/AIDS burden as they represent only 11% of the Idaho total population
2. White
   - During 2008-2010, Whites constituted 131 of the 193 HIV and AIDS cases (68%)
3. Trends in diagnoses among other race/ethnic categories were minimal

Table 12. **HIV (not AIDS) and AIDS cases by race/ethnicity and year of report— Idaho, 2008–2010**

Year of Report						
	2008		**2009**		**2010**	
Race/Ethnicity	HIV	AIDS	HIV	AIDS	HIV	AIDS
Hispanic - any race	2	8	7	8	1	9
American Indian/AK	1	1	0	0	2	0
Asian/Pacific Islander	0	0	0	0	0	1
Black	1	1	1	3	0	4
White	3	19	30	20	26	33
Other	0	0	0	1	0	0
Unknown	0	0	3	1	3	4
	7	**29**	**41**	**33**	**32**	**51**
TOTAL	**66**		**74**		**83**	

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update

Section 3: Unmet Need Estimate

A. Calculating Unmet Need

A critical component of community planning is calculating the needs of people living with HIV/AIDS not accessing care. While getting an accurate estimate is a challenge, the following table provides information about people living with HIV/AIDS in care by gender, race/ethnicity and health district. This method compares the number of PLWH/A with the number of PLWH/A enrolled in Ryan White Part B medical case management (MCM) and/or receiving care at one of the Part C clinics serving Idaho residents.

The formula used to calculate Unmet Need in Idaho is included as Appendix E.

Table 13. **PLWH/A in Care by Gender, Race/Ethnicity, Age, and Health District (2010)**

Column A	*Column B*	*Column C*	*Column D*	*Column E*
Demographics	**PLWH/A as of 12/31/10***	**Part B MCM and Part C Enrollment as of 12/31/10****	**Percent (%) PLWH/A enrolled in MCM**	**(+/-) %**
Gender	**Number**	**Number**	**Percent (%)**	
Male	1,057	520	49.2%	-.2
Female	237	135	56.9%	+7.5
Total	**1,294**	**655**	**50.6%**	
Race/Ethnicity				
White	1006	500	49.7%	+.3
Black/African-American	85	43	50.5%	+1.1
Hispanic	145	83	57.24%	+7.8
Asian/Pacific Islander	10	3	30.0%	-19.4%
American Indian/Alaskan Native	26	12	46.1%	+3.3%
Multi-Race	5	11	63.6%	+14.2
Other/Unknown	17	3		
Total	**1,294**	**655**		
Health District				
1	149	61	40.9%	-8.5%
2	85	12	14.1%	-35.3%
3	160	582	83.38%	+34.4%
4	538			
5	118	40	33.8%	-15.6%
6	135	49	36.2%	-13.2%
7	109	52	47.7%	-1.7%
Total	**1,294**	**796**		
Column C/Column B = Column D %		(Column D) (49.4%) = Column E		
* Living in Idaho at time of initial report		**Number of Clients in Care from 2010 RDR (RWPB report)		

Source: FY 2012 Ryan White Care Program Part B Grant Application/HIV/AIDS Epidemiology Profile Update
Note: The number of PLWH/A in Idaho in this table is 1,294 (accounting for PLWH/A diagnosed through December 31, 2010 as compared to the 1,254 included in the 2010 Epidemiologic Profile)

After review of the above table during the February 2012 IACHA meeting, members concluded the following:

- Females are 7.5 percent more likely to be engaged in Ryan White Care Systems than males
- Hispanics are twice as likely to be engaged in care as any other race
- PLWH/A residing in primarily rural and frontier health districts are seriously under- represented in Ryan White Care systems, while those living in Health District 4 (a metropolitan area) are over-represented in care
- Demographics based on age were removed because age at diagnosis does not change over time, obviously, leading to skewed results

Additionally, note that there are several limitations to this method including:

- The number of PLWH/A reported living in Idaho is dependent on residency at time of initial case reporting to HIV Surveillance and is not sensitive to the current residence of the PLWH/A.
- The number of PLWH/A reported in the 2010 Epidemiological Profile only indicates age at the time of diagnosis, while the Ryan White Data System, CAREWare, tracks current ages for those in care. This effectively invalidates the age range comparison.

Overall, 49.9% of all PLWH/A are indicated as in care. Please note that Column E indicates the degree to which a specific population **is or is not** represented in Ryan White based care. A *negative* percentage may indicate under representation and a *positive* percentage may indicate the specific population is well represented (for example, females are accessing care at a 7.5 percent rate higher than males).

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

To obtain a local estimate of undiagnosed persons living with HIV at the end 2009, Idaho applied the CDC National Estimates (National Proportions Undiagnosed) using the formula below.

National Proportion Undiagnosed HIV (21%) = p
Idaho PLWHA as of December 31, 2009 (1,254) =N

$$\frac{P \times 1{,}000}{.(79)} = \textbf{Local Undiagnosed}$$

Idaho Unaware Estimate:

$$\frac{.21 \times 1{,}254}{.(79)} = \textbf{333}$$

Idaho thus estimates 333 individuals are living in Idaho unaware of their status.

C. Activities to Improve Unmet Need Calculation

The activities designed to improve the unmet need calculation include:

1. Match HIV/AIDS data with death certificates from the Bureau of Vital Records and Health Statistics (BVRHS) using the LinkPlus software to perform a probabilistic match using selected variables to identify matches. New death information will improve the unmet need calculation by allowing greater accuracy determining the number of persons presumed living with HIV. The proposal, submitted by the Surveillance Program, is awaiting approval from BVRHS.
2. Match HIV/AIDS data with RW/HRSA clinic client data from The Wellness (RW Part C clinic) Center, its associated satellite clinics, and Community Health Association of Spokane (CHAS) patient data systems. The Wellness Center provided 2009 data for HIV medical care clinics in all of Southern Idaho (including Districts 3 and 4, which comprise Idaho's most heavily populated districts). Additional clinic data from CHAS and MCM agencies were included in the match. Statewide clinic data will be used to identify access to medical care, which might not have been received through HIV surveillance due to limitations of laboratory reporting criteria for HIV viral load and CD4 results.
3. The Office of Epidemiology, Food Protection and Immunization (OEFI) was given permission by the Public Health Division Administrator to pursue the expansion of laboratory reporting criteria. OEFI will review the impacts of expanded laboratory reporting on costs, personnel, infrastructure, and determine whether or not benefits of capacity for useful analysis and program evaluation or actual value to the public health would exist if such changes occur. OEFI has gathered information about other states' efforts at expanding reporting limits, supporting documentation, and basic information from laboratories for comparison with currently reported tests. The CDC Public Health Prevention Service Fellow assigned to Idaho will assist in creating the report, likely to be completed by the end of 2012.

Outreach activities used to find PLWH/A not in care include:

1. Ryan White Program Brochure:
   During FY2011, the RWPB Program, in collaboration with Ryan White Part C Clinics in Washington and Idaho, developed a Ryan White/ADAP Program Brochure describing the services available, the location of services, and contact information of service providers throughout Idaho and Washington. To try reaching places where newly diagnosed HIV positive individuals and PLWH/A not in care might go seeking assistance, brochures were sent to the following service provider types:
   - Idaho Health District HIV MCMs and Disease Investigation Specialists
   - Major hospital emergency department social workers and discharge planners
   - HIV Prevention funded testing and prevention service providers
   - Private HIV medical providers known to the Ryan White Part B and C Programs

The goal is to ensure that providers likely to engage with high risk clients have a readily available information resource to assist with referral to care. Brochures will also be sent to the following list of providers and others as they are identified:

- Clinics and hospital emergency room staff in each of the seven health districts
- Federally Qualified Health Centers located in Idaho
- Homeless and domestic violence shelters
- Mental health facilities
- Substance abuse treatment programs
- Communities of Faith known to assist our target groups
- College and university health clinics
- Pride agencies

All sites will also receive brochures printed in Spanish.

2. Collaboration:
   Idaho continues to collaborate with Ryan White and non-Ryan White providers as needed to ensure PLWH/A in Idaho have access to care, payment for services, and quality care services.

D. Barriers to Accessing HIV Care

PLWH/A are sometimes unable to access HIV care due to a number of barriers, following their HIV diagnoses, which respondents to the Ryan White Program Consumer Survey identified. In particular, the survey asked, "What would have helped you get HIV medical care sooner after testing?" Among respondents diagnosed with HIV within the last five years, the majority (79%) claimed, "Nothing-I got help right away." Several of these respondents did, however, identify the following three areas of need:

1. Help with addressing anxiety/fear (13.8%)
2. Knowing how important early care was for my health (10.3%)
3. Knowing who to call/where to go (10.3%)

Additionally, survey respondents identified barriers they had faced when receiving HIV-related care services. Highlights per district are as follows (respondents were able to identify more than one selection):

Northern Region (Districts 1 and 2):
- Did not know where to go for services (28%)
- Fear of disclosing HIV status (26%)
- Cost of needed medical services (23%)

Southwest Region (Districts 3, 4 and 5):
- Cost of needed medical services (23%)
- Cost of drug treatment (17%)
- Fear of disclosing HIV status (17%)

Southeast Region (Districts 6 and 7):
- Fear of disclosing HIV status (23%)
- Lack of transportation to medical care (20%)
- Cost of drug treatment (20%)
- Cost of needed medical services (20%)
- Did not financially qualify (20%)

Among respondents of the HIV Provider Survey, 38% of providers indicated that there are an insufficient number of primary care providers in Idaho. Related to this barrier, comments from providers fell into the following categories:

- Uninsured clients living in North Idaho have to go to Washington for care
- The number of primary care providers who serve PLHW/A is limited
- Clients have to travel to primary care providers
- Fear of confidentiality being breached (clients may be afraid to disclose because providers may know family or friends they have not disclosed to)

Section 4: People Unaware of Their HIV Status

Identifying individuals, who are unaware of their HIV status, and are aware of their status but not in care, is of primary importance to the Family Planning, STD and HIV Program's HIV Prevention and Care Programs. HIV community based organizations, Regional Planning Groups, and members of IACHA, are committed to researching, designing and implementing strategies to reach individuals with the highest risk, those of moderate to low risk, and historically underserved communities in order to educate and provide linkage to testing, referral to care and service, and ensure those referred have accessed care.

The strategy incorporates methods to determine those who are unaware of their status, (testing), informing individuals of their status, referring them into care (disease investigation) and following up to ensure that positive individuals have accessed care (prevention, disease investigation, and care).

FPSHP is committed to the following goals:

Goal 1. Increase the number of individuals aware of their HIV status by increased testing of groups at highest risk

Goal 2. Increase the number of newly diagnosed HIV positives linked to care by determining necessary system level changes involving testing agencies and local disease investigation specialists and care providers

Goal 3. Provide training opportunities to increase the capacity and number of HIV prevention and care providers

Goal 4. Increase the number of HIV positive individuals in care by working with the state surveillance program and other providers to improve the state unmet need calculation to target activities to PLWH/A not in care

Goal 5. Increase access to care and improve health outcomes for PLWH/A with support of Medical Case Management and access to HIV medications

Goal 6. Reduce new HIV infections by implementing prevention with positive activities in care settings

Idaho's Ryan White Part B and Part C Programs coordinate on nearly every activity. Again, given the lack of funding resources, geographic distances, and lack of providers, collaboration and coordination are required in order to meet the needs of each program.

To access those unaware of their HIV status, Idaho is currently undertaking the following activities:

1. Identifying Individuals Unaware of Their HIV Status

Essential Activities:

- Target and increase HIV testing resources to the highest risk groups including MSM, IDU, and HRH
- Provide HIV testing in Title X Family Planning clinics
- Encourage healthcare providers to provide opt out HIV testing
- Utilize social marketing to increase awareness of HIV testing
-

Activities Implemented Immediately:

- Target and increase HIV testing resources to the highest risk groups including MSM, IDU, and HRH
- Provide HIV testing in Title X Family Planning clinics
- Utilize social marketing to increase awareness of HIV testing

Proposed Activities NOT Able to be Implemented Immediately:

Activity	Parties Responsible	Timeline
1. Encourage health care providers to provide opt out HIV testing	Family Planning, STD and HIV Programs HIV Surveillance Program	Ongoing

2. Informing Individuals of Their HIV Status

Essential Activities:

- All individuals who have a positive rapid test will receive a confirmatory test and will be notified of their result
- All individuals who have a confirmed positive HIV test will be offered services from a Disease Investigation Specialist (DIS)
- CBOs are required per their contract to report to the local health department the client's contact information and agency of referral to help facilitate client follow-up and a confirmatory test from a private provider, Ryan White Part C clinic, or the health department
- Determine DIS policies and procedures in each health district
- Analyze health district DIS policies and procedures and make recommendations to IDHW Epidemiology Program

Activities Implemented Immediately:

CBOs are required per their contract (1/1/2012 start date) to report to the local health department the client's contact information and agency of referral to help facilitate client follow-up and a confirmatory test from a private provider, Ryan White Part C clinic, or the health department.

Proposed Activities NOT Able to be Implemented Immediately:

Activity	Parties Responsible	Timeline
1. Determine DIS policies and procedures in each health district	HIV Prevention and Care Programs, Contractors, Health Department Staff	01/01/2012 – 12/31/2012
2. Analyze health district DIS policies and procedures and make recommendations to IDHW Epidemiology Program	HIV Prevention and Care Programs, Contractors, Health Department Staff, HIV Surveillance	01/01/2012 – 12/31/2012

Section 5: Current HIV Continuum of Care

The Family Planning, STD and HIV Programs house the HIV Prevention Program, the Ryan White Part B Program and the ADAP Program. The following describes the continuum from HIV prevention to HIV care in Idaho.

A. Idaho's HIV Prevention Program

The Idaho HIV Prevention Program funds prevention activities which include: HIV testing in clinical and non-clinical sites, HIV partner services, condom distribution, comprehensive prevention for HIV positives, social marketing, evidence-based HIV prevention for HIV-negative persons, and provider training.

The following table provides a service description for all of the HIV prevention services that are available in the seven health districts in Idaho.

Statewide	
Service / Integration	**Service Description & Outcome Goals**
Clinic Based HIV Counseling Testing and Referral Services (CTRS)	Service Description: Provide HIV testing targeting clients based on Selective Screening Criteria: MSM/IDU, MSM, IDU, Sex partner at risk, Child of HIV+ woman, STD diagnosis, Sex for drugs/money, pregnant, active TB diagnosis. Cost is based on a sliding scale fee. Outcome Goal: Increase number of clients who know their HIV status.
Community Based HIV Testing (CTRS)	Service Description: Provide free HIV testing to persons most at-risk for HIV in community settings that they may frequent or to persons who have barriers to accessing clinic based testing. Target populations include MSM, IDU, and high-risk heterosexual persons. Testing venues are determined by agency work plan. Outcome Goal: Increase access to and the number of free rapid HIV tests provided to at-risk clients.
HIV Partner Services	Service Description: Idaho code directs the DHD to provide partner services to all persons who have tested positive for HIV. Each reported case of HIV infection must be investigated to obtain specific clinical information, identify possible sources of transmission, and identify risk factors. Partners of positives are voluntarily solicited and attempts are made to locate, test, and refer partners for prevention services. Outcome Goal: Locate potential infected clients and get them tested and connected to services if they are HIV positive.
Condom Distribution	Service Description: Condoms are made available to all clients attending a STD clinic and community based HIV testing location. Condoms are distributed to agencies in the community that request them for their at-risk clients. Target populations include HIV positive persons, MSM, IDU, and high-risk heterosexual persons. Outcome Goal: Provide at-risk clients with condoms and education to support behavioral risk reduction.
Social Marketing, Media, and Mobilization	Service Description: Develop and print posters, brochures to raise awareness for community based testing events, purchase print media space and TV and radio airtime to promote CDC's HIV testing recommendations. Outcome Goal: Build awareness and attendance at community based testing events.

Prevention Programs Offered in Limited Areas	
Service / Integration	**Service Description & Outcome Goals**
¡Cuidate! (Health District #3 only)*	Service Description: ¡Cuidate! is a cultural- and theory-based HIV sexual risk-reduction program designed specifically for Latino youth age 13-18. Outcome Goal: Build condom skills and acceptance and relationship negotiation in a culturally acceptable format to decrease the disproportionate burden of HIV among the Hispanic population.
Comprehensive Risk Counseling and Services (CRCS) (Health District #4)	Service Description: Recruit and engage HIV positives and high-risk negatives in HIV risk-reduction counseling sessions. Develop a written client centered prevention plan and assess client's needs, risk, and progress toward decreasing risk. Outcome Goal: Decrease risk of PLWH/A and HIV–negative individuals from acquiring or transmitting HIV and STDs.
Personalized Cognitive Counseling (PCC)(Health District #4 only)	Service Description: PCC will be provided to MSM clients in Health Districts 3 and 4 through enhanced individual HIV test counseling sessions. Target population includes MSM who are HIV sero-negative, have had at least one HIV negative test in the last 6 months, and engaged in at least one episode of receptive/insertive unprotected anal sex in the last 12 months. Outcome Goal: Counselors help clients identify rationalizations for risky behavior and help clients decrease their risk for HIV.
Mpowerment (Health District #4 and #6 only)	Service Description: Implementation of Mpowerment project in Health Districts 4. Mpowerment conducts formal outreach to young gay, bisexual, and curious men, ages 18-35 to promote safer sex, HIV and STD prevention, HIV testing, and community building. The program is recommended by Idaho's CPG. Outcome Goal: Create a safer and stronger community in Central Idaho where young men can feel empowered to make a difference in their own lives, the lives of their peers, and their community.

**The Idaho Adolescent Pregnancy Prevention program funds Cuídate in Health Districts 4 and 5.*

B. Idaho's HIV Care Systems

The following table describes the providers and types of HIV care services available in each of the seven health districts in Idaho.

North Idaho (Health Districts #1 and #2)	
Service Provider	**Available Services**
Community Health Associations of Spokane (CHAS), located in Spokane, Washington, is the RWPC clinic serving the top ten counties of Idaho. All clients are eligible for care services, though some individuals may be required to make co-pays depending upon income level. The clinic serves individuals with Idaho Medicaid, Medicare and private insurance as well as uninsured Idahoans.	Services funded by CHAS: • HIV primary care, diagnostic and monitoring labs • Referral for health care and supportive services • Local pharmacy assistance: 340b pharmacy, which supplies all prescribed meds except for Idaho ADAP formulary drugs • Early Intervention Services: HIV testing and counseling • Clinic based medical and non-medical case management • Oral health care: Idaho clients are able to access any dental need they may have (dentures may be the exception) • Mental Health Services: CHAS Clinic provides payment for Mental Health services to a limited number of providers within Idaho. However, clients can access mental health services on site in Spokane. • Medical Nutrition: Provided at the clinic subject to insurance coverage limits for non-Ryan White clients • Medical Transportation: gas vouchers are available to Idaho clients. • Health education and risk reduction provided in-house during medical visits
Southern Idaho (Health Districts #3, #4, #5, #6, and #7)	
Service Provider	**Available Services**
For clients living in southern Idaho, the Wellness Center, housed at the Family Practice Residency of Idaho (FMRI) in Boise, is the primary Ryan White Part C clinic. Additional satellite clinics are available in Pocatello, through the Pocatello FMRI, Pocatello Family Medicine Clinic (PFMC), and once per month staff from the Wellness Center and PFMC travel to Twin Falls, Idaho for a monthly HIV clinic. All clients are eligible for care services, though some individuals may be required to make co-pays depending upon income level. The clinic serves individuals with Idaho Medicaid, Medicare and private insurance as well as uninsured Idahoans.	Services funded by the Wellness Center: • HIV Primary Care, diagnostic and monitoring labs • Referral for Health Care and Supportive Services • Local Pharmacy Assistance • Idaho ADAP formulary drugs • Early Intervention Services: HIV testing and counseling • Clinic based medical and non-medical case management • Oral health care: limited to Idaho State University Dental Program and Terry Reilly • Mental Health Services • Medical Nutrition: provided at the clinic subject to insurance coverage limits for non-Ryan White clients • Medical Transportation: within Boise City limits, clients receive bus tokens, outside of Boise, gas cards are provided when clients have appointments for medical services • Health education and risk reduction provided in-house during medical visits • Linguistic services provided for Wellness Center clients only

Statewide	
Service Provider	**Available Services**
Idaho Ryan White Part B Program	• Medical Case Management • Medical Transportation • Emergency Financial Assistance (limited to housing, utilities, and emergency food assistance) • HIV diagnostic and monitoring labs for ADAP clients including any individuals on a waitlist for ADAP services for all of Southern Idaho (Uninsured and ADAP clients in Northern Idaho receive labs through CHAS funding)
Idaho AIDS Drug Assistance Program (ADAP)	• Formulary of HIV medications including all classes of anti-retrovirals and a number of opportunistic infection treatment medications
Housing Opportunities for Persons living with AIDS (HOPWA)	• Housing • Case management • Support services to help augment Ryan White Parts B and C-funded services • Housing assistance exists in each of the seven health districts (however, there are waitlists for housing vouchers in nearly every county in Idaho. The wait can be as much as two years or in some cases more than two years for a voucher to be available)

For additional information about the resources available for PLWH/A in Idaho, review the IACHA Resource Inventory by District (Appendix F)

Section 6: Idaho Priority Populations

In 2011, Regional Planning Groups in Districts 1, 2, 4, 5, 6 and 7 conducted meetings to prioritize populations using the 2010 HIV/AIDS Epidemiologic Profile (Appendix B). The IACHA Administrative Committee completed the prioritization for Health District 3. As mandated by CDC, each district ranked Persons Living with HIV/AIDS (PLWH/A) as priority population number one. Ranked district priority populations for each health district are as follows:

District 1

1. PLWH/A
2. MSM [2]
3. IDU 20-29[3]
4. HRH
5. Age 30-49 all risk categories
6. Age 20-29 all risk categories

District 2

1. PLWH/A
2. MSM, White, ages 20-49[4]
3. IDU ages 20-29
4. Hispanic and General Population

District 3

1. PLWH/A
2. Hispanic (with an emphasis on Hispanic women)
3. MSM
4. HRH Women
5. Risk not specified (with an emphasis on men)

District 4

1. PLWH/A

2.0 MSM ages 18-35
2.1 MSM ages 36 and above
3.0 Injection Drug Users including MSM
4.0 High Risk Heterosexual Female
5.0 Risk not specified

[2] North Idaho MSM groups are largely underground. District 1 RPG members see a need to determine how to get the prevention message to this group.

[3] North Idaho and Spokane, Washington area are seeing increased IV drug users with increased heroin use; this should be a focus for education.

[4] It is believed that many MSM are late-testers with infection occurring in earlier age; the age was expanded to include 20-49 year olds with the intention of promoting early testing to prevent infection and testing after possible infection.

District 5[5]

1. PLWH/A
2. 20-49 yr old, white MSM
3. 20-39 Hispanic & White females
4. IDU and General Population

District 6[6]

1.0 PLWH/A

2.0 MSM 18-29 years of age

2.1 MSM 30-49 years of age

3.0 HRH Female

4.0 IDU

5.0 HRH Hispanic

District 7

1. PLWH/A
2. White men with an emphasis on young men up to age 29
3. MSM
4. Risk not specified (with an emphasis on males)
5. Hispanic

[5] In District 5, it is believed that many people within the age range of 20-39 are late-testers with infection occurring at earlier ages. They suggest expanding the age range to include 13-49 for white MSM, and 13-39 for Hispanic and White Females to promote early testing and education for preventing new infection.

[6] In District 6, testers have noticed that there are many "repeat testers" that know the risks they are taking, but continue to take risks and then come to get tested again. Often they say they "dodged another bullet" or "got lucky again." Among client cases managed by the Pocatello Part C clinic and District 6 Medical Case Managers, 15 cases of HIV positive clients were co-infected with Hepatitis C. There was insufficient data available at the meeting to help target interventions.

Section 7: Ryan White Funded Services: Prioritization and Gaps

A. Prioritization of Ryan White Services

In the Consumer survey, respondents ranked the importance of Ryan White services. Dividing the state into three regions, the results are as follows:

Northern Region (Districts 1 and 2)

1: HIV medical care
2: Payment for ARVs
3: Critical Ryan White services regarded as having equal importance:

- Payment for other medications
- Medical case management
- Dental care
- Mental health care
- Social support groups
- Help paying for health insurance premiums/co-pays
- Education about preventing HIV transmission
- Help paying for HIV diagnostic and monitoring labs
- Help paying for housing/emergency food

Southwest Region (Districts 3, 4 and 5)

1: HIV medical care
2: Payment for ARVs
3: Critical Ryan White services regarded as having equal importance:

- Payment for other medications
- Medical case management
- Dental care
- Mental health care
- Help paying for health insurance premiums/co-pays
- Outpatient substance abuse service
- Education about preventing HIV transmission
- Help paying for HIV diagnostic and monitoring labs
- Help paying for housing/emergency food
- Payment for transportation to medical care

Southeast Region (Districts 6 and 7)

1: HIV medical care
2: Payment for ARVs
3: Critical Ryan White services regarded as having equal importance):

- Payment for other medications
- Medical case management
- Dental care
- Help paying for HIV diagnostic and monitoring labs
- Help paying for housing/emergency food
- Payment for transportation to medical care

Based on results from the survey of providers, the following services are most critical to HIV care in Idaho:

a. Doctor visits/labs
b. HIV drug assistance
c. Medical Case Management
    i. Without being linked to MCM, the client cannot receive services or know that services are available
    ii. Provide standardized training for MCMs to ensure ability to help clients navigate eligibility requirements
d. Medical transportation
e. Addiction and Mental Health services
f. Oral health

B. Identified Gaps in Ryan White Services

In the Consumer survey, respondents identified services that they needed but did *not* receive. Dividing the state into three regions, the gaps in services are as follows (a higher ranking indicates a greater need; "AND" indicates an equal ranking):

Northern Region (Districts 1 and 2)

1. Get emergency payments for housing
2. Attend a support group
3. Get emergency food voucher AND See an eye doctor
4. Get help applying for Medicaid AND Get help applying for Medicare AND Get help applying for private insurance AND Talk to HIV+ peer advocate

Southwest Region (Districts 3, 4 and 5)

1. See an eye doctor
2. Get help with health insurance premiums/co-pays AND See a dentist
3. Get emergency payments for housing
4. Get help applying for Medicaid AND Get help applying for private insurance

Southeast Region (Districts 6 and 7)

1. Attend a support group
2. See a dentist
3. See an eye doctor
4. Get help applying for a Medicare drug plan AND Get help applying for disability AND Get help applying for private insurance AND Get help paying for utilities AND See a mental health counselor AND Talk to HIV+ per advocate

According to respondents of the provider survey, the following list represents gaps in Ryan White services (in no particular order):

- Homeless services
- Substance abuse/addiction services
- Transportation to medical appointments
- Payment for medical care
- Number of primary care providers
- Assistance with health insurance premium/co-pay

A panel of HIV+ individuals (MSM from 5 of the 7 health districts in Idaho) made the following recommendations:

1. Provision of eye care needs to be addressed
2. Provision of dental care needs to be addressed
3. Clients need to be made aware of their rights to choose providers (i.e., Medical Case Management, mental health, etc.)
4. Clients need help from medical providers to arrange transportation
5. IACHA needs to consider developing a speakers' bureau to provide HIV messages throughout the state
6. Increased focus on HIV education in schools
7. The HIVUSA-Idaho video needs to be more widely distributed in Idaho

Section 8: Specific Priorities Regarding Underserved Populations

Increasing funding for HIV testing will provide access to affected subpopulations and underserved communities by creating more opportunities for testing. Targeting testing resources to the highest risks groups provides more access for affected subpopulations including IDU, Hispanic, and High Risk Heterosexual (HRH) women. Many of the agencies providing MCM also provide HIV testing services. MCM agencies are located in each of the state's seven health districts.

Idaho's HIV Prevention and Care Programs are very small compared to many other states. Inherent in being a low incidence state is that funding levels are also low. Future funding levels for HIV Prevention is unknown; CDC may decide to continue to decrease funding to Idaho based on its low incidence status. With a decrease in funding the HIV Prevention program and IACHA may be tasked with targeting testing resources to the highest risk groups which include IDU, MSM, Hispanic, and High Risk Heterosexual (HRH) women to ensure that affected subpopulations are provided with needed services.

Another potential barrier is that Idaho does not have a law that requires HIV testing for all pregnant women, nor is there a policy, or law, that requires HIV testing in emergency departments in hospitals. Additionally, Idaho has geographically isolated cities and town with low population, meaning that that most agencies providing testing and care services are distanced from other programs providing the same services.

Underserved populations, their specific needs and essential activities are as follows:

1. MSM		
Priority Needs: • Repeat testers who continue to engage in risk taking behavior • Substance use other than IDU • Continued stigma against LBGT individuals		
Cultural Challenges: • Young MSM may not identify HIV as a serious disease • Certain areas in Idaho are highly influenced by religious entities and may lead to higher incidents of anonymous sex		
Essential Activities	**Responsible Parties**	**Timeline**
1. Condom distribution funded through the HIV Prevention program to target HIV positive, high-risk negatives, and the general population.	Service Provider Contractors: ▪ 7 local health departments ▪ 3 CBOs	01/01/2012 – 12/31/2012
2. Social Marketing, Media and Mobilization activities funded through the HIV Prevention program to increase awareness for health department and CBO testing events.	Service Provider Contractors: ▪ 5 local health departments ▪ 3 CBOs	01/01/2012 – 12/31/2012

3. Contract requirements for HIV clinic and community-based testing include requirement to test individuals at high risk including: a. MSM b. MSM/IDU c. Heterosexual IDU d. Sex partner at risk (Partner of IDU, Partner of MSM, Partner of HIV positive, Anonymous partner) e. Exchange sex for drugs/money/or something they need f. Diagnosis of sexually transmitted infection g. Sex with multiple partners	Service Provider Contractors: ▪ 7 local health departments ▪ 3 CBOs	01/01/2012 – 12/31/2012

2. Hispanic Women

Priority Needs:

- Latinas are disproportionately affected by HIV
- Rate of HIV infection is more than four times that of white women
- No law requiring pregnant women to be tested for HIV during pregnancy
- Late entry into prenatal care
- Health-care providers' perceptions that their patients are at low risk for HIV
- Lack of time for counseling and testing, particularly for rapid HIV testing during labor and delivery

Cultural Challenges:

- Undocumented immigrants' fears of disclosure
- Higher rates of STIs in Latina population
- Unaware of their male partner's risks
- Socioeconomic factors including poverty, migrant status, inadequate or no health insurance
- Language barriers

Essential Activities	Responsible Parties	Timeline
1. The Title X Family Planning Program implemented an HIV integration project in January 2011 with Idaho's seven health departments. All Title X clients are provided with free rapid HIV tests thereby increasing the number of previously untested clients.	Service Provider Contractors: 7 local health departments Title X Family Planning Program FPSHP HIV Prevention Program	01/01/2012 – 12/31/2012
2. Fund ¡Cuidate! (Evidence-based HIV Prevention for HIV-Negative Persons)	HIV Prevention Program Center for Community and Justice	01/01/2012 – 12/31/2012

3. Hispanic (Men and Women)		
Priority Needs: • Latinos are disproportionately affected by HIV • From 2008-2010, Hispanics consistently had more new AIDS diagnoses than HIV (this was not the case with any other race/ethnic group) • Health-care providers' perceptions that their patients are at low risk for HIV		
Cultural Challenges: • Undocumented immigrants' fears of disclosure • Higher rates of STIs in Latino population • Socioeconomic factors including poverty, migrant status, inadequate or no health insurance • Language barriers		
Essential Activities	**Responsible Parties**	**Timeline**
• Fund ¡CUÍDATE! (Evidence-based HIV Prevention for HIV-Negative Persons)	FPSHP HIV Prevention Program Center for Community and Justice	01/01/2012 – 12/31/2012
4. IDU		
Priority Needs: • MSM/IDU and IDU represent nearly 19% of newly diagnosed individuals between 2005 and 2009 • According to the consumer survey, barriers faced by IDU or "possible IDU" (meaning that HIV risk was not specified) include the following: 1. Cost for needed medical services (21.4%) 2. Fear of disclosing HIV status (21.4 %) 3. Did not know where to go for services (17.9%)		
Cultural Challenges: • Repeat testers who continue to engage in risk taking behavior • Continued stigma against IDU		
Essential Activities	**Responsible Parties**	**Timeline**
• Develop needs assessment for IDU and IDU/MSM	IACHA FPSHP HIV Prevention	2012

5. Homeless		
Priority Needs: • As of February 2012, there were 41 people on the HOPWA waitlist (with wait lists Regions 3, 4 and 5/6 of Idaho)		
Cultural Challenges: • Potentially increased sexual risk taking by using sex to gain access to resources • Increased stress that leads to greater progression of the disease • Difficulty in adequately obtaining and using ARVs • Adherence to treatment regimens very difficult due to lack of resources (food, water, refrigeration) • Many do not have health insurance and are generally in poorer health regardless of HIV Status		
Essential Activities	**Responsible Parties**	**Timeline**
1. Medical Case Managers make links to HOPWA program	MCMs	ongoing
6. HRH and General Population		
Priority Needs: • Partner's risk is unknown • Missed diagnosis because of lack of perceived risk		
Cultural Challenges: • Individuals claiming to have no risk • Risk based testing rather than routine opt out testing		
Essential Activities	**Responsible Parties**	**Timeline**
1. The Title X Family Planning Program implemented an HIV integration project in January 2011 with Idaho's seven district health departments. All Title X clients are provided with free rapid HIV tests thereby increasing the number of previously untested clients.	Service Provider Contractors: ▪ 7 local health departments Title X Family Planning Program HIV Prevention Program	01/01/2012 – 12/31/2012
2. The HIV Prevention Program contracts with Idaho's seven district health departments to provide clinical HIV testing. The program also contracts with five of the health departments and three CBOs to provide free HIV testing at community based testing sites that reach individuals who may have barriers to accessing clinic based testing.	Service Provider Contractors: ▪ 7 local health departments ▪ 3 CBOs HIV Prevention Program	01/01/2012 – 12/31/2012
3. The RWPB Program recently developed an updated brochure to be distributed to places individuals at higher risk for HIV may frequent, including but not limited to, hospital emergency rooms, infectious disease private clinics, homeless shelters and others.	Ryan White Part B Program	01/01/2012 – 12/31/2012

7. Incarcerated PLWH/A (county jails)

Priority Needs:

- County jails are increasingly taking inmates off of HIV medication regimens due to the high cost
- There is no way to identify clients in jail unless reported by family, friends, etc.
- Access to medical systems in county jails is different across the state
- It is difficult for clients to receive medications, lab testing, appropriate HIV care
- Prison inmates lack programs specifically designed to re-engage them in HIV care upon release

Cultural Challenges:

- County budgets are shrinking and historically have not been able to provide high cost medications
- The HIV training needs of medical providers serving county jails are unknown
- IACHA has no corrections representative on the council

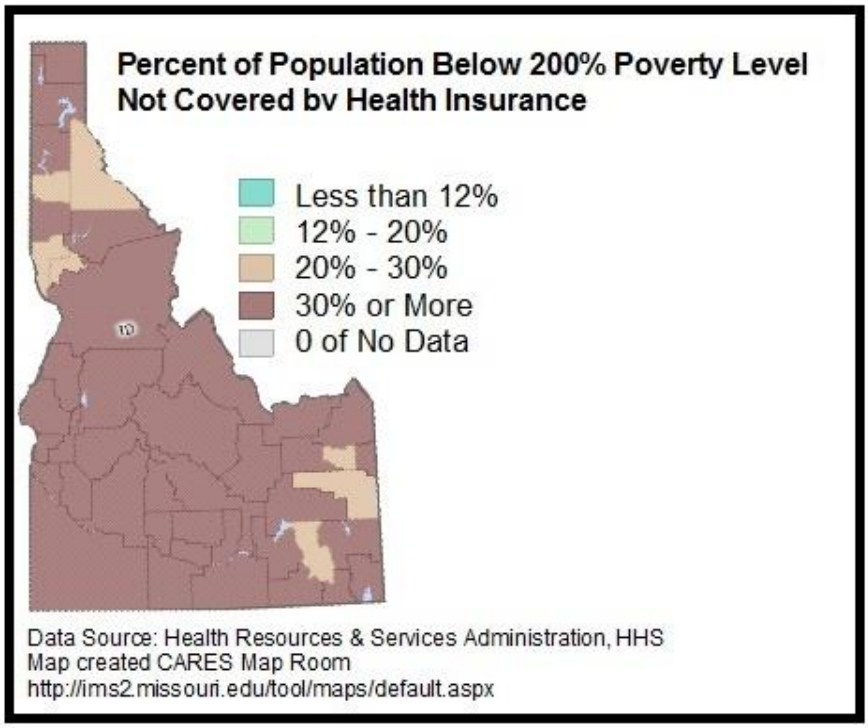
Essential Activities	Responsible Parties	Timeline
1. Ensure spot on ADAP waitlist for clients in jail	RW Part B Program	01/01/2012 – 12/31/2012

8. Uninsured Idahoans

Priority Needs:

- Respondents to the Idaho Ryan White Consumers Survey were asked to indicate the number of times they had seen a doctor in the past 12 months. While not statistically significant, one pattern did surface in our sample: Respondents with private or employer-sponsored health insurance were more likely to visit a doctor, one or two times, than those without insurance or some combination of Medicaid and/or Medicare.
- Most Idahoans living below 200% of poverty are not insured as noted in the map below.

Essential Activities	Responsible Parties	Timeline
2. Explore options for providing health insurance for ADAP clients	RW Part B Program	01/01/2012 – 12/31/2012



The following table compares the general Idaho public to Idahoans receiving care funded by Ryan White programs.

Table 14. **Idaho Population Compared with PLWH/A Poverty Levels, and Insurance Coverage (2009)**

Column A	Column B	Column C	Column D	Column E	Column F
2009 Co-Morbid and Demographic Data	**Idaho Population Numbers**	**Percent of Total Morbidity**	**HIV Positive In Care Numbers**	**Percent of Total Morbidity**	**+/- Percent[1]**
Idaho Poverty Levels					
≤ to 100% FPL	208,980	13.72%	264	45.9%	+33.7%
101 – 200% FPL	326,190	21.41%	160	27.8%	+4.9%
201 – 299% FPL	331,929	21.78%	78	13.6%	-8.7%
≥ 300% FPL	656,619	43.09%	66	11.5%	-31.1%
Unknown	0	0	7	1.2%	+1.2%
Total	1,523,718	100%	575	100%	
Insurance Coverage					
Private[3]	472,000	30.9%	188	32.7%	-3.5%
Medicare	205,772	13.5%	116	20.2%	+7.7%
Medicaid	204,222	13.4%	74	12.9%	+3.0%
Other Public	412,476	27.0%	7	1.2%	-24.6%
No Insurance	231,905	15.2%	188	32.7%	+17.1%
Other/ Unknown	0	0	7	1.2%	+1.2%
Total	1,526,375	100%	580	100%	

Column C – Column E = Column F standard deviation.

[1]This is the percent deviation from the rates of individual measures in the general population.

[2]Diagnosed concurrently or after HIV diagnosis. Individuals may have had multiple STD report.

[3]Includes Private Insurance and Employment Based Insurance Coverage.

This method compares the number of PLWH/A with the number of PLWH/A enrolled in Ryan White Medical Case Management (MCM) and Ryan White Early Intervention Services Clinics or Part C. In Idaho, MCM and Part C clinics serve individuals with a variety of payer sources including, private insurance, Medicare, Medicaid and other public insurance. The Ryan White Part B Program in Idaho does not purchase insurance or wrap around any insurance plans other than Medicare Part D through our State Prescription Assistance Program, IDAGAP. In Column E, a negative percentage may indicate under representation while a positive percentage may indicate the specific population is well represented in Ryan White MCM and HIV Specific Medical Care.

Please note, there are several limitations to this method including:

- The number of PLWH/A reported living in Idaho is dependent on residency at time of initial case reporting to HIV Surveillance and is not sensitive to the current residence of the PLWH/A.

- HRSA Provided CAREWare Data Systems throughout the state are stand-alone systems and do not communicate with one another; possibly resulting in some duplication of Ryan White client numbers.

- The number of PLWH/A reported in the 2009 Epidemiological Profile only indicates age at the time of diagnosis, while CAREWare tracks current age for those in care. This effectively invalidates the age range comparison.

From the data reported in the above table, females are 6.5 percent more likely to be engaged in Ryan White Care Systems than males, Hispanics count for 17 percent of diagnoses while they only represent 10 percent of Idaho's population[7]. However, in 2009 rates of Hispanic individuals in care rose to 54.5 percent—an increase of 7.1 percent from 2008. Am. Indian/Alas./Pacific Islander category dropped from 6.7 percent more likely to be engaged in care in 2008 to 7.3 percent less likely to receive care in 2009 a 14 percent decrease. It is clear from the data, that PLWH/A residing in primarily rural and frontier health districts are seriously underrepresented in Ryan White Care Systems, while others living in metropolitan areas are over represented in care.

Idaho has only one Ryan White Part C funded health clinic within its borders, the Wellness Center in Boise. The Wellness Center also provides funding for a satellite clinic in Pocatello, Idaho, which serves the southeastern part of the state. Community Health Associations of Spokane (CHAS), HIV Clinic, serves the ten most northern counties of Idaho. North Idaho AIDS Coalition (NIAC) is Idaho's RWPB MCM provider for Health District 1 (Panhandle Health District I) and has the highest number of clients of any RWPB MCM agency. In Health District 2 (Idaho North Central District Health Department), Inland Oasis received a contract for MCM and Outreach Services on October 1, 2010. Outreach services are targeted toward finding persons who know their status but are not in care.

[7]Kaiser Family Foundation, State Health Facts, "Demographics and the Economy", May 6, 2010 (www.statehealthfacts.org).

Section 9. Description of Shortfalls in Healthcare Workforce

A. Training Needs

Training needs as identified as "very important" in the HIV providers' survey:

1. Addressing stigma in the community
2. HIV/AIDS prevention for positives
3. Medication adherence for HIV positives
4. Conducting hepatitis interventions

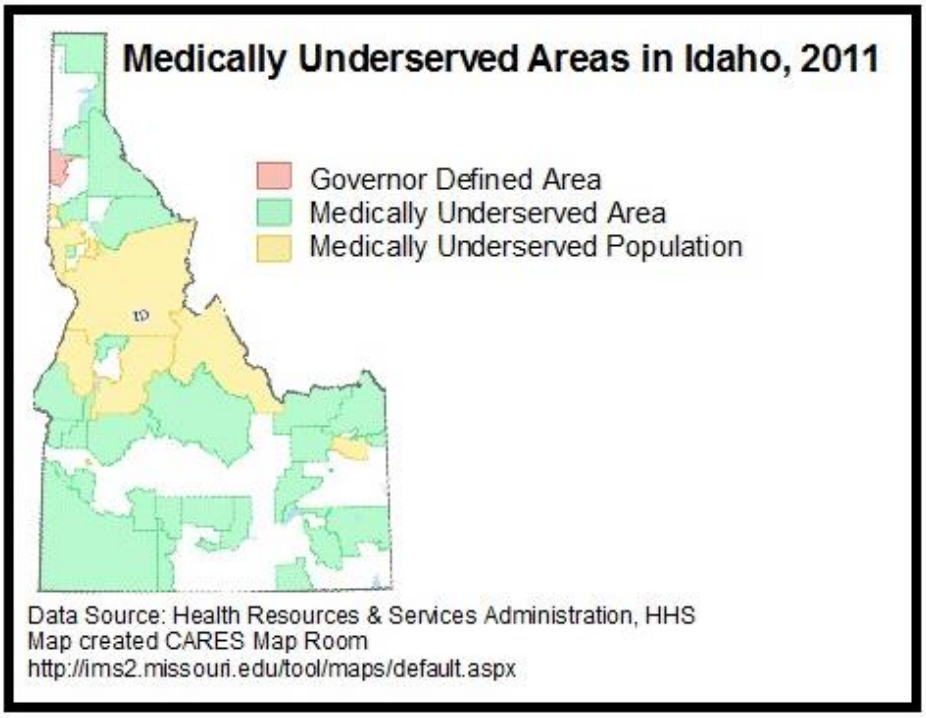
In regards to addressing cultural diversity, 27% of providers indicated that their agencies do not currently address cultural diversity.

B. Medically Underserved

The designation of areas or populations as medically underserved is based on an index of the following four variables:

1. Ratio of primary care physicians per 1,000 population
2. Infant mortality rate
3. Percent of the population with incomes below the poverty level
4. Percent of the population age 65 and over

Most of Idaho is considered medically underserved, as shown in the map below.



In addition, the entire state of Idaho is defined as a physician shortage area with some areas having very limited access to physicians. For people lacking insurance, there are few providers willing to provide care. For PLWH/A this lack of providers is increased due to the fact that some providers do not want to serve HIV+ clients or gain training about HIV for fear of the stigma associated with HIV. Ultimately, lack of insurance for many HIV positive individuals limits the willingness of existing providers to garner the training to provide HIV care.

For individuals living with HIV or AIDS, the need is much greater for infectious disease specialists. Infectious disease specialists in Idaho are located in the major population centers of the state (Coeur D' Alene, Caldwell, Boise and Pocatello). Boise has the majority of specialists and nearly all serve HIV positive clients.

C. HIV Training for Providers

In communication with the Northwest AETC, many providers indicate that if they had Ryan White funds to support their work and training, they would be more inclined to care for HIV+ individuals in their communities. They are hesitant to spend the resources, time, expertise, and funding to become trained in HIV care when there is a Ryan White clinic in Idaho.

1. Medical School

Idaho has no medical schools and a limited number of residency programs for doctors. While the Ryan White Part C-funded Wellness Center is a part of the Family Practice Residency of Idaho, limited time is spent in comprehensive HIV primary care.

2. Nursing Programs

There are several nursing programs in Idaho with limited exposure to HIV training. All district health department nurses receive HIV training through the "Fundamentals of Waived HIV Rapid Testing" course as mandated by the Idaho Department of Health and Welfare's Family Planning, STD and HIV Program.

3. Dental Programs

HIV-related dental training is limited in Idaho. The Idaho State University Department of Dental Hygiene program has standardized HIV testing for all clients, which has helped normalize HIV testing among the dental program.

D. Current Response to Health Care Needs

1. ECHO (Extensions for Community Healthcare Outcomes) Telehealth Programs

- Three sites (Pocatello, FMRI, Twin Falls) have a lead provider for Hepatitis C and HIV
- Rural providers have an opportunity to link with HIV specialists
- ECHO assists providers in skill building, case review, medication management

2. Family Medicine Residency of Idaho Wellness Center and Pocatello Family Medicine

- "Fundamentals of Waived HIV Rapid Testing" for all new residents
- "Fundamentals of Waived HIV Rapid Testing Update" for general staff annually
- Family Medicine Residency of Idaho was awarded an AETC grant to increase HIV primary care training to residents

3. Northwest AIDS Education Training Center (AETC) Preceptorship Program

- 400-500 providers are trained every year in Idaho
- The Northwest AETC preceptorship programs give health care providers the opportunity to work with expert clinician-preceptors, observing care and assisting the preceptor with direct patient care and treatment. All preceptorships are provided free of charge.

Section 10. HIV and Viral Hepatitis Jurisdictional Comprehensive Plan Development Process

A. Partners in the Process

To complete the tasks as designated by the SCSN Guidance and Community Planning Guidance, Idaho's Department of Health and Welfare's Family Planning, STD and HIV Programs (FPSHP) worked closely with the following entities:

1. Idaho Advisory Council on HIV and AIDS (IACHA)
2. Idaho's state HIV epidemiologist
3. Local public health districts
4. Medical Case Management agencies
5. Ryan White grantees in Idaho, including the Ryan White Part C Clinic, Wellness Center, and the Northwest AETC Local Performance Site, Idaho State University HIV Trainer

B. Data Research and Information Gathering

Idaho community planning revolves on a three year planning process. Years one and two (2010 and 2011) are spent gearing up and planning the submission of the state's combined HIV prevention and care comprehensive plan document.

IACHA used years 2010 and 2011 as planning years and focused primarily on the development of the SCSN and the HIV and Viral Hepatitis Jurisdictional Comprehensive Plan. At the beginning of 2011, FPSHP staff and the IACHA Coordinator created an inventory of past needs assessments, focus groups, IACHA panel presentations, and other existing qualitative and quantitative data. During the February 2011 IACHA meeting, members and guests reviewed prior comprehensive plan documents, Health and Resources Service Administration (HRSA) guidance for the SCSN and care specific Comprehensive Plan requirements and this inventory to determine risk groups in need of an updated assessment. IACHA continued to provide feedback and receive data results at each of the three yearly meetings and via minutes from monthly IACHA Administrative Committee conference calls.

Table 15: **Inventory of Available Data Sources as of January 1, 2011**

Document	Year of Completion	Geographic Area(s)
HIV+ Survey Results	2008	Statewide
Strategic Planning Reports	2009	D1, D3, D4, D5, D6, D7
Hispanic Needs Assessment	2008	District 3
MSM Needs Assessment	2004	Statewide
IDU Needs Assessment	2003	Statewide
Community Resource Inventory	2007	Statewide
Ryan White Funding for Core & Support Services	2010	Statewide
Priority Population Rankings	2011	Statewide
Idaho Epidemiology Profile	2010	Statewide
LGBT Resources in Boise	2009	Boise, Idaho

Upon reviewing the above resources, IACHA recommended that assessments be completed for MSM, IDU, Ryan White Consumers and HIV providers and that the Community Resource Inventory and the Quality Management data report be updated. The rationale and process are as follows:

1. *MSM*

   Reviewing the Epi Profile, IACHA members recognized the great burden of HIV on MSM. Consequently, IACHA's Research Committee worked with the HIV Prevention Program to organize a focus group of young gay men in Boise (ages 18-29) in February 2011. The outcome of the focus group was less than desired: seven men registered but only four participated. IACHA's Research Committee and the HIV Prevention Program also made efforts to administer an MSM survey online, but due to insufficient funding and time, the survey was not completed.

   In October 2011, IACHA organized a panel of HIV+ individuals to answer HIV care and prevention related questions. Seven MSM participated representing five of the seven health districts.

2. *Intravenous Drug Users (IDU)*

   Beginning in fall 2011, IACHA's Data Committee recommended that the HIV Prevention Program conduct a needs assessment of IDU and MSM/IDU due to the following reasons:
   1. A needs assessment of IDU has not been completed in Idaho since 2003
   2. According to the Epi Profile for 2005-2009, IDU as a risk group individually represents 8% of new infections, but when combined with MSM/IDU, represents nearly 19% of newly diagnosed individuals

3. Following this recommendation, IACHA's Research Committee in collaboration with the HIV Prevention Program, developed a survey to be distributed to IDU (both MSM and non-MSM). This survey was further refined during the February 2012 IACHA meeting. IACHA members continue to work with the HIV Prevention Coordinator to improve this survey and determine the best mode of distribution. The HIV Prevention program contracted with Closed Loop Marketing (CLM) to pilot the survey to take place late September 2012 and full implementation to occur October 2012. CLM will analyze the results of the survey and will provide a final report to IDHW's HIV Prevention program.

4. *Ryan White Consumers*

   In January 2012, IACHA and the Ryan White Part B Program developed and disseminated a survey to 435 (9 were returned by mail as undeliverable) consumers of HIV services (including consumers in all areas of Idaho, those receiving HIV medical care through the Veterans Administration or private providers, and recipients of Ryan White Part B, Part C and ADAP programs). In total 156 consumers responded to the survey (5 of which were not used due to incomplete information). The ultimate response rate was 37%. Please see Appendix G for HIV Consumers Results.

5. *Providers*

   In December 2011, IACHA and the Ryan White Part B Program developed and disseminated a survey to 39 providers of HIV services (including Medical Case Managers, Part C Clinic staff, mental health providers, private HIV specialists, the state HOPWA administrator, health department staff, hospitals, Emergency Rooms, Epidemiologists, Federally Qualified Health Centers, Community Based Organizations, and Community Action Programs). In total, 24 providers responded to the survey. Please see Appendix H for HIV Providers' Survey Report.

6. *Resource Inventory*

   With the assistance of contracted medical case management agencies, existing RPG members, Ryan White Part B and C staff from Idaho and Washington, and the contracted Quality Management Coordinator, a statewide inventory of resources was developed.

7. *Quality Management Program Data*

   Co-chairs of IACHA's Research Committee, Data Committee and Finance Committee also serve on the Idaho Quality Management Committee. This link helps maintain communication between the two committees. IACHA reviewed the 2011 Quality Management data during the February 2012 meeting (please see Appendix I for the 2011 QM Data Report).

C. Pulling the Information Together for the Comprehensive Plan

During the February 2012 IACHA meeting, workgroups formed to review all available data sets as described above to develop the Idaho HIV and Viral Hepatitis Jurisdictional Comprehensive Plan. The state provided the groups with guidance to identify disparities in care, access to services and service gaps. The groups focused on the following tasks:

1. Review data from a consumer perspective and identify service gaps and priorities
2. Review data from a provider perspective and identify service gaps and priorities
3. Review data to identify service gaps in various regions in Idaho

Each group provided a summary of their work and identified recommended goals to be included in the SCSN and Comprehensive Plan. A fourth group met during the IACHA meeting to continue to refine the IDU needs assessment and address state survey requirements.

Following the February IACHA meeting, the IACHA Coordinator, FPSHP staff and IACHA Administrative Committee reviewed the recommendations and began to piece together the Jurisdictional Comprehensive Plan. During the May 2012 IACHA meeting, members further refined the goals as presented in the Plan. Beginning on June 1, consumers had an opportunity to review the finalized Plan and submit comments to the state. The finalization of the HIV and Viral Hepatitis Jurisdictional Comprehensive Plan will be submitted to HRSA by June 15, 2012 to CDC by September 28, 2012.

D. Successes and Challenges of the 2009-2011 Comprehensive Plan

An evaluation of successes and challenges IACHA faced when implementing the 2009-2011 HIV Care and Prevention Comprehensive Plan is included as Appendix M.

Section 11. Idaho's Healthy People 2020 Strategy

Healthy People 2020 is a national initiative led by Health and Human Services that sets priorities for all HRSA programs. Healthy People 2020 established new 10-year national objectives for improving the health of all Americans. The initiative has two major goals: (1) to increase the quality and years of a healthy life; and (2) eliminate our country's health disparities. The program consists of 28 topic areas and 467 objectives. One of the topic areas is HIV, which includes specific objectives.

The HIV-related objectives identified in the Healthy People 2020 initiative reflect the National HIV Strategy, as do the goals developed by IACHA. The following are specific Ryan White services that will assist in achieving the Healthy People 2020 goals.

Service: ADAP **Goal**: Ensure Access to HIV medications, HARRT, and improve health outcomes	
Healthy People 2020 Objectives	**Objective 13-1**, Reduce AIDS cases
	Objective 13-2, Reduce AIDS cases among MSM
	Objective 13-3, Reduce AIDS cases in females and Intravenous Drug Users
	Objective 13-4, Reduce AIDS cases in MSM and IDU
	Objective 13-5, Reduce new HIV cases in Idaho
Service: Outpatient Ambulatory Medical Care **Goal**: Ensure access HIV treatments consistent with PHS treatment guidelines	
Healthy People 2020 Objectives	**Objective 13-12**, Increase the number of screening labs performed for common STDs
	Objective 13-13, Increase testing, treatment, and prophylaxis as per PHS Treatment Guidelines

Section 12. Idaho's HIV/AIDS Strategy

Aligning with the National HIV/AIDS Strategy, IACHA is dedicated to following three focus areas:

1. **Reduce HIV incidence**
2. **Increase access to care and optimize health outcomes**
3. **Reduce HIV-related health disparities**

Please see Attachment The following tables provide the framework for which IACHA and the Family Planning, STD and HIV Programs will operate in the next three years.

To view Idaho's HIV/AIDS Strategy, please see Appendix N.

Section 13. Idaho's Viral Hepatitis Strategy

The CDC provides Idaho with funding for a .25 FTE Viral Hepatitis Prevention Coordinator. IACHA is dedicated to supporting the Viral Hepatitis Program. As such, IACHA endorses the following four goals set to help prevent and treat viral hepatitis in Idaho:

GOAL 1: Increase the number of high risk individuals screened for Hepatitis C infection in Idaho

GOAL 2: Enhance the referral information provided to individuals receiving an HCV reactive result through screening

GOAL 3: Enhance integration of viral hepatitis into the work of current HIV service providers

GOAL 4: Improve overall viral hepatitis awareness throughout Idaho

Idaho's strategy for the prevention, care, and treatment of viral hepatitis mirrors the United States Health and Human Services (HHS) Action Plan Priorities, which include:

1. Educating Providers and Communities to Reduce Viral Hepatitis-Related Health Disparities - Confront viral hepatitis by breaking the silence.
2. Improving Testing, Care, and Treatment to Prevent Liver Disease and Cancer - Take full advantage of existing tools.
3. Strengthening Surveillance to Detect Viral Hepatitis Transmission and Disease - Collect accurate and timely information to get the job done.
4. Eliminating Transmission of Vaccine-Preventable Viral Hepatitis - Take full advantage of vaccines that can prevent hepatitis A and B.
5. Reducing Viral Hepatitis Caused by Drug Use - Stop the spread of viral hepatitis associated with drug use.
6. Protecting Patients and Workers from Health Care-Associated Viral Hepatitis - Quality health care is safe health care.

Idaho recognizes the national goals within the HHS Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis Updated, 2014–2016. Viral Hepatitis Prevention Coordination services offered through the Department of Health and Welfare will assist in achieving the following national goals:

- Increase the proportion of persons who are aware of their HBV infection from 33% to 66%.
- Increase the proportion of persons who are aware of their HCV infection from 45% to 66%.
- Reduce the number of new cases of HCV infection by 25%.
- Eliminate mother-to-child transmission of HBV.

Section 14. Monitoring Process

IACHA has three face-to-face meetings each year. At each of these meetings, a portion of the agenda will be spent reviewing the status of the Jurisdictional Comprehensive Plan goals. IACHA understands

that these goals are fluid and may need to be reevaluated, refined or altered in the coming years. In particular, it is difficult at best to plan action steps for a full three years, when many of the components of the HIV Prevention and Care Programs are in flux.

Idaho's plan to monitor and evaluate progress in achieving the jurisdictional comprehensive plan goals, identifying and meeting challenges in the process is as follows:

- At each meeting, the three subcommittees will review and update the Strategy to assess the progress of goal attainment, action step completion, and identified challenges and steps to meet those challenges.

- HIV Prevention testing data, Ryan White and ADAP service utilization data will be monitored internally and reported during IACHA meetings.

- To determine the impact of the Early Identification of Individuals with HIV/AIDS (EIIHA) initiative, an annual update detailing the priority needs and progress on essential activities of the priority populations will be completed according to the required EIIHA data points.

- Service utilization and clinical data collected from RWPB and ADAP clients will be monitored and updated on an annual basis. Ryan White Part B and C service utilization will be provided to IACHA each spring, in order to review progress on goals. ADAP client level data reporting will begin according to the HRSA timeline and guidance. When the data becomes available, it will also be provided in a useful format with Part B and C level data.