

*2009-2011 Statewide Coordinated Statement of Need
and Comprehensive Strategic Plan*

Ryan White Part B Services for the State of Oklahoma



Oklahoma State
Department of Health
Creating a State of Health

Prepared by:

The Oklahoma State Department of Health

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This is a copy of the Integrated 2009-2011 Oklahoma SCSN and Part B Comprehensive HIV/AIDS Care and Services Plan produced by the Oklahoma State Department of Health, HIV/STD Service with the assistance of the Oklahoma HIV Planning Council (OHPC). Copies may be obtained by contacting the OSDH HIV/STD Service at (405) 271-4636.



Oklahoma State Department of Health
Creating a State of Health

Over recent years the epidemiology and picture of HIV/AIDS in Oklahoma has changed. A new HIV incidence study shows us that the number of new HIV infections is higher than previously thought. Also, persons are living longer and healthier due to advances in medical treatment for HIV. These facts create significant challenges for service providers. Not only are there more people who are in need of services, but there are significant numbers of HIV infected persons whose needs are not met, often because they have yet to be identified as HIV positive, or possibly because they have competing needs for survival.

Periodic assessment of need and resources available to meet the need is necessary to determine how best to strengthen services. This assessment is a time to bring all parties to the table and a time to reinforce that we are all in it together. Pooling resources and collaboration between agencies is a tried and true means to accomplish goals.

The Oklahoma State Department of Health is committed to collaboration in order to bring people in need into care. We are pleased to provide this document as a guide for improving health to Oklahomans who are infected with HIV disease.

Sincerely,

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This document is the result of countless hours of participation, input and effort by members of the HIV/AIDS community committed to improving the HIV care delivery system and advancing the treatment of ALL persons living with HIV/AIDS in Oklahoma. The integrated Statewide 2009-2011 SCSN and Comprehensive Plan provides for means to understand the severe need groups that constitute the epidemic, with the ability to reduce disparities in access to health care services and prevent further HIV infection. This plan reflects the diversity of the State of Oklahoma with specific details given about geographic composition, ethnic and racial backgrounds, income and insurance levels and the burden of HIV disease and other co-morbidities that challenge the delivery of HIV primary medical care and support services in the planning area. We wish to thank all those who volunteered their time and informed input, and we acknowledge their commitment to continuously improve the continuum of care in the State of Oklahoma. Our intent is to continue to refine the care delivery system and facilitate the optimal engagement with and use of all available services by all those living with HIV disease in Oklahoma. The 2009-2011 SCSN and Comprehensive Plan represents the efforts of many individuals. Thanks go to participating Ryan White Parts B, C, D and AETC providers and agencies, representatives from other State agencies, representatives from Indian Health Service agencies and community-based service organizations, and individual members of the Oklahoma HIV Planning Council (OHPC). Special thanks go to all the PLWHA who contributed to this statewide planning effort.

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- Section I: (Where We Are Now: What is Our Current System of Care?);**
- Section II: (Where Do We Need to Go: What System of Care Do We Want?);**
- Section III: (How Will We Get There: How Does Our System Need to Change to Assure Availability and Accessibility of Core Services?); and**
- Section IV: (How Will We Monitor Our Progress: How Will We Evaluate Our Progress in Meeting Our Short- and Long-term Goals?).**

Section I: (Where We Are Now: What is Our Current System of Care?) includes an overview of the State of Oklahoma, a summary of Needs Assessment findings from the Client Survey, with identified needs, uses, barriers and gaps for the ‘In Care’ and ‘Out of Care’ populations. An overview of the epidemic is described with emphasis on disparately impacted populations, and a resource inventory is included, with a review of existing barriers to care and challenges to service delivery in the State discussed.

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Section II: (Where Do We Need to Go: What System of Care Do We Want?) describes the Ideal Continuum of Care and contrasts it with the existing Care Continuum. Section outlines a shared vision and shared values for system changes with operational definitions of the continuum of care and core services.

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Section III: (How Will We Get There: How Does Our System Need to Change to Assure Availability of and Accessibility to Core Services?) Section III links Sections I and II with Goals & Objectives for the triennial period derived from our Guiding Principles and Shared Values. The current Planning Process is examined in an effort to improve the care system. Goals and Objectives relate to increasing access and reducing disparities and converting the number of “Aware but Not in Care” to “In Care” by resolving identified barriers to and gaps in care. These aim to attain a Continuum of Care closer to the Ideal.

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EXECUTIVE SUMMARY

HRSA's primary goals are to achieve '100% access, 0% disparity' for all PLWHA. The Ryan White Treatment Modernization Act emphasizes quality management, oversight and accountability, consistent with the reauthorization principles that include: 1) a focus on primary care and treatment; 2) efforts to increase flexibility to target resources; and 3) ensuring accountability using sound fiscal management and tools to evaluate program effectiveness.

Oklahoma's integrated SCSN and Comprehensive HIV Services Plan provides a road map for the statewide development of systems to address the care needs of low income People Living with HIV/AIDS and their affected families. The combined SCSN and Planning document comprehensively describes the needs, gaps and barriers to care and services by In care and Out of Care PLWHA; responsively addresses the disparities in HIV care; improves access and availability of services within affected subpopulations and historically underserved communities; establishes and supports an ideal HIV care continuum; coordinates Ryan White and non-Ryan White resources (local and federal) in the planning area; and speaks to the needs of the 'late to care' and 'out of care' individuals.

The vastness of the service area and the diversity of the epidemic in the State of Oklahoma pose substantial challenges for planners and providers, alike, as they strive to create a system that provides high quality primary medical care and supportive services for PLWHA. The HIV epidemic in Oklahoma as of 2007 includes a total of 6,005 PLWHA (3,195 PLWA and 2,810 PLWH). Whites still carry the majority of cases among all the races, comprising 55% of new HIV cases, 51.3% of new AIDS cases, 47.9% of AIDS prevalence, and 40.5% of HIV prevalence. Blacks are disproportionately impacted, comprising 32% of new HIV infections, 26% of new AIDS cases, 15.3% of HIV prevalence, and 15% of AIDS prevalence, while making up only 7.8% of the general population. Hispanics, while comprising only 6.9% of the general population, also evidence an increasingly disparate impact, making up 7.1% of new HIV cases, 10.5% of new AIDS cases, and 3.4% and 3.8% respectively, of the living HIV and AIDS cases. Youth, ages 15-24 years comprise 22% of the HIV prevalence, and Youth, ages 20-29 years make up 34% of the new HIV cases. Females are increasingly impacted by HIV/AIDS, comprising 19.1% of HIV prevalence and 18% of new HIV cases. The total number of living HIV/AIDS cases attributable to MSM risk behavior among all races and age groups is 61.3% (including MSM and MSM/IDU). The total number of PLWHA whose behavioral risk includes IDU is 22.9% (including IDU and MSM/IDU).

Oklahoma is characterized by extreme poverty and many of its citizens are uninsured. The epidemic in Oklahoma is increasingly impacting minorities, women and youth, including some of our most marginalized citizens. The expansive rural areas result in substantial distances to travel for specialized health care without a supporting public transportation infrastructure. Planning care for Oklahoma's PLWHA requires awareness of the unique demographics and geography of the service area, along with the evolving trends in HIV disease, and the medical and social responses to it.

Statewide needs assessments identify service barriers and gaps in the HIV service delivery system. At the state level, the *2006 Statewide Coordinated Statement of Need (SCSN)* identifies five gaps in the continuum of care for the following service categories: 1) Oral Health care; 2) Housing assistance; 3) Medications; 4) Medical Transportation; and 5) Third Party/Health insurance benefits. (*OSDH, 2006*)

The Oklahoma State Department of Health estimates that 48% of the Oklahomans who know they are HIV positive have not made a primary medical care visit in the past year, indicating that an unacceptably high proportion of Oklahoma PLWHA needs are going unmet. According to a 2008 study of unmet need, Youth, ages 13-19 years who are living with HIV bear the greatest disproportion among the populations with unmet need at 73%; followed by Lawton area PLWHA at 66% with unmet need. PLWH Youth, ages 20-29 years evidence an Out of Care fraction of 63%; Hispanics 64%; Blacks 52% and Rural PLWHA evidence a 54% Out of Care fraction. Of those persons living with AIDS, Youth ages 13-19 years demonstrate a 45% level of unmet need, followed by Youth, ages 20-29 years at 42%. PLWA, ages 30-39 years demonstrate a 41% Out of Care fraction.

The Oklahoma HIV Planning Council has prioritized the following risk behavior groups to receive priority HIV prevention interventions in 2009: 1) HIV Positive Persons; 2) MSM (African American, White, Hispanic, Native American, Youth ages 13-24 years and rural MSM); 3) Females, ages 13 and above, at risk for heterosexual transmission and/or IDU risk behavior and or other transmission risk (with special emphasis on African American females, females ages 13-49 and 50+ of all races); and 4) IDU of all ages and races/ethnicities.

The Oklahoma Part B continuum of care over the past five years has been evolving from a largely social services case management model of care to a robust and responsive medical model of HIV care and services. Primary medical care is supported by a strong HIV medication infrastructure and by a wide range of supportive services, including mental health and substance abuse treatment services, medical and social services case management, oral health care, medical transportation, and other services essential to keeping PLWHA in care.

The Oklahoma HIV Planning Council (OHPC) has identified an ideal continuum of care consisting of both core medical services and the supportive services that help PLWHA to access, engage with and remain in care. All of these services exist in the context of the five key goals of the Health Resources and Services Administration (HRSA): 1) improve access to care; 2) eliminate health disparities; 3) improve the quality of care; 4) assure cost effectiveness, and 5) improve health outcomes.

The OHPC and its committees have worked with local planning area collaborators to identify the means by which the Oklahoma State Department of Health will meet the key goals of the SCSN and Comprehensive Plan, through rigorous attainment of the following objectives:

- 1) Increase access to care by 10% annually for PLWHA populations in the State.
- 2) Reduce lag time from testing to care entry by at least 5% annually.

- 3) Reduce level of Unmet Need by 10% over the next three years.
- 4) Evaluate barriers to existing MH/SA services and address HIV disease and co-morbidity management among new and returning Part B clients.
- 5) Ensure parity of urban/rural service delivery, including assurance of access to transportation services by rural residents.
- 6) Increase by 5% annually the number of Part B clients retained in HIV primary medical care and services.
- 7) Reduce the further spread of HIV infection through continued secondary prevention efforts in case management and primary care settings.
- 8) Implement and evaluate the 2009 system-wide Quality Management Plan, with an emphasis on PCP prophylaxis, Oral health visits, and Case Management documentation of care, reflective of all HRSA/HAB clinical performance measures.
- 9) Strengthen medical and non-medical case management quality care and systems to enhance access/retention in care.
- 10) Ensure adequate levels of medical and non-medical case management to support access into and retention in primary medical care and services.
- 11) Implement and evaluate system-wide Client Level Data Reporting process.
- 12) Ensure the effective utilization of Part B Funds to fill service Gaps and reduce disparities in care.
- 13) Increase by 10% annually the achievement of improvements in key health outcome indicators, as evidenced by individual level client data and aggregate provider data.
- 14) Ensure the Oklahoma Part B planning process has wide community participation and is consumer driven.

In collaboration with the Oklahoma State Department of Health, the Oklahoma HIV Planning Council assumes responsibility to implement, monitor and evaluate its SCSN and Comprehensive Plan, which together will serve as a roadmap and touchstone for HIV/AIDS planning and service delivery in Oklahoma for the next three years.

OVERVIEW OF OKLAHOMA'S 2009-2011 SCSN AND COMPREHENSIVE PLAN

2009 SCSN and Comprehensive Plan Update Process

In early January 2009, OSDH convened an all day workshop as part of the Oklahoma HIV Planning Council to update the SCSN and formulate the Comprehensive Plan. The Planning Council membership and invited guests included a wide representation of Ryan White Providers among all Parts, numerous PLWHA, Medical Providers, and representatives from other State agencies, Indian Health Services agencies and community-based service organizations.

The workshop began with HRSA legislative guidance and policy updates and a review of the following information:

- 2006 Statewide Coordinated Statement of Need for Oklahoma
- 2007 Oklahoma Epidemiologic profile
- 2006/2007 Statewide In Care and Out of Care Needs Assessment Study Findings
- 2008 Unmet Need Study
- Updated Resource Inventory
- 2008 RW Part B and Part C Client Demographics
- Under-represented populations in Part B and Part C funded services
- Disproportionately impacted PLWHA populations in Oklahoma
- Emerging PLWHA populations in Oklahoma
- Report of community-based services and resources that are not funded by Ryan White

The second component of the workshop was an interactive dialogue among participants to identify significant statewide care issues in the following areas:

- Existing service delivery and care needs
- Unmet needs
- Service Gaps and Barriers
- Emerging trends (disproportionately impacted and emerging PLWHA populations, third party reimbursement trends and new resources, and how to facilitate greater client access to resources through care coordination activities, etc)
- Cross cutting issues (transportation, data management, training needs, improving communication and information sharing among all RW providers, etc.)
- Challenges (access, linkages, resource management, quality management, etc.)

The final module of the workshop was the development of a work plan for the State of Oklahoma including goals, activities, responsibilities and timelines for achieving the goals.

For the upcoming 2009-2011 project period, Oklahoma opted for HRSA's alternative of producing a single document that addresses both the Statewide Coordinated Statement of Need (SCSN) and the Comprehensive Strategic Plan requirements. Sections I & II of this document satisfactorily fulfill HRSA's requirements for the Statewide Coordinated Statement of Need, while Sections I, II, III and IV respond to the HRSA requirements for the Comprehensive Plan. The combined 2009-2011 Oklahoma Statewide Coordinated Statement of Need and Comprehensive Plan reflect the important changes in the Ryan White Treatment Modernization Act.

The 2009-2011 Oklahoma Statewide Coordinated Statement of Need and Comprehensive Plan is a combined document that comprehensively updates the previous SCSN and Comprehensive Plan, which covered the years 2006 - 2008. Each of the document's sections and how each section relates to the integrated elements of the SCSN and Comprehensive Plan are briefly described below.

Section I of the updated and combined SCSN and Comprehensive Plan contains introductory information, explaining what data sources were reviewed and how the current SCSN and Plan were developed. An overview of the Ryan White Part B Continuum, other Ryan White Program Parts across the State, and the available non-Ryan White resources for HIV care and services are discussed.

In Section II, the summary of the Oklahoma Epidemiologic Profile describes the characteristics and trends of the Oklahoma HIV/AIDS epidemic including a detailed description of the disproportionately impacted populations, the emerging PLWHA populations in Oklahoma, and under-represented populations in Part B and Part C HIV care and treatment services. This section also includes a discussion of unmet need for HIV-related medical care in Oklahoma.

Section II provides a comprehensive summary of the most recent Statewide needs assessments among In Care and Out of Care PLWHA populations, with stratification by severe need group (SNG) and geographic region of residence. The Needs, Gaps and Barriers to care are documented by SNG and geographic region.

In Section III, there is an overview of the crosscutting issues, barriers to care, critical gaps, emerging trends and recommended strategies to address these issues. Section III describes the overall goals for improving the overall Statewide HIV service delivery system, derived from the combined SCSN and Comprehensive Planning process. Section III also details the specific measurable objectives and action steps to guide the implementation of the Plan over the next three years.

Section IV describes the evaluation strategies that will be used to monitor the statewide progress in achieving the stated goals and objectives of the 2009-2011 SCSN and Comprehensive Plan, along with specific plans for addressing the quality management, clinical data and outcomes evaluation activities to be implemented over the next three years.

SECTION 1: WHERE ARE WE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?

Introduction to Section I

The Ryan White Treatment Modernization Act of 2006 requires that grantees conduct activities to enhance coordination across Ryan White Program Parts in the development of the Statewide Coordinated Statement of Need and the Comprehensive Plan. The legislation states: "...that the public health agency administering the grant for the State will periodically convene a meeting of individuals with HIV/AIDS, members of a Federally recognized Indian tribe as represented in the State, representatives of grantees under each part under this title, providers, and public entity representatives for the purpose of developing a SCSN."

The purpose of the SCSN is to provide a collaborative mechanism to identify and address the significant HIV care issues related to the needs of PLWHA, and to maximize coordination, integration and effective linkages across the Ryan White Program Parts. HRSA strongly encourages Grantees to use the SCSN to support Statewide HIV Planning, including using the goals outlined in the SCSN to set measurable objectives, to inform resource allocation decisions, create a Statewide Comprehensive Plan, as well as conduct other activities to enhance the statewide delivery of HIV care and services. The Comprehensive Plan must include data from local needs assessments and/or statewide needs assessments that meet the legislative requirements. These identified needs, particularly HIV-related core services needs, should be a primary impetus for developing the Comprehensive Plan, guiding the State in setting goals, identifying clinical performance measures, and making resource allocations. HRSA's primary goals are to achieve '100% access, 0% disparity' for all PLWHA. The Ryan White Treatment Modernization Act emphasizes quality management, oversight and accountability, consistent with the reauthorization principles that include: 1) a focus on primary care and treatment; 2) efforts to increase flexibility to target resources; and 3) ensuring accountability using sound fiscal management and tools to evaluate program effectiveness.

To meet these mutually complimentary objectives, Oklahoma combined the statewide assessment of need and statewide planning processes which culminated in the joint development of the 2009-2011 Oklahoma SCSN and Comprehensive Plan. The Oklahoma SCSN and Comprehensive HIV Services Plan provide a road map for the development of systems to address the care needs of low income People Living with HIV/AIDS and their affected families. The integrated SCSN and Plan addresses disparities in HIV care; improves access and availability of services within affected subpopulations and historically underserved communities; establishes and supports an ideal HIV care continuum; coordinates resources (local and federal) in the planning area; and speaks to the needs of the 'late to care' and 'out of care' individuals.

This plan is concerned with effectively responding to the needs of people living with HIV/AIDS (PLWHA) in the State of Oklahoma. In addressing the life-long needs of residents who are HIV positive, planners must first understand the environment that surrounds them. This chapter describes the: the geography and population of the area served by the Oklahoma State

Department of Health Part B funds as well as other Ryan White and non-Ryan White funding sources. The State’s five MSAs are described, followed by a description of the demographic and socio-economic composition of the area’s residents. This section also includes a review of the regional and state HIV epidemics, the results of recent needs assessment activities, identification of service gaps and barriers, and concludes with a discussion of the Ryan White provider profile, local resource inventory and a description of the existing continuum of care in Oklahoma.

CHAPTER 1: Description of the State of Oklahoma

The Oklahoma Service Area comprises the entire state. Oklahoma, located in the geographic center of the United States, ranks 18th in land area among the 50 states, covers approximately 70,000 square miles, and is divided into 77 counties. A population density of 50.3 persons per square mile reflects Oklahoma’s rural character. Oklahoma is characterized by three (3) major urban areas; Oklahoma City, Tulsa and to a lesser degree, Lawton. These three MSAs comprise 64% of Oklahoma’s population, while 36% reside in non-metropolitan rural and deeply rural areas, including twelve actual ‘frontier’ counties still existing in the northwestern part of the state with less than 3,000 persons residing in each county. Racial/ethnic profiles are unique in Oklahoma due to the high percentage of Native Americans residing within the State.

According to the U.S. Census Bureau, (2006), Oklahoma has an estimated population of 3,579,212 which is an increase of 35,770, or 1.0%, from the prior year and an increase of 128,558, or 3.6%, since the year 2000. (2008 Wikipedia: Demographics of Oklahoma)

Table 1. Oklahoma Demographics By Race/Ethnicity	White	Black	AIAN*	Asian	NHPI*
2005 (total population)	82.20%	8.55%	11.31%	1.92%	0.16%
2005 (Hispanic only)	6.10%	0.24%	0.35%	0.06%	0.03%
Growth 2000–05 (total population)	2.33%	5.76%	2.04%	15.49%	9.51%
Growth 2000–05 (non-Hispanic only)	0.50%	5.17%	2.22%	15.19%	9.47%
Growth 2000–05 (Hispanic only)	32.58%	31.44%	-3.27%	25.17%	9.69%
* AIAN is American Indian or Alaskan Native; NHPI is Native Hawaiian or Pacific Islander (Source: 2008 Demographics of Oklahoma, Wikipedia)					

The five largest ancestry groups in Oklahoma are German (14.5%), American (13.1%), Irish (11.8%), English (9.6%), African Americans (8.1%) and Native Americans (7.9%, with Cherokees as the largest tribe, although the total number of Oklahoma's American Indian tribes is 50). Descendants of these people still live in Oklahoma today. There are estimates that over a quarter of Oklahoma's white (and Black) populations have a certain degree of American Indian ancestries. This in part explains the perception that American Indians are underrepresented in the numbers of reported HIV and AIDS cases. Oklahoma has the second highest number of Native Americans in the country estimated at 395,219 as of 2003. Only California has a higher American Indian population at 682,720. [*Oklahoma Chamber of Commerce. Oklahoma Chamber of Commerce. March 2007*]. Oklahoma also has the second highest concentration of Native Americans in the nation with 11.4% of the state's population, topped only by Alaska at 19% of that state's population. According to the Bureau of Indian Affairs (BIA), the state is home to more than 350,000 registered **American Indian** tribal members and includes not only members of its 39 land-based tribes, but also members of 150 tribes who were urged by the BIA to relocate to the state in the 1950's and 1960. The majority of Oklahoma's American Indian population resides in the eastern corridor of the state.

African Americans are a plurality in Lawton and Oklahoma City, but have their own communities in Central parts of the state and within the historic Black community of Greenwood inside the city of Tulsa. Oklahoma City has the largest Asian American population in the state. In fact, Oklahoma City ranks 12th highest in the nation for the percentage of its population that is Vietnamese (1.6%). Oklahoma City's gentrified Asian District grew from Vietnamese American immigrants who were relocated to the state in the 1980s. While many of the neighborhood's residents and businesses are Vietnamese American, significant numbers of Chinese, Thai, Filipino, and Koreans also live, work, and study in the Asian district and surrounding area. (2008 *Wikipedia: Demographics of Oklahoma*)

A few western counties have significant Mexican American populations. Since 1990, immigrants from Latin America have arrived in large numbers; with most living in enclaves in sections of Tulsa and Oklahoma City. Mexican Americans settled in urban areas and western counties as farm laborers in much of the 20th century. From the years 1990 to 2005, the Hispanic percentage has grown over 500 percent through high immigration rates. (2008 *Demographics of Oklahoma, Wikipedia*)

African Americans are the most disproportionately impacted of the racial/ethnic minorities for their rate of HIV and STIs in Oklahoma and experience high rates of unintended pregnancy, teen births and infant mortality. **Hispanics** constitute the fastest growing minority population in Oklahoma, and are the second most disproportionately impacted by HIV infection and first for teen births, premature births and inadequate prenatal care. This racial/ethnic and geographic distribution of the largely rural service area populations is highly pertinent to the provision of HIV prevention and care services in Oklahoma. Racial and ethnic minorities are projected to reach 50% of the entire Oklahoma population by 2010-2015, which is expected to substantially

increase the disparate impact of persons living with HIV/AIDS within minority communities, and significantly strain existing HIV services.

Table 2. General Population Estimates in Oklahoma, by MSA, 2007

MSA	Estimated General Population -2007	% of Oklahoma
Oklahoma City	1,192,989	34.5%
Tulsa	905,755	26.2%
Lawton	113,811	3.3%
Subtotal MSA	2,212,555	64%
Oklahoma	3,450,654	100%

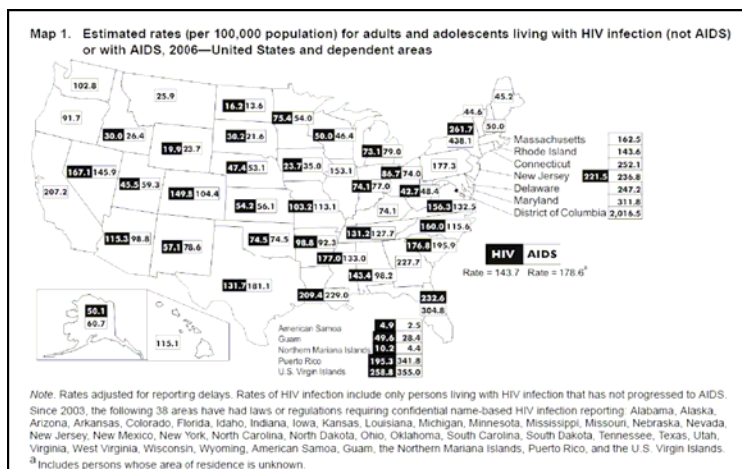
(Source: U.S. Census Bureau)

The state of Oklahoma has a higher rate of poverty (14.7%) than the remainder of the United States (12.4%). Oklahoma citizens are some of the least insured in the nation, and have some of the poorest health rankings among all the states. Unemployment in Oklahoma exceeds the national average. Oklahoma has an age profile similar to that of the United States. The proportion of Oklahomans under age 18 years constitute 25.9% in Oklahoma compared to 25.7% in the United States. A slightly higher percentage of 65+ age individuals reside in Oklahoma, with 13.2% of the population declared ‘elderly’ compared to 12.4% in the United States.

CHAPTER 2: Current State Epidemiological Profile

Nationally, Oklahoma is considered a 'moderate' incidence state for its level of new infections. The Southern States Manifesto: 2008 Update documents the moderate rates of HIV/AIDS in Oklahoma, as compared to the other states in the nation in the map below:

Figure 1. National Map of State's HIV/AIDS Case Rates



Oklahoma HIV Disease Statistics

Newly Reported HIV Cases

2007 Case Total 190 2007 Rate 5.5 per 100,000

In 2007, approximately 16,500 HIV tests were performed at the reported sites in Oklahoma. Of these tests, approximately 75% were conventional tests and 25% were rapid tests. There were 127 positive tests, of which 55 (43%) were identified as new HIV infections, meaning a positive HIV test result was received by an individual who received a previous test result of negative and now has a test result of positive. (OSDH, 2008)

Race, Gender and Risk of Newly Identified HIV Cases Reported by Oklahoma Counseling, Testing and Referral Sites, 2007

Race: According to the Oklahoma HIV and AIDS Surveillance System, as of December 31, 2007, there were a total of 6,005 persons living with HIV or AIDS in the state of Oklahoma. There were 2,810 people known to be living with HIV and 3,195 people known to be living with AIDS in Oklahoma. These data include 190 new HIV cases and 243 new diagnoses of AIDS reported in 2007. For newly identified HIV infections, this equates to a rate of 5.5 cases per 100,000 population. Six of the newly diagnosed HIV cases and 15 of the newly diagnosed AIDS cases died in 2007.

Of those new HIV diagnoses, most cases (34%) were between the ages of 20 to 29 years old, followed by 30% of cases within the age group of 30 to 39 years. Whites accounted for 54% of the HIV diagnosis in 2007, while Blacks accounted for 32% of new HIV diagnosis. Per the 2000 census, Blacks comprise approximately 7.6% of Oklahoma’s population.

The rate of newly diagnosed HIV infection in non-Hispanic Blacks for 2007 is 22.9 per 100,000, while the rate in non-Hispanic whites is 3.7 per 100,000. **Thus, the rate of new HIV diagnoses for Blacks is six times higher than the rate for whites.**

Comparing the proportion of gender and race/ethnicity to the general population, the AIDS case rate per 100,000 for Blacks is 3.5 to 8 times greater than for any other group (**3.5 to 4 times greater for Black males and 5.75 to 8 times greater for Black females**).

Gender: Males continue to account for a disproportionate amount of the new HIV diagnoses, representing 78% of the total new cases in 2007. As males make up about 49% of the Oklahoma state population, the new HIV case rate for males (8.5 per 100,000) is almost four times higher than the rate for females (2.3 per 100,000).

Risk: Among **males**, 56% are MSM, 5% IDU, 7% MSM/IDU, 7% Heterosexual contact, 1% transfusion related, and for 24% risk was not specified.

Among **females**, 43% cited Heterosexual contact, 17% IDU, 2% Transfusion, and 38% risk was not specified.

AIDS Incidence, AIDS Prevalence and HIV Prevalence

Unless otherwise stated, all of the HIV/AIDS statistics are from OSDH Surveillance and Analysis Statistics, 2008.

Table 3. 2007 Exposure by Gender by AIDS Incidence, AIDS Prevalence and HIV Prevalence

GENDER	AIDS Incidence #	AIDS Incidence %	AIDS Prevalence #	AIDS Prevalence %	HIV Prevalence #	HIV Prevalence %
Male	370	83.0	2,738	85.7	2,273	80.9
Female	76	17.0	457	14.3	537	19.1
TOTAL	446	100.0	3,195	100.0	2,810	100.0

Males witnessed a 1% decrease in diagnosed AIDS cases, a 2.3% reduction in AIDS Prevalence and a 2.1% decrease in HIV Prevalence from 2004 to 2007. In contrast, while females experienced a significant increase of 1% AIDS Incidence, 2.3% increase in AIDS Prevalence and 2.1% increase in HIV Prevalence over the same time period. Females comprised 18% of the newly diagnosed cases of HIV infection in 2007. Among males, MSM was the highest category of exposure while females were infected through sex with an infected partner or through injection drug use. (*OSDH, 2008*)

Table 4. 2007 Race/ethnic group by AIDS Incidence, AIDS Prevalence and HIV Prevalence:

RACE	AIDS Incidence #	AIDS Incidence %	AIDS Prevalence #	AIDS Prevalence %	HIV Prevalence #	HIV Prevalence %
White	229	51.3	1,532	47.9	1,137	40.5

Black	116	26.0	462	14.5	430	15.3
Hispanic	47	10.5	122	3.8	96	3.4
Asian/P.I.	3	0.7	0	0.0	2	0.1
Am.Indian/AN.	32	7.2	151	4.7	99	3.5
Multi- Race	19	4.3	0	0.0	0	0.0
Unknown	0	0.0	928	29.0	1,046	37.2
Total	446	100.0	3,195	100.0	2,810	100.0

As evidenced above, whites continue to experience a majority of the HIV/AIDS incidence and prevalence in Oklahoma. Both Blacks and Hispanics carry a disproportionate burden of the new AIDS cases, at 26% and 10.5% respectively. Blacks are also disproportionately represented for their high representation in AIDS Prevalence (14.5%) and HIV Prevalence (15.3%), and as stated above, comprised 32% of the new HIV cases reported in 2007.

Table 5. 2007 Age Group by AIDS Incidence, AIDS Prevalence and HIV Prevalence

AGE	AIDS Incidence #	AIDS Incidence %	AIDS Prevalence #	AIDS Prevalence %	HIV Prevalence #	HIV Prevalence %
<13	1	0.2	11	0.3	37	1.3
13-14	1	0.2	2	0.1	2	0.1
15-24	24	5.4	180	5.6	610	21.7
25-34	108	24.2	1,120	35.1	1,125	40.0
35-44	177	39.7	1,302	40.8	733	26.1
45-54	109	24.4	474	14.8	246	8.8
55-64	20	4.5	92	2.9	48	1.7
>=65	6	1.3	14	0.4	9	0.3
Total	446	100.0	3,195	100.0	2,810	100.0

While the 25-34 and 35-44 year old age groups continue to make up the greatest volume of HIV/AIDS diagnoses, it is of concern that the 15-24 year old age group comprises 22% of the HIV Prevalence in 2007. As stated above, the 20-29 year old age group comprised over one third or 34% of the new HIV/AIDS cases in 2007.

Table 6. 2007 Risk Exposure Category by AIDS Incidence, AIDS Prevalence and HIV Prevalence

RISK-Adult & Adolescent Exposure Category	AIDS Incidence #	AIDS Incidence %	AIDS Prevalence #	AIDS Prevalence %	HIV Prevalence #	HIV Prevalence %
MSM	197	44	1,674	53	1,345	49
IDU	57	13	384	12	330	12
RISK-Adult & Adolescent Exposure Category	AIDS Incidence #	AIDS Incidence %	AIDS Prevalence #	AIDS Prevalence %	HIV Prevalence #	HIV Prevalence %
MSM/IDU	40	9	412	13	250	9
Hemophilia/ coag disorder	1	0	14	0	7	0
Heterosexual contact	58	13	343	11	336	12
Receipt of blood/tissue	2	0	22	1	20	1
Risk not specified	88	0	331	10	485	17
Total	443	100	3,180	100	2,773	100

The total proportion of new AIDS cases attributable to MSM risk behavior was 53% in 2007 and the total proportion of new AIDS cases attributable to IDU risk behavior in 2007 was 22%. Heterosexual contact resulted in 13% of the new AIDS cases in 2007.

The Oklahoma State Department of Health reports a higher proportion of MSM and MSM/IDU risk transmission categories among its reported AIDS cases than that of the national average (MSM: 56% Oklahoma versus 44% U.S.; MSM/IDU: 13% Oklahoma/7% U.S.)

The total proportion of living HIV/AIDS cases attributable to MSM risk behavior is 61.3% (including both MSM and MSM/IDU). The total proportion of living HIV/AIDS cases attributable to IDU is 22.9% (including both IDU and MSM/IDU).

If the 'Risks Not Specified' among PLWHA were specified, (currently representing almost 14% of all PLWHA and second in size to only the MSM risk exposure group), the Oklahoma risk profile would likely change considerably.

Table 7. Reported AIDS Cases Among Adults and Adolescents, by Transmission Category, Cumulative through 2006-KFF State Health Facts

	OK #	OK %	US #	US %
Male-to-Male Sexual Contact	2,713	56%	429,897	44%
Injection Drug Use	572	12%	230,763	24%
Male-to-Male Sexual Contact and Injection Drug Use	626	13%	65,524	7%
Hemophilia/Coagulation Disorder	48	1%	5,524	1%
Heterosexual Contact	401	8%	134,796	14%
Receipt of Blood Transfusion, Blood Components, or Tissue	77	2%	9,389	1%
Other/Risk Factor Not Reported or Identified	399	8%	107,450	11%
Total Cumulative Adult/Adolescent AIDS Cases	4,836	100%	983,343	100%

Blacks are disproportionately impacted for their proportion of reported AIDS cases in Oklahoma.

Table 8. Distribution of Reported AIDS Cases, All Ages, by Race/Ethnicity, Cumulative through 2006, OK vs. US--KFF State Health Facts

	OK #	OK %	US #	US %
White	3,321	68%	387,771	39%
Black	911	19%	400,854	40%
Hispanic	222	5%	187,762	19%
Asian/Pacific Islander	6	0%	7,714	1%
American Indian/Alaska Native	341	7%	3,267	0%
Unknown Race or Multiple Races	61	1%	5,497	1%
Total	4,862	100%	992,865	100

Blacks are also disproportionately represented among the new AIDS cases reported in Oklahoma.

Table 9. Distribution of New AIDS Cases by Race/Ethnicity, 2006, OK vs. US				
	OK #	OK %	US #	US %
White	110	54%	11,312	29%
Black	55	27%	18,759	48%
Hispanic	15	7%	7,890	20%
Asian/Pacific Islander	1	8%	519	0%
American Indian/Alaska Native	16	7%	165	0%
Unknown Race or Multiple Races	8	4%	357	1%
Total	205	100%	39,002	100%

(Source: KFF State Health Facts)

CHAPTER 3. Emerging Populations

Disproportionate Impact of HIV/AIDS on Certain Populations

The populations in Oklahoma who are most disproportionately impacted by HIV disease include African Americans, Males, MSM and Youth, ages 15-29 years. Hispanics evidence an increasing disparity relative to AIDS Incidence and Females evidence continuing increases in their number and proportion of cases, owing to Heterosexual contact, IDU behavior and unrecognized risk.

PLWH (persons living with HIV) evidence the greatest level of unmet need (with 63% out of care); followed by Youth, ages 13-19 years (73% out of care); Youth, 20-29 years (63% out of care); Hispanics (64% out of care); Blacks (52% out of care); PLWHA residents of Lawton (66% out of care); and rural PLWHA, residing outside MSAs have 54% with unmet need. (2008 *Unmet Need Study, OSDH*)

(See Table 10 on the following page)

Table 10. Disproportionate Impact of HIV/AIDS in Oklahoma 2007

% General Population v. HIV+	A	B	C	D	E
Group in Oklahoma	General Population (2000 census)	NEW CASES 2007	PLWHA 2007	New Disparity	Existing Disparity
Race/Ethnic Group					
African American	7.8%	34% HIV 26% AIDS	15.3% HIV 15% AIDS	26.2% HIV 18.2% AIDS	7.5% HIV 7.2% AIDS
American Indian	8%	7% HIV 7.2% AIDS	3.5% HIV 4.7% AIDS		
Asian/P.I.	1.7%	<1% HIV .7% AIDS	2% HIV 0% AIDS		.3% HIV
Hispanic/Latino/a	6.9%	7.1% HIV 10.5% AIDS	3.4% HIV 3.8% AIDS	.2% HIV 4.6% AIDS	
White	82.5	55% HIV 51.3% AIDS	40.5% HIV 47.9% AIDS		

Gender					
Male	49%	82% HIV 83% AIDS	80.9% HIV 85.7% AIDS	33% HIV 34% AIDS	31.9% HIV 36.7% AIDS
Female	51%	18% HIV 17% AIDS	19.1% HIV 14.3% AIDS		
Age Group					
<14	21.2%	0% HIV .2% AIDS	1.4% HIV .4% AIDS		
15-24	14.9%	++HIV 5.4% AIDS	22% HIV 5.6% AIDS	approximately 15% HIV	7.1% AIDS
25-34	13.1%	**HIV 24.2% AIDS	40% HIV 35.1% AIDS	approximately 16% HIV 11.1% AIDS	27% HIV 10.9% AIDS
35-44	15.2%	**HIV 39.7% AIDS	26.1 % HIV 40.8% AIDS	approximately 15% HIV 14.5% AIDS	10.9% HIV 25.6% AIDS
45+	35.5%	**HIV 30.2% AIDS	10.8% HIV 18.1% AIDS		

Sources: Column A. US Census Bureau, 2007; Columns B & C:Oklahoma State Department of Health (OSDH); 2007--(**Bold font that is shaded in Columns D** indicates the extent of the disparity for 'new' HIV and AIDS cases & denotes the scale of disparity for PLWHA in Column E.) ** New HIV cases in 2007 are reported for the following age groups: 13-19 years: 3 cases or 2.4%; 20-29 years: 41 or 32.3%; 30-39 years: 42 or 33%; 40-49 years: 33 or 26%; 50-59 years: 6 or 4.7%; and 60-69 years: 2 or 1.6%.

Disproportionately Impacted Populations in Oklahoma

African Americans

African Americans are the most disproportionately impacted racial/ethnic group in Oklahoma with 32% of all new HIV cases, 26% of all new AIDS cases, 15.3% of HIV prevalence and 15% of AIDS prevalence, despite a 7.6% composition in the general population. No other racial or ethnic group is as disproportionately impacted by the disease. The level of Unmet Need, or the percent of PLWHA not in care that know that they are HIV-positive, is decreasing in Oklahoma, though remains unacceptably high at 48%. The level of unmet need is higher for African Americans at 52%, per a study conducted in 2008 by the Oklahoma State Department of Health. Despite their dominance among racial/ethnic groups in Oklahoma and continued new diagnoses at an equal or higher rate, the percent of African Americans utilizing Ryan White Part B services is 19.8%, and the proportion of African Americans in Ryan White Part C funded primary medical care in 2007 was 22.5%.

Hispanics

Hispanics represent an emerging population which evidences increasing disparity, particularly with regard to their relative proportion of AIDS Incidence (10.5%) compared to their proportion of the general population (6.9%). Hispanics comprise 7.1% of the new HIV cases in 2007, evidencing a slight disparity in new infections. While Hispanics comprise 3.4% of the HIV prevalence and 3.8% of the AIDS prevalence in 2007, Hispanics make up the largest single racial/ethnic group of the Out of Care population in Oklahoma at 64%. Hispanics evidence fair representation in Ryan White Part B (8.3%) and Part C services (7%) in 2007).

Males who have Sex with Males (MSM)

Males are disproportionately impacted by HIV/AIDS in Oklahoma. Males consistently comprise 81-86% of all new and living cases of HIV/AIDS, yet comprise only 49% of the state's population. MSM are historically the highest exposure group in the state for newly diagnosed HIV and AIDS cases. The 2007 percentage of new AIDS cases was 44%. MSM comprise 49% of the HIV prevalence and 53% of the AIDS prevalence. High overlap exists between African American and MSM and Youth and MSM. Minority MSM often cope with stigma related to their minority status, sexual orientation, HIV status, and the documented intolerance for these factors in their communities. Added to this intolerance is the prominent role of religion in the state. Oklahoma is known as a state in which residents identify strongly as Baptist and evangelical, that historically have not embraced or tolerated gay or bisexual individuals. As a result, there is a tendency for minority (Black and Hispanic) MSM to not identify as gay or even bisexual. This factor might partially explain the high "Risk Not Reported or Identified." MSM of color are hesitant to seek services at AIDS service organizations for fear of disclosure. MSM comprised 54.5% of the Part B medical service and 57% of the Ryan White Part C primary medical care population in 2007. Black, Hispanic and rural MSM are all underrepresented in HIV primary medical care, evidencing the impact of continuing stigma among these marginalized population groups.

Youth, Ages 13-24 years /20-29 years

Youth, defined as between the ages of 13 to 29 years represent a continued subpopulation of increasing concern in Oklahoma. **For new cases of HIV, 34% of all cases were among Youth, ages 20-29 years in 2007.** Youth, ages 15-24 years comprise 5.4% of the AIDS Incidence, 5.6% of the AIDS Prevalence, and **22% of the HIV Prevalence.**

As a group, Youth tend to be the least compliant with treatment regimens due to issues with adolescent rebellion, stigma attached to their HIV diagnosis, and belief that with the advent of modern antiretroviral therapy, they can remain invulnerable to their infection. Overestimation of

the power of antiretroviral therapy is a concern given the latest figures that 25% of new HIV diagnoses in the US are among those under 25 years of age (*Office of National AIDS Policy, 2000*). Estimates show that only 11% of HIV-positive youth in the United States receive adequate health care (*American Academy of Pediatricians Meeting, 2000*). The majority of HIV-infected youth are asymptomatic, do not know they are infected, and are not enrolled in treatment. (*Physician Resource Network Notebook, 2003*) In addition, the age segment below 24 years of age continues to be documented as the least covered by health insurance. (*US Census Bureau, 2006*)

Among PLWH Youth, ages 13-19 years, 73% are Out of Care and among PLWH Youth, ages 20-29 years, 63% are Out of care. Of perhaps greater concern is the fact that among Youth, ages 13-19 years who are living with AIDS, 45% have an unmet need for primary medical care and PLWA Youth, ages 20-29 years have unmet need. Youth, ages 13-29 years are significantly underrepresented in Ryan White care and services, with only 10.3% receiving Part B services in 2007. Youth comprised less than 3% of the Ryan White Part C primary care population in 2007.

Females-Heterosexual and/or IDU

Women are increasingly impacted by HIV disease in Oklahoma. Over the past decade, women of all ages and races have continued to comprise an expanding number and proportion of new and living cases of HIV/AIDS. In 2007, females comprised 18% of the new HIV cases, 17% of new AIDS cases, 19.1% of the HIV prevalence and 14.3% of AIDS prevalence. The majority of cases in women continue to be attributable to Heterosexual contact and IDU risk behavior. In 2007, the proportion of new HIV cases among women attributable to Heterosexual contact was 43% and the proportion of new HIV cases attributable to IDU risk behavior among women was 17%. Many women report lack of risk personalization and monogamous sex with a steady partner, with lack of awareness of their partner's risk behavior(s).

When HIV disease trends for Women and Heterosexuals are examined from 2004 to 2007, it is evident that AIDS Incidence, AIDS Prevalence and HIV Prevalence are on the rise for these intersecting risk populations, as evidenced in the table below:

Table 11. HIV/AIDS Trends among Females and Heterosexuals

Risk Group	HET			Female		
	AIDS Incid	AIDS Prev	HIV Prev	AIDS Incid	AIDS Prev	HIV Prev
2007	13	11	12	17	14.3	19.1
2004	11	10	11	16	12	17
Percent Increase	2%	1%	1%	1%	2.3%	2.1%

Women comprised 18.4% of the Part B medical services population in 2007 and 20% of the Ryan White Part C primary medical care population in 2007

Summary of Emerging Populations in Oklahoma

1. Race/Ethnic Group – The most disproportionately impacted racial group compared to their proportion in the general population is the African American group of PLWHA. African Americans comprise 32% of newly diagnosed HIV cases and 26% of new AIDS cases, and make up 15.3% of HIV prevalence and 15% of AIDS prevalence, compared to the relatively small proportion of African Americans in the general population of Oklahoma (7.8%). Blacks make up a disproportionate share of the OOC at 52%.

Hispanics are the next most disproportionate share group, representing 7.1% of all newly diagnosed HIV cases and 10.5% of all new AIDS cases, 3.8% of PLWA and 3.4% of PLWH. Hispanic representation in the general population of Oklahoma has doubled from 1990 to 2000, but still only accounts for 6.9%.

This close correlation of general population representation to HIV-infected percentage makes only newly diagnosed AIDS cases an area of disproportionate burden among Hispanics. Hispanics evidence the greatest disparity among all racial/ethnic groups for their level of unmet need at 64%. *(It is worthy of note that almost one-third or 32.9% of the reported cases of PLWHA have no assigned race/ethnicity).*

2. Gender – Fully 82% of newly diagnosed HIV cases are male and 18% are female. A higher figure (83%) of new AIDS cases is reported among males and 17% among females. A total of 80.9% of HIV prevalence is among males, with 19.1% among females, and 85.7% of AIDS prevalence is among males, with 14.3% among females. This transition represents earlier stage diagnoses for females combined with a later stage diagnosis for females of color.

3. Age group - While the 35-44 year old age group continues to carry the heaviest burden for HIV disease in Oklahoma, there is an increasing disparity among Youth, ages 15-24 years for their HIV prevalence and for Youth, ages 20-29 years for their level of new HIV infection (34%).

4. Risk Exposure – MSM risk behavior continues to comprise the majority of new and living HIV/AIDS cases in Oklahoma. The highest volume of MSM is reported among PLWA. The most disparate figure (highest for newly diagnosed AIDS cases) is evidenced by African Americans, followed by Hispanics.

Twelve percent of the new HIV cases among males and 17% of the new HIV cases among females are attributable to IDU risk behavior. Female cases are increasing, validating the

observation in ‘Gender’ that increasing heterosexual transmission of the disease is occurring. *It is noteworthy that among reported cases of PLWHA that 13.6% have no risk specified.*

5. Geography--Rural PLWHA experience a higher level of unmet need than the state as a whole, recording a 54% Out of Care fraction. Lawton PLWHA have a 66% unmet need.

In conclusion, the newly diagnosed AIDS cases are occurring among people of color with a severe disproportionate burden experienced by African Americans and an increasing disparity experienced by Hispanics. HIV is spreading through heterosexual transmission to females, particularly to females of color.

Due to detail collected by the Surveillance division of OSHD, we know that approximately 60% of exposure through heterosexual transmission, whether to males or females, occurs through sex with injection drug users. Of all positive HIV tests completed in 2007 (N=127), 92 were among males (73%), 23 among females (18%) and 12 were unknown gender (9%).

Blacks comprise 32% of the total positive tests (N=41 of 127); Hispanics comprised 7.1 % (N=9 of 127) and Whites made up approximately 55% of the positive HIV test results in 2007 (N=70).

These testing trends data evidence continuing disparities in HIV infection among Blacks and Hispanics, and youth ages 20-29 years (34%).

Emerging Populations

African Americans

The prevalence of HIV/AIDS in the African American community reflects its disproportionate representation among persons with adverse socio-economic indicators, and residence in low income neighborhoods where HIV is endemic. Injection drug users, heterosexual women who have sexual relations with substance abusers, co-morbid infections, and poverty with its attendant lack of health insurance and inadequate health care are major factors driving the prevalence upwards in the African American community.

In the 2008 Unmet Need Study, African Americans had the second highest number of people out of care among their racial/ethnic counterparts at 52% (second only to Hispanics at 64%). General studies on adherence with HIV treatment have found a variety of factors, which may influence willingness to begin medical care for HIV and/or to remain in care. Those factors can include certain demographic characteristics, alcohol/substance abuse, disease stage and health status, stigma, and trust, beliefs about treatment efficacy, psycho-social issues, gender and race. For minorities, traditional beliefs join discrimination, poverty, the provider-patient relationship including cultural competence, inadequate health care and education as barriers to treatment

(Greeley, *Concerns about AIDS in minority communities, 1995*). Sometimes patients do not comply because the treatment is incompatible with their belief systems (COSSA Congressional Briefing, Executive Summary, 2001). In some cases, HIV+ individuals believe that they are responsible for their disease, that they are socially deviant (Parsons, *et al. Religious beliefs, practices and treatment among individuals with HIV in the Southern United States. AIDS Patient Care and STDs, 20 (2), 2006*).

Special Population	Client Count	% of Total
African Americans	356	19.8%

Source: 2007 CAREWare Report

Hispanics

Hispanics pose the most distinct emerging population. Hispanics comprise 6.9% of the general population but make up 7.1% of new HIV infections, and 10.5% of new AIDS cases. This population is the fastest growing minority in the state per state census estimates, with a noticeable increase over the last two decades. Unique challenges resulting in service gaps related to this emerging, yet insulated population include language barriers, different cultural mores related to sexual or drug-taking behavior, societal perception of the use of medical services including fear of being deported (for the undocumented), cost, and also lack of HIV testing. Service providers are making every effort to include staff members that can remove language barriers by employing personnel that are fluent in Spanish because of the increase of Hispanics in the state.

Special Population	Client Count	% of Total
Hispanics	149	8.3%

Source: 2007 CAREWare Report

Females (Heterosexual and/or IDU)

Heterosexual females are at risk in a state characterized by non-disclosed or bisexual men who are transmitting the HIV infection to their married or heterosexual partners. Females are also at risk for HIV through heterosexual sex with IDU partners. Women with HIV present unique service delivery challenges because in addition to substance abuse, many are unaware of their risk and become infected through heterosexual sex with men in high risk groups. HIV is more transmissible from men to women than vice versa; the epidemic is growing in young women of

reproductive age who are, or may become mothers. Infected mothers have a high risk of transmitting HIV to their babies at birth.

African American, Hispanic and White females of reproductive age are at increased risk for HIV and other STIs. Efforts to increase risk awareness, prevention education, and HIV testing are definitely needed for this population.

Special Population	Client Count	% of Total
Females	330	18.4%

Source: 2007 CAREWare Report

Youth, Ages 13-29 years

Youth, ages 13-29 years, represent a high risk group with Youth ages 15-24 years comprising 22% of HIV prevalence, and Youth ages 20-29 years comprising 34% of new HIV infections. This age bracket reports the highest incidence of STIs in the state contributing to some of the highest rates of STIs in the nation. As with heterosexuals, efforts to increase awareness, education, and HIV testing are essential to reduce further HIV transmission.

The risk behaviors driving the epidemic among male youth are first MSM and then IDU, or both MSM/IDU. The primary transmission risks among young females are heterosexual contact followed by IDU risk behavior.

Minors may be covered under Medicaid, but young adults lack access to and resources for health insurance. This population has experienced higher rates of unemployment, lack of insurance coverage, significant drug and alcohol abuse and high rates of STIs. Youth's general sense of invulnerability further complicates personalization of risk and acts as an obstacle to testing and care. Sexually active teen and young adult women are at peak fertility, and may become pregnant. Young men and women often lack the skills and confidence or remain in power-imbalanced relationships which impede their ability to successfully negotiate safer sex practices. Substance abuse and homelessness are additional major risk factors in this population. Runaway teenagers are at high risk for HIV infection through the exchange of sex for money, drugs, or shelter.

Teens, ages 13-17, are dependent upon adults for care. Young adults, ages 18-24, are of the age of majority, and may access care independently. For youth above the age of majority, insurance is a lack and treatment adherence a significant service need. Youth in Oklahoma have exceptionally high levels of unmet need, at 42-45% among PLWA youth and 63-73% unmet need among PLWH Youth. Youth, ages 13-24 years are seriously underrepresented in HIV primary medical care, comprising less than 3% of the RW Part C population in 2007.

Special Population	Client Count	% of Total
Youth	186	10.3%

Source: 2007 CAREWare Report

IDU

Male and female IDU and males, whose risk for transmission of HIV includes MSM and IDU, continue to constitute important risk behavior groups in Oklahoma. Twelve percent (12%) of the new HIV cases among males is attributable to IDU. Seventeen percent (17%) of the new HIV cases among females is attributable to IDU risk behavior. New cases of AIDS attributable to IDU risk behavior total 22% when IDU and MSM/IDU are combined. Among living cases of PLWA, fully 25% of their risk exposure is attributable to ID (12% IDU and 13% MSM/IDU). Almost 12% of the living HIV/AIDS cases are among IDU, and when combined with living cases MSM/IDU, the total proportion of PLWHA whose risk includes IDU increases to almost 23% (IDU 11.9% plus MSM/IDU at 11%). As evidenced in the table below, IDU PLWHA (who comprise a total of 22.9% of the living epidemic in Oklahoma), are underrepresented in Ryan White funded care and services, with only 18% in care in 2007.

Special Population	Client Count	% of Total
IDU	165	9.2%
MSM/IDU	158	8.8%
TOTAL	323	18.0%

Source: 2007 CAREWare Report

Rural PLWHA

There are numerous barriers to HIV prevention, testing and care in rural Oklahoma which must be bridged, including:

- The geographic distances to be traversed to reach sources of HIV primary care and support;
- Transportation is non-existent or unreasonably expensive;
- Stigma is greater and PLWHA fear breach of confidentiality;
- There is an absence of a cohesive supportive community for PLWHA;
- There is shortage of medical and dental specialists and mental health and substance abuse treatment resources; and
- Rural citizens are frequently less knowledgeable about HIV/AIDS and less tolerant of diversity.

Each of the above barriers to varying extents, act to reduce access to HIV testing, care, and treatment in rural Oklahoma. Innovative strategies are necessary to bridge the distance between the needed services and the rural PLWHA, so that rural residents living with HIV/AIDS may enjoy the same level of access to the needed HIV primary medical care and support services as their urban counterparts. Rural PLWHA evidence a disproportionate share of the Out of Care population at 54% for total non-MSA areas and 66% for Lawton area PLWHA.

Special Population	Client Count	% of Total
Rural PLWHA	288	16%

Source: 2007 CAREWare Report

Co-Morbidities

Oklahoma PLWHA are at high risk for multiple co-morbid conditions. The introduction of highly effective anti-retroviral treatments has reduced the proportion of HIV cases that progress to AIDS and premature death overall, but have the perverse effect of allowing the survival of a population that grows more susceptible to co-morbidity as they age and have been exposed to antiretroviral treatment for longer periods of time. The costs include the costs of preventing additional infections, as well as treatment of existing conditions. Multiple diagnoses in PLWHA add greatly to cost and complexity of care. As costly as treatment is, failure to adequately treat PLWHA increases the cost short term as well as long term. Failure to treat also opens the door to the establishment of treatment resistant strains of both HIV and co-morbid conditions such as TB. In addition to communicable diseases such as tuberculosis (TB), hepatitis, and sexually transmitted infections (STI), other psychosocial and socioeconomic factors such as substance abuse, chronic mental illness, homelessness, lack of health insurance, and poverty contribute to the cost and complexity of care for PLWHA.

STI (Sexually Transmitted Infection) Rates

Unless otherwise noted, all of the STI statistics are derived from the Oklahoma State Department of Health, 2007.

Overview of STIs and Oklahoma Adults and Youth: Among all women in Oklahoma, the rate of Chlamydia infection was 461.8 and for gonorrhea infection, the rate per 100,000 women was 138.6 (*Quick Health Data Online, 2008*). Young people ages 15-24 account for half of all reportable STIs in Oklahoma. Every year, one in four (or 25%) of sexually experienced teens acquires an STI, but less than 1 in 3 of those teens have been tested for HIV. Teens ages 19 years and younger account for 37% of all the Chlamydia cases; 30% of the gonorrhea cases and 2% of the Oklahoma's HIV/AIDS cases. Of the 2005 HIV/AIDS cases among Oklahoma youth, 38% were African American and 22% were female. STI trends in Oklahoma are a critical predictor of future unintended pregnancy and HIV/AIDS risk.

Higher rates per 100,000 populations in Blacks are reported for early syphilis, gonorrhea and Chlamydia. For every one white male reported with early syphilis in 2004, over eight African American males were reported. For every one white female reported, over nine African American females were reported. Of all the cases of gonorrhea diagnosed in 2004, 65% were among 15-24 year olds and 64% were reported in African Americans (rate of 1,233/100,000 among African Americans males versus 26/100,000 in white males and 1,045 in African Americans females compared to 55 in white females). The majority of cases of Chlamydia are reported in white females, and 80% of all cases diagnosed in 2004 were among youth ages 15 to 24 years.

Sexually transmitted infections in Oklahoma are among the highest in the United States. Individuals with STIs are two to five times more likely to acquire HIV infection if exposed to the virus through sexual contact. Substantial biological evidence also exists that STIs increase susceptibility to HIV infection through breaks in genital tract linings or increased infectiousness.

Chlamydia: 2007 Case Total 12,529 2007 Rate 363 per 100,000

In 2007, 12,529 Chlamydia trachomatis infections were reported to the Oklahoma State Department of Health. From 1997, the reported number of chlamydial infections in Oklahoma has increased from 7,419, which constitutes a rate increase of 215 to 363 per 100,000 population. This increase mirrors the national trend and is likely due to increased screening, increased use of more sensitive diagnostic tests (nucleic acid amplification tests), and improved reporting-- as well as a true increase in disease. **According to the CDC, Oklahoma ranked 17th highest in the nation for rate of chlamydial infections in 2006.** (2007 Oklahoma Communicable Disease Report) Seventy-three percent (73%) of cases reported in Oklahoma are among women. **More than 80% of the reported cases among females in 2007 were under the age of 25.** The preponderance of cases in young women may represent the increased screening in this age and gender group. Nonetheless, because of this high rate in young women, it is important to note that chlamydia and gonorrhea are the most important preventable causes of infertility. Untreated, infected women can develop pelvic inflammatory disease (PID) that can lead to infertility and ectopic pregnancy. Annual chlamydia screening for all sexually active females 25 and under and for women older than 25 with risk factors such as a new sex partner or multiple partners is recommended, and offers the opportunity to discuss STI/HIV prevention activities..

In addition to gender-related disparities, racial differences also persist. Case rates among African Americans continue to be substantially higher than rates among other race/ethnicity groups. In 2007, **the rate of chlamydial infection among African Americans was over seven times higher than that of whites** (1,439 and 197 cases per 100,000 population, respectively). Of cases with single race/ethnicity identification, 4,129 were Black (32% of cases) and 5,584 were white (45% of cases). Chlamydia rates among American Indians and Native Hawaiian/Pacific Islanders were also higher than whites (2.4 and 5.0 times, respectively). Although the Native Hawaiian/Pacific Islander population has a high rate of infection, 985 per 100,000, this only accounts for 36 cases (less than 1% of all reported in Oklahoma).

Chlamydia is the most commonly reported sexually transmitted disease (STI). Chlamydial infection can facilitate the transmission of HIV infection. The 12,529 reported cases counted in 2007 in Oklahoma are at serious risk of contracting HIV. Pregnant women infected with Chlamydia can pass the infection to their infants during delivery, potentially resulting in neonatal ophthalmia and pneumonia.

Chlamydia screening and reporting are likely to expand in response to the recently implemented Health Plan Employer Data and Information Set (HEDIS), which measures Chlamydia screening in sexually active women ages 15 through 25 years, who receive medical care through managed care organizations. Under-reporting is substantial because most people with Chlamydia are unaware of their infections and thus do not seek testing.

Table 12. Healthy People 2010 Objectives for Chlamydia and National Trend-line of Actual Results

HP 2010 Objectives	Baseline Year	Baseline	2002	2003	2004	2005	2006	HP 2010 Target
25-1 Reduce the proportion of adolescents and young adults with Chlamydia	1997	5.0%	6.0%	6.4%	6.9%	6.9%	7.1%	3.0%
a. Females aged 15-24 attending family planning clinics	1997	5.0%	6.0%	6.4%	6.9%	6.9%	7.1%	3.0%
b. Females aged 15-24 attending STI clinics	1997	12.2%	13.5%	14.1%	15.3%	15.4%	14.85	3.0%
c. Males aged 15 -24 attending STI clinics	1997	15.7%	17.5%	19.3%	20.8%	20.5%	20.8%	3.0%

Gonorrhea: 2007 Case Total 4,827 2007 Rate 124 per 100,000

Gonorrhea is the second most commonly reported disease in Oklahoma as well as the United States. Infections due to Neisseria gonorrhoea, like those resulting from Chlamydia trachomatis, are a major cause of Pelvic Inflammatory Disease (PID). PID can lead to serious outcomes in women such as tubal infertility, ectopic pregnancy, and chronic pelvic pain. In addition, epidemiologic and biologic studies provide strong evidence that gonococcal infections facilitate the transmission of HIV infection.

The bacterium can grow and multiply in the reproductive tract, including the cervix (opening to the womb), uterus (womb), and fallopian tubes (egg canals) in women, and in the urethra (urine canal) in women and men. The bacterium can also grow in the mouth, throat, eyes, and anus. The CDC estimates that more than 700,000 persons in the US acquire new gonorrheal infections each year, with only half of these infections reported.

Table 13. Healthy People 2010 Objectives for Gonorrhea and National Trend-line of Actual Results

HP 2010 Objectives	Baseline Year	Baseline	2002	2003	2004	2005	2006	HP 2010 Target
25.2 Reduce gonorrhea (cases per 100,000 population)	1997	123.0	122.0	115.2	112.5	114.6	120.9	19.0

According to the CDC, Oklahoma ranked 14th highest in the nation for the rate of gonorrhea in 2006. During 2007, 2,827 (59%) of the cases reported were Black. The rate of gonorrhea in the Black population is over 20 times the rate in the white population (1,070 per 100,000 population versus 50 per 100,000). Almost 56% of the gonorrhea cases reported among Blacks were males, whereas among whites, 68% were reported among females. Among all races, more than 60% of the cases were under the age of 25 years with 90% of the cases under the age of 35. It is important to note that although the rate of infection among Native Hawaiian/Pacific Islander is quite high, this only accounts for 12 cases in 2007. The 4,827 reported cases counted in 2007 are at serious risk of contracting HIV.

Primary & Secondary Syphilis: 2007 Case Total: 62 2007 Rate: 2.0 per 100,000

Syphilis, a genital ulcerative infection, facilitates the transmission of HIV and thus may contribute to HIV transmission. Although the rate of Primary & Secondary Syphilis in the US declined by 89.7% during 1990-2000, the rate of Syphilis remained unchanged between 2000 and 2001 and increased in 2002 and 2003. Overall increases in rates during 2001-2003 were observed only among men in the US. Between 2001 and 2002, the number of reported Syphilis cases increased 12.4 percent. Rates in women continued to decrease, with the rate in men 3.5 times that of women. This suggests that rates of Syphilis in MSM are increasing.

There were 62 cases of primary and secondary (P&S) Syphilis reported in Oklahoma in 2007. The rate of reported P&S syphilis cases in 2007 was 2.00 per 100,000 population. The 62 cases were reported from three counties: Oklahoma, Tulsa, and Cleveland

Table 14. Healthy People 2010 Objectives for P & S Syphilis and National Trend-line Actual Results

HP 2010 Objectives	Baseline Year	Baseline	2002	2003	2004	2005	2006	HP 2010 Target
25-3 Eliminate sustained domestic transmission of P&S Syphilis (cases per 100,000 Pop)	1997	3.2	2.4	2.5	2.7	2.9	3.3	0.2

The cost and complexity of treating these cases depends on whether they are early syphilis or latent syphilis. The estimated cost of treating a case of latent syphilis is \$409/case as compared to \$219 for early syphilis. Latent syphilis is more complex to treat because it requires three rounds of doctor visits and treatment while treatment for primary and secondary syphilis require only one visit. Compliance with timely medical care is required to eradicate latent syphilis.

Hepatitis: Viral hepatitis is an infection that affects the liver. There are at least **seven** different types of hepatitis (A-G), with the three most common types being hepatitis A (HAV), hepatitis B (HBV) and hepatitis C (HCV). It is speculated that there are many more forms of hepatitis that have yet to be discovered.

Hepatitis A: 2007 Case Total 13 2007 Rate 0.38 per 100,000

Hepatitis A is an acute, transient infection usually requiring no treatment with 99% of those infected fully recovering. There is a vaccine to prevent hepatitis A.

Hepatitis B: 2007 Case Total 152 2007 Rate 4.40 per 100,000

Hepatitis B can be either an acute and transient infection, with immunity to repeated infection, or can cause a chronic carrier state, which can lead to chronic liver disease and failure.

Approximately 2-10% of adults and 25-80% of children under the age of 5 will not clear HBV after six months of infection, and are thus chronically infected. There is a vaccine to prevent Hepatitis B. ***From 2006 to 2007, Oklahoma experienced a 58% increase in reported cases of acute hepatitis B***, marking the second consecutive year of increased hepatitis B captured by state surveillance. Enhanced reporting requirements, which require reporting the entire hepatitis panel into the Public Health Investigation and Disease Detection of Oklahoma (PHIDDO) system and receipt of liver enzyme results, contributed to the ability of program staff to classify more cases as confirmed that may have previously been of unknown status. However, it is unclear to what extent this reporting change contributed to the increase in acute cases.

Parallel with national reporting, a higher proportion of acute HBV infections were among men; eighty-eight of 152 cases (58%) were males. Hepatitis B rates varied by age with the highest case rates reported among persons 25 to 34 years of age (12.6 per 100,000) followed by 35 to 44 years of age (8.0 per 100,000) and 45 to 59 years of age (5.6 per 100,000). Adults aged 25 to 44 years accounted for 65% of the total acute hepatitis B infections identified in 2007.

The highest race-specific rates of acute hepatitis B were reported among Native Americans (7.7 per 100,000), followed by whites (4.3 per 100,000), Asian/Pacific Islanders (4.3 per 100,000), and Blacks (3.8 per 100,000). One case occurred in a person of Hispanic ethnicity. While no deaths were reported to have occurred related to acute hepatitis B infection, 39 cases (26%) were hospitalized as a result of acute HBV infection.

Hepatitis B Incidence rates of 10 per 100/000 or greater occurred in ten counties which include Adair, Cotton, Jefferson, Le Flore, Love, McIntosh, Okmulgee, Pittsburg, Sequoyah and Woodward.

Hepatitis C: 2007 Case Total 49 2007 Rate 1.42 per 100,000

Following a peak in the late 1980s, the U.S. incidence of acute hepatitis C declined through the 1990s; however, since 2003, disease rates have plateaued with a slight increase in reported cases in 2006. In 2006, as in previous years, the majority of these cases occurred among adults, and injection drug use (IDU) was the most common risk factor.

Prevention of hepatitis C relies on identifying and counseling uninfected persons at risk for hepatitis C (e.g., injection drug users) regarding ways to protect themselves from infection and on identifying and preventing transmission of hepatitis C virus (HCV) in health-care settings. Oklahoma surveillance data does not reflect the plateau; instead, the incidence of acute hepatitis C has increased each year since 2003 after a temporary decrease that year. Enhanced reporting guidelines and the electronic reporting system (PHIDDO) may be in part responsible for the increase. Enhanced clinician awareness and a related increase in testing could also be contributing to increased hepatitis C case detection. While the increased case trend may be artificial, it is of interest and requires continued monitoring.

In Oklahoma, it is estimated that 44,859 persons are infected with HCV. As of 2006, the Oklahoma State Department of Health (OSDH) has identified 14,750 Oklahomans with past or present HCV infections; demographics, laboratory test results, symptoms, and risk factors are entered into the OSDH viral hepatitis database.

Forty-nine (49) acute cases of hepatitis C were reported in 2007. Of those, twenty-one (43%) were female and twenty-eight (57%) were male. The youngest case was 18 years of age and the oldest was 77 years of age. The highest rates were among the ages of 25 to 34 years (4.87 per 100,000) and 45 to 59 years (1.75 per 100,000), followed by 15 to 24 years (1.35 per 100,000) and 35 to 44 years (0.95 per 100,000). The highest race-specific rates were seen among Native Americans (2.56 per 100,000), followed by whites (1.52 per 100,000) and Blacks (0.38 per 100,000). Risk factor information collected during case investigations again revealed that tattooing and IDU are common risks in acute HCV infection. Twenty-three (47%) had obtained a tattoo and 18 (37%) admitted to participating in IDU. Acute hepatitis C cases were dispersed across 23 Oklahoma counties in 2007.

Hepatitis C can cause liver disease and failure, liver cancer and cognitive impairment. Hepatitis C co-infection with AIDS can act as a catalyst in developing these co-morbidities. There is no vaccine to prevent HCV; however, currently there is treatment. This treatment is taxing to the individuals' body and quality of life, as common side effects include anemia, depression and flu-like symptoms that mimic opiate withdrawal. If individuals can tolerate the entire one-year treatment, it is only around 50% effective. Nationwide, about 30% of people with HCV are co-infected with HIV. The genotype of the HCV virus has a major impact on costs. Genotype 1

costs about \$36,000/case to treat, while treatment for genotypes 2 and 3 costs about \$12,000 per case.

Tuberculosis: 2007 Case Total 149 2007 Rate 4.1 per 100,000

Tuberculosis (TB) is often considered a disease of the past. Nearly one-third of the world's total population, or about two billion people, are infected with the bacteria that cause TB. Each year, approximately 9 million people around the world become sick with TB. Through public health efforts of timely case diagnosis, contact investigation, administration of therapy, prevention, and education, the United States has seen a steady decline of TB. Oklahoma has followed the national trend dropping from 190 cases reported with active tuberculosis disease in 2002 to 149 persons in 2007. Although the rate of TB has declined, TB remains a public health concern in Oklahoma. The incidence of TB/HIV co-infection has been declining in Oklahoma, with 10 cases reported in 2005; 6 cases reported in 2006 and five cases of HIV/TB co-infection reported in 2007. (*OSDH, 2008*) Active cases of TB understate the extent of the HIV/TB co-morbidity. Latent TB must also be treated. Fully 7% to 10% of PLWHA who have latent TB will develop active TB annually. Expensive as it is, treating latent TB in HIV positive people is clearly more cost effective than treating active TB. Inconsistent treatment of HIV and co-morbid diseases can select for drug resistant strains, however, Multi-Drug Resistant (MDR) TB is not yet prevalent in Oklahoma. Concern exists over the growing Hispanic population, especially illegal immigrants who have emigrated directly from Mexico where MDR TB cases may be found.

Mental Health Issues: Mental health and addictive disorders impose a greater burden of disability on Oklahoma citizens than cardiovascular disease or cancer. This was the surprising finding of the Oklahoma State Board of Health and the Board of Mental Health and Substance Abuse Services in a 2003 joint report. Though the leading cause of disability worldwide is infectious disease (22.9%), the leading cause in developed nations is neuropsychiatric disorders (25.5%). These reports make Oklahoma's predicament especially dire. Oklahoma has one of the nation's highest rates of mental illness, estimated to be at 11% of the adult population, or almost 300,000 people. The national average is 9.2%. (*Oklahoma KIDS Count, ACE Issue Brief #4, Mental Health and Substance Abuse, 2006-2007*)

Addictive disorders, including alcohol, tobacco and other drugs, are the number one public health problem in Oklahoma and nationally. It is estimated that nearly 140,000 Oklahoma adults need treatment for alcohol addiction, and an additional 21,000 people need treatment for other types of drug addiction. Especially worrisome are the numbers of pregnant and parenting mothers in need of treatment. Nearly 38,000 Oklahoma women are in need of substance abuse treatment, and almost 3,000 of those are pregnant. These numbers do not include figures for tobacco addiction. (*Oklahoma KIDS COUNT, ACE Issue Brief #4, Mental Health and Substance Abuse, 2006-2007*)

A study of Medicaid recipients showed that the prevalence of HIV infection was 0.6% among those who did not have a diagnosis of serious mental illness, and 1.8% among those who did. Patients with schizophrenia were 1.5 times as likely to have a diagnosis of HIV, and patients with a major affective disorder were 3.8 times as likely. Vice versa, HIV also can cause some

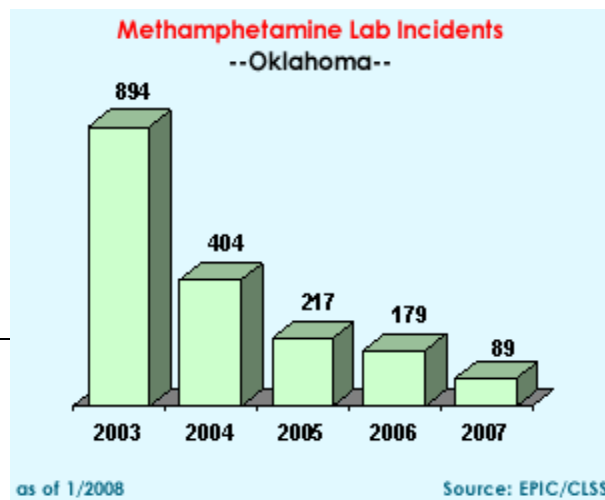
types of mental illness notably HIV/AIDS dementia, and movement disorders such as tardive dyskinesia. (*Co-occurrence of HIV and SMI among Medicaid Recipients, APA, 2002*) HIV also opens the door to opportunistic infections such as cytomegalovirus, and toxoplasmosis of the brain. Consequently HIV is more prevalent among mentally ill people than the general population. According to one study of mentally ill inpatients and persons in shelter, dually diagnosed persons are most likely to be HIV+ (18.4%); followed by the homeless (8.5%); acute cases (6.9%); and forensic cases (5.4%). Recent sexual interactions with IDUs or multiple partners, without taking risk reduction measures, contribute to co-morbidity. Non-injection drug users and alcoholics have reduced control over their behavior while under the influence and are more likely to engage in risky sexual behaviors. Triply diagnosed persons with HIV and alcohol or other substance abuse; and persons with depressive, anxiety, or personality disorders have the highest risks. Many PLWHA express a need for substantial mental health care.

Treating PLWHA with mental illness is complex and costly. The APA promotes integrated medical, psychiatric, and substance abuse treatment to stem the spread of HIV. It considers treatment of alcohol and substance abuse as risk reduction strategies. Among those already infected, their capacity for or adherence to treatment is a major problem. PLWHA who are homeless, substance abusers or who present with severe mental illnesses are difficult to engage and retain in care. Compounding this difficulty, many of the psychotropic and antiretroviral medications interact and may either inhibit or potentiate each other. Like HIV, some psychotropic medications can cause tardive dyskinesia. Based on a 1996 analysis of Medicaid claims, the cost for mental health treatment for people without serious mental illnesses was \$1,800 for persons without HIV, and \$7,400 for PLWHA (*Cost of Care for Medicaid Recipients with SMI and HIV Infection or AIDS, Psychiatr Serv 54, 2003*).

The Adverse Childhood Experience Study found that Tulsa is the worst region in the state for its percentage of adults experiencing severe psychological distress, followed by Lincoln, Creek, Okfuskee, Okmulgee, Wagoner, Cherokee, Muskogee, McIntosh, Adair and Sequoyah counties (*Oklahoma KIDS COUNT, ACE Issue Brief #4, Mental Health and Substance Abuse, 2006-2007*)

Substance Abuse Disorders: Addictive disorders, including alcohol, tobacco and other drugs, are the number one public health problem in Oklahoma and nationally. It is estimated that nearly 140,000 Oklahoma adults need treatment for alcohol addiction, and an additional 21,000 people need treatment for other types of drug addiction. Especially worrisome are the numbers of pregnant and parenting mothers in need of treatment. Nearly 38,000 Oklahoma women are in need of substance abuse treatment, and almost 3,000 of those are pregnant. (*Oklahoma KIDS Count, ACE Issue Brief #4, Mental Health and Substance Abuse, 2006-2007*)

Drug Situation: Methamphetamine, particularly crystal methamphetamine, which is produced in Mexico and the Southwest United States, remains the principal drug of concern in the State of Oklahoma. Cocaine,



particularly crack cocaine, is a significant problem in the urban areas of the state. Oklahoma also serves as a transshipment point for drugs being transported to the eastern United States via Interstates 40 and 44. Interstate 35 also provides a critical north-south transportation avenue for drug traffickers. (Source: http://www.ncbuy.com/health/drugs/us_ok.html)

Cocaine: Cocaine continues to be readily available throughout Oklahoma. The cocaine is transported from Texas and Mexico via commercial airlines and motor vehicles. Mexican poly-drug traffickers dealing in marijuana and methamphetamine bring some of the cocaine into the state. Much of the cocaine HCl is converted into crack cocaine for sale at the retail level. Cocaine is distributed primarily by Mexican and African American traffickers. An increase in the number of cocaine couriers over the past year have been white females in their mid to late 30s. The majority of the cocaine purchased in the Oklahoma City area is transported in by local suppliers who travel to large cities in Texas and return to distribute the product. (Source: http://www.ncbuy.com/health/drugs/us_ok.html)



Heroin: Black Tar heroin is available in extremely limited quantities near the metropolitan areas in Oklahoma. It is rare to encounter brown or white heroin. Colombian heroin hasn't been seen in the state for several years. Demand for heroin has declined in recent years. The majority of heroin traffickers in Oklahoma receive their heroin from Mexico. Most of the heroin transported into Oklahoma is concealed in hidden compartments in passenger vehicles. (Source: http://www.ncbuy.com/health/drugs/us_ok.html)

Club Drugs: The state of Oklahoma is seeing an increase in the abuse of club drugs, such as MDMA and GHB. MDMA is found at rave parties in eastern and central Oklahoma. The majority of the MDMA seen in Oklahoma comes from the West Coast, Nevada, and Texas. A small number of seizures have involved MDMA originating in Canada.

Marijuana: Marijuana is readily available in all areas of Oklahoma. Marijuana is the main illegal drug of abuse in the state. Marijuana imported from Mexico is prevalent and is usually imported in combination with other illegal drugs being transported to Oklahoma and other states north and east. The majority of the marijuana is imported from the southwest border via passenger vehicle and occasionally in freight vehicles. Mexican "Sensimilla", usually found in "pressed/brick" form, is the most common type of marijuana seen in Oklahoma, particularly in urban areas. Domestically produced marijuana is also available in Oklahoma, though not as readily in recent years. (Source: http://www.ncbuy.com/health/drugs/us_ok.html)

Other Drugs: The most popular pharmaceutical substances abused /diverted in Oklahoma are hydrocodone products. Oxycodone products as well as alprazolam, and phentermine are also

often abused/diverted. Methadone is a pharmaceutical drug of abuse on the rise in Oklahoma. Much of the diversion is through indiscriminate prescribing by physicians, unscrupulous pharmacists, the passing of fraudulent prescriptions, doctor shopping, pharmacy break-ins, and hospital thefts. (Source: http://www.ncbuy.com/health/drugs/us_ok.html)

Substance abusers are often faced with adherence and treatment issues due to the nature of their addictive behaviors. HIV infected substance users often require multiple levels of care and coordination because relapses are common. This population has a higher risk for developing bacterial infections, has higher rates of TB and HCV infections, and is likely to be on a variety of medications which contribute to the cost and complexity of care. According to a CDC Surveillance report, although the major risk factor for HIV infections among men is same-sex contact, among women with AIDS it is either IDU or heterosexual contact with another IDU. (CDC, 2006)

The estimated cost of treating drug abusers is highly dependent upon whether treatment is rendered in an outpatient or residential setting. On an outpatient basis, it would cost about \$3,000/case for treatment. The total costs for the residential treatment averages \$12,000-\$14,000/case including detox and primary treatment.

Household substance abuse significantly increases the risk of an unpredictable home life, and is linked to higher rates of domestic violence, divorce, unemployment, and involvement in the criminal justice system. The ACE Study found that the presence of an alcoholic parent doubled the risk of every other ACE category. This certainly plays out in Oklahoma, where research found that drug and alcohol addiction contributes to:

- 85% of all homicides
- 80% of all incarcerations
- 75% of all divorces
- 65% of all child abuse cases and 55% of all domestic assaults.

The financial costs of dealing with mental illness and diseases caused by tobacco, alcohol and other drug abuse in Oklahoma are staggering. The Governor's and Attorneys General Blue Ribbon Task Force conservatively placed the costs at more than \$3.2 billion annually in direct expenditures. (*Oklahoma KIDS Count, ACE Issue Brief #4, Mental Health and Substance Abuse, 2006-2007*) In Oklahoma, the worst counties for their percent of adults dependent on alcohol or drugs include Tulsa and Oklahoma counties, followed by Canadian, Grady, Cleveland, and McClain counties. (*Oklahoma KIDS Count, ACE Issue Brief #4, Mental Health and Substance Abuse, 2006-2007*)

Homelessness: As the housing crisis worsens throughout the United States, there are increased demands placed on emergency shelters without adequate shelter space to meet these increased needs. In 2005, 14 percent of overall emergency shelter requests went unmet and 32 percent of shelter requests by homeless families were unmet. (*U.S. Conference of Mayors, A Status Report on Hunger and Homelessness in America's Cities: A 24-City Survey 5 (Dec. 2005)*). There are more than 3.5 million Americans who will experience homelessness in a given year. Of these 3.5 million homeless Americans, 1.35 million are children — the fastest growing homeless

population. More than half of these children are under the age of 6. (*Martha Burt et al., Helping America's Homeless 49-50 (The Urban Institute Press, 2007)*). Oklahoma is not immune.

In Oklahoma, a survey and analysis of homelessness statewide has been conducted annually since 2005. The 2007 Statewide Point-In-Time Count evidenced the following homeless statistics in Oklahoma:

- Individuals: 2,448
- Persons in Families: 1,001
- Total Homeless: 3,449
- Chronically Homeless: 673

(Source: *Oklahoma's 10 Year Plan to End Homelessness, Governor's Interagency Council on Homelessness and the Oklahoma Department of Commerce, August 2008*)

It's estimated that more than 3,400 Oklahomans are homeless at any one time, including about 1,000 families. The majority of the state's homeless are in Oklahoma City (about 2,000 people on any given day), where families with children are a minority but also represent the fastest-growing demographic (*The Oklahoman, October 20, 2008*). **Oklahoma City's 2007 "Point-in-Time"** count of the homeless was approximately 1,930, an increase of almost 500 homeless individuals in a two-year span. On January 25, 2007, a one-night point-in time count revealed there were 890 homeless persons in **Tulsa**. This total included 772 adults and 118 children under the age of 18. This count included people meeting HUD's general definition of homelessness that were staying in shelters, transitional living homes, safe havens, and other institutions. (*Community Service Council of Greater Tulsa, 2007*)

The **top five services** most frequently cited as unmet needs by the 2007 Tulsa homeless survey participants included: 1) housing placement (48%); 2) transportation (30%); 3) dental care services (28.4%); 4) health care services (28.4%); and 5) job training (16.5%).

According to The Journal Record (June 16,2006) the 2006 'Point in Time' Homelessness survey in Oklahoma City found 1,555 countable homeless individuals in Oklahoma City, up from 1,482 a year earlier. Specific findings included:

- One-quarter were chronically homeless.
- 28 percent of those surveyed had been homeless for more than one year.
- 18 percent were military veterans.
- 28 percent reported mental illness.
- 16 percent reported being a member of a homeless family, while 84 percent reported being alone. (12 percent of the homeless were age 17 and under).
- As their last permanent residence: 52 percent reported Oklahoma City, 24 percent reported Oklahoma, and 24 percent reported out of state.
- 62 percent reported having at least one of the following special needs: mental illness, physical illness, and HIV disease.

Rural homelessness makes up approximately 9 percent of overall homeless population. In Oklahoma City, 28 percent met HUD’s definition of chronic homeless. Twenty-eight percent report mental illness. Thirty-nine percent (39%) report substance abuse and 19 percent report physical illness or disability. (*Hoch, W.H: Does Oklahoma Need a Homeless Court?, Oklahoma Bar Journal, 2008*)

Poverty: Oklahoma is the 6th poorest state in the nation with 42% of all Oklahomans having incomes below 200% of the federal poverty level. Oklahoma ranks 46th worst in the nation for its level of profound poverty (Kaiser Family Foundation Website, 2008).

Table 15. Percent of Low and Very Low Income in Oklahoma (KFF, 2006)

46: Oklahoma	Percent	0.0% - 100.0%
Under 100%	19.8%	
100-199%	21.7%	
▶--Low Income Subtotal	41.5%	
200% +	58.5%	

As evidenced in the table below, Blacks, Hispanics and American Indians carry the heaviest burden for level of poverty in Oklahoma, with Hispanics and African Americans faring worse than their national counterparts. (*Source: KIDSCOUNT, Updated September 2008*)






Table 16. Oklahoma Families Living Below 100% Poverty, by Race

RACE	2005	2006	2007	US 2007
White	18%	18%	16%	11%
Black	47%	46%	37%	35%
American Indian	27%	33%	29%	33%
Asian/Pacific Islander	NA	19%	9%	12%
Hispanic/ Latino	36%	37%	40%	27%
Total	23%	24%	22%	18%

Lack of Insurance: According to the Kaiser Commission on Medicaid and the Uninsured, 644,292 of Oklahoma's residents are uninsured (21.3%) compared to 16% nationally.

Oklahoma has the 46th worst rate of residents without medical insurance and the state ranks sixth for uninsured adults ages 18 to 64 (*Kaiser Family Foundation, 2008*).

Table 17. Percent of Oklahomans who are Uninsured (*Source: KFF State Health Facts, 2008*)

46: Oklahoma	Percent	0.0% - 100.0%
Employer	55.8%	
Individual	4.6%	
Medicaid	14.3%	
Other Public	4.0%	
▶ Uninsured	21.3%	

The rates for lack of health insurance are only grimmer for rural residents of Oklahoma. (*US Census Bureau, 2005*). The minority populations, particularly the rural American Indian, African American and Hispanic communities, make up a disproportionate share of the uninsured. Prevalence rates for not having health care coverage for adults' ages 18 to 64 in Oklahoma are 28.7% for American Indians, 19.1% for African Americans, 28.7% for Hispanics, and 19.5% for whites, with an average non-insurance rate for all races of 20.4%.

Poor Health Rankings: Oklahoma ranks #45 among the 50 states for its overall health rankings. Oklahoma's rankings in outcomes associated with poor health include: #47 for total mortality; #44 for premature death; and #38 for infant mortality.

Oklahoma ranked 43rd in the nation for its performance based on the 10 KIDS COUNT measures of child well-being for the years 2000-2006, including percent of low-birth weight babies; infant mortality rate; rate of teen deaths by accident, homicide and suicide; teen birth rate; percent of teens who are high school drop-outs; percent of teens not attending school and not working; percent of children living in families where no parent has full-time, year-round employment; percent of children in poverty; and percent of families headed by a single parent. (*KIDS COUNT On-Line Data Book, 2008*).

HIV Risk Factors: Male and female Oklahomans, and African American and Hispanic youth in

particular, rank at very high risk on a number of key reproductive health indicators in Oklahoma, including but not limited to unintended pregnancy and teen pregnancy, and STIs, which place them at risk for HIV disease.

As evidenced in the table below, a greater proportion of Oklahoma teens are sexually active than teens across the nation.

Table 18. Teen Sexual Activity Data: Sexually Experienced Youth in Oklahoma (Centers for Disease Control and Prevention (2008). Youth Risk Behavior Surveillance United States, 2007)		
Statistic	Oklahoma	United States
Proportion of High School Students Who Have Ever Had Sex, 2007, by Grade, Gender, Race	50.9 %	47.8%
Grade 9th	31.3 %	32.8%
Grade 10th	50.4%	43.8%
Grade 11th	59 %	55.5%
Grade 12th	67.9%	64.6%
Statistic	Oklahoma	United States
Males	52.5 %	49.8%
Females	49.3%	45.9%
Non-Hispanic White	46.3 %	43.7%
Non-Hispanic Black	64.7%	66.5%
Hispanic	52.5 %	52%

Other Race	55.6%	35.2%
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Youth Risk Behavior Survey: Oklahoma’s percentage of students who have ever had intercourse is 51%, compared to the US rate of 47.8% (*YRBSS, 2007*). A third (33%) reported having had four or more sexual partners: a risk for STIs and HIV infection. Nearly half (48%) of the students had used a condom during their most recent sexual intercourse, during the last three months; 10% “withdrew” and 17% used birth control pills, evidencing the high unmet need for confidential family planning counseling, education and services for minors (*YRBSS, 2007*).

Teen and Unintended Pregnancy Rates in the Oklahoma Service Area: While the national teen birth rate has declined to its lowest level in 60 years, Oklahoma remains among the 10 worst states in the nation. On the average, every three hours an Oklahoma child (age 17 or younger) becomes a mother. (*Oklahoma Kids Count Data Book, 2007*) A total of 59 of Oklahoma’s 77 counties have teen birth rates higher than the national average of 41.1/1,000 girls (ages 15-19 years). **Oklahoma ranked among the top 10 states with the highest (worst) teen birth rates in the nation in 2006 in the following categories: 3rd highest in the percentage of births to teens, as a percentage of all births; and 10th highest in the percentage of births that are repeat births to teens** (*National and Oklahoma Vital Statistics, Oklahoma Interagency Coordinating Council for the Prevention of Adolescent Pregnancy and STDs, 2007*).

The 6.9% increase in the adolescent birth rate evidences a significant unmet need for contraceptive services and supplies for teens in underserved counties in Oklahoma, as well as a strong risk indicator for HIV and other STIs. (*Oklahoma Health Services Commission, 2007*).

According to KIDSCOUNT, 2008, Oklahoma females of all races demonstrate higher rates of teen births across all age groups, as compared to the national averages. (See Table 19 on the following page)

Table 19. Oklahoma Teen Birth Rates per 1,000 Female Population

Oklahoma Teen births, by Age Group (Rate per 1,000)	2001	2002	2003	2004	2005	US 2005
15 to 17	31	30	29	30	28	21
18 to 19	97	98	95	92	92	70
15 to 19	58	58	56	56	54	40

Health Disparities among Minorities and Special Populations: American Indians are heavily

and disproportionately impacted by poor health rankings and premature deaths. African American youth and adults are the most disproportionately impacted population for their level of STIs and HIV in the state. Hispanic women and girls bear the greatest burden of teen births, premature births and inadequate prenatal care, as well as bear a disproportionate share of new AIDS cases. All of these disparities are compounded for rurally residing minorities who also bear the greatest levels of poverty, un-insurance and lack of access to health care services.

Racial and ethnic minorities are projected to reach 50% of the entire Oklahoma population by 2010-2015, which is expected to substantially increase the disparate impact of persons living with HIV/AIDS within minority communities, and significantly strain existing HIV services.

CHAPTER 4: Description of Current State Response to the Epidemic

In the early 1980's the Acquired Immune Deficiency Syndrome (AIDS) virus had begun to claim the lives of thousands of Americans. In response to a public outcry, Congress recognized AIDS as a national crisis, and responded with the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act. The Act was named as a memorial to Indiana teenager Ryan White. Ryan educated the public and Congress about HIV/AIDS before he died of the illness in 1990.

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, enacted in 1990 and re-authorized in 1996 and 2000, was intended to help communities and states increase the availability of primary health care and support services, reduce utilization of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the HIV/AIDS epidemic. The Act was created to establish services for patients with Acquired Immunodeficiency Syndrome (AIDS) or HIV who would otherwise have no access to health care. It was meant to provide emergency relief funding to communities with the highest number of reported AIDS cases.

In 2006, Congress enacted the Ryan White HIV Treatment Modernization Act, which created several important funding and programmatic changes. Oklahoma does not qualify for Ryan White Part A funds, as they provide emergency relief grants to metropolitan areas with over 500,000 population and at least 2,000 Persons Living With HIV/AIDS for at least a five-year period. Oklahoma does receive Part B funds which provide formula grants to states and territories to improve the quality, availability, and organization of health care and support services for individuals and families with HIV disease. Ryan White Part C funds provide grants for local Early Intervention Treatment. (Oklahoma contains two Part C funded comprehensive primary care clinics, in Oklahoma City and in Tulsa). Ryan White Part D funds provide health care funding for women, children, youth and families, with a Part D funded program located in Oklahoma City. Part F makes available grants for community-based organizations to provide services to people living with HIV disease and training for health care professionals.

Oklahoma has been granted Part B funds every year since the inception of the Ryan White CARE Act legislation. Eligibility for Oklahoma residents requires that they have a documented HIV infection and/or documented AIDS diagnosis. HDAP does have prescription co-pay and deductible assistance for persons with insurance, however, HDAP is the secondary or payer of last resort. Applicants must have a documented monthly family household gross income (before deductions) of not more than 200% of the current Federal Poverty Guidelines, after a work related deduction and out-of-pocket documented medical expenses are deducted from the gross monthly income. Eligible applicants may be placed on a waiting list due to demand exceeding resources. Currently Ryan White Part B funding is being used for the HIV Drug Assistance Program (HDAP), the Home Health Care Program, the Health Insurance Assistance Program (HIAP), and the Supportive Services Program. The table below documents all HIV funding by source in Oklahoma for the 2007 fiscal year.

Table 20. Oklahoma Distribution of Ryan White Program Part B Funding By Component, FY2007 (Source: Kaiser Family Foundation State Health Facts, 2007)

	OK %	OK \$	US %	US \$
Part B Base	42%	\$3,808,981	28%	\$324,389,800
Part B ADAP	47%	\$4,253,231	67%	\$775,320,700
Part B ADAP Supplemental	11%	\$1,028,438	3%	\$39,477,300
Part B MAI	0%	\$20,313	1%	\$6,739,600
Part B EC	0%	\$0	0%	\$5,000,000
Total	100%	\$9,110,963	100%	\$1,150,927,400

CHAPTER 5: Assessment of Need for In Care & Out of Care; Unmet Need Estimate; Service Gaps & Prevention Needs

Assessment of Need and Service Planning:

The Oklahoma HIV Planning Council (OHPC) is the integrated Statewide HIV prevention and care planning body of physicians, Ryan White providers, community leaders, State agency representatives, HIS and other service providers, and consumers. Working in partnership with the Oklahoma State Department of Health, HIV/STD Service, the Oklahoma HIV Planning Council reviews numerous data sources and makes recommendations as to the best utilization of the Ryan White Part B funds and helps to develop and maintain a comprehensive continuum of care for those living with HIV disease. After analyzing regional and statewide needs assessments, service barriers, gaps in services, all Ryan White and other resources available, they develop and submit an HIV service delivery plan for Oklahoma and evaluate these services for cost effectiveness and efficacy in meeting consumer needs. It is the policy and mission of the OHPC to ensure active, diverse and substantive input and involvement of persons living with HIV or AIDS (PLWHA) in the planning process.

As an integrated HIV prevention and care planning body, the composition of the OHPC membership meets both CDC and HRSA expectations. CDC requires adherence to certain principles for the HIV prevention community planning process. Parity, inclusion and representation characterize the process. In accordance with HRSA guidelines for HIV care planning, OHPC ensures that at least 20% of the voting membership includes persons living with HIV/AIDS. As consumers of Ryan White funded services, PLWHA have a unique understanding of prevention and service needs, which make them essential participants in the planning, implementation and evaluation of HIV prevention and care services. The changing face of AIDS requires diverse PLWHA representation, including women, people of color, youth, recovering substance abusers, urban and rural residents, and members of other affected populations.

The primary responsibilities of the OHPC are:

- To develop and maintain a comprehensive Statewide HIV prevention and care service delivery system
- To establish annual prevention priorities for CDC funded interventions and develop triennial HIV treatment and care service priorities and determine Ryan White Part B funding allocations on an annual basis for each service

The Planning Council is comprised of a committee structure and each committee serves to respond to specific duties. Six (6) committees function on a voluntary basis, including:

- Executive Committee
- Needs Assessment and Evaluation Committee
- Membership Committee
- Policy Committee
- Care Committee
- Prevention Committee

The Assessment and Evaluation Committee is charged with the commission of two key documents: a Comprehensive Strategic Plan over a three-year timeframe and Needs Assessment (annual update and comprehensive three year plan). The Plan is a compilation of all planning documents required by HRSA and is monitored on an ongoing basis. The SCSN is reviewed and updated on a triennial basis to identify the evolving medical care and social service needs and trends in needs of persons living with HIV/AIDS in Oklahoma with emphasis the identification of gaps in service or unmet needs.

Needs assessment in Oklahoma is particularly important with an estimated 48% of HIV positive individuals who are aware of their HIV status, but are not receiving primary healthcare (*Diehl et al., 2007*). When assessing the prevention needs of HIV positive individuals, a high rate of HIV positive individuals were engaging in unprotected sex and felt uncomfortable disclosing their status to sex partners. (*Spector, Diehl, & Shah, 2004*). With nearly 50% of HIV positive individuals in Oklahoma out of care based on unmet needs in 2008, this is cause for concern. Clients in care reported fewer instances of unprotected sex, and have the opportunity to receive risk reduction counseling. Studies suggest that ancillary services (such as case management) have positive impacts on access and retention in medical care (*Lo, MacGovern, & Bradford, 2002; Friedman et al., 2000*).

In order to better target HIV prevention and treatment/ care services, healthcare providers and government agencies need to know more about the services clients need that are already in care and any barriers they experience in trying to access these services. In addition, providers and government agencies need to know the demographics and characteristics of clients out of care, why they are out of care, and what services help bring them into care and remain in treatment to improve the quality of life of clients and prevent further spread of HIV infection in Oklahoma. The 2006/2007 needs assessment includes analysis and comparison of a number of data sources including:

- Demographics of the state, subdivided by metropolitan statistical areas (MSAs)
- Epidemiology of the state, subdivided by metropolitan statistical areas (MSAs)
- Client Surveys (questionnaires, individual interviews and/or focus groups)
- Annual program service usage and spending

In addition, the Needs Assessment presents detail regarding vulnerable sub-populations or severe need groups including:

- ❖ Traditionally underserved populations such as women and minorities
- ❖ Disproportionately affected populations such as minorities, men who have sex with men and injection drug users
- ❖ Individuals currently in care
- ❖ Individuals who know their status but are not in care
- ❖ Individuals who are newly or recently diagnosed.

The survey instrument used for the comprehensive Statewide needs assessment provided information to assist the Oklahoma HIV Planning Council in establishing priorities for future

service funding, including: 1) A sample that derived valid and reliable statistical conclusions on service needs of people with HIV/AIDS related to the epidemiological profile for the state; 2) Information that assisted the Council to address the question of which Ryan White eligible services are needed most by persons living with HIV/AIDS, in order to keep them healthy and maintain independence; 3) Identified gaps in services (In Care) or unmet service needs (Not in Care) for persons with HIV/AIDS; and 4) Identified reasons why people are not in care including listing barriers to accessing specific services so that the OHPC could determine how to enhance the current service delivery system.

Summary of 2006/2007 Needs Assessment Findings

2006 In Care Survey Participant Demographics: A total of 115 individuals participated in the 2006 In Care survey, reporting they had at least one viral load, CD4 count, or evidence of ART in the last 12 months. Of these individuals, 102 (88.7%) were male, 11 (9.6%) were female, and 2 (1.7%) were of unknown gender. The mean age of respondents was 42 years of age, ranging from 24 years to 68 years. Of those with known race/ethnicity, 6 (5%) were Hispanic, 78 (69%) were White, 13 (11%) were Black, and 17 (15%) were American Indian/ Alaska Native (Fifty-six (49%) of respondents were receiving case management services in the OKC MSA, 14 (12%) in the Lawton MSA, and 45 (39%) in the Tulsa MSA. Of those with known risk/exposure, 64 (71%) were MSM, 1 (1%) MSM/IDU, 10 (11%) IDU, 12 (13%) Heterosexual, and 3 (3%) were exposed through blood products/ transfusion. In addition, 16 respondents were unaware of how they were exposed, and 9 respondents preferred not to disclose their risk/exposure. All female respondents with known risk/exposure were heterosexual, whereas the majority of male cases were MSM, followed by injection drug use and heterosexual exposure. Table 21 below represents HRSA-defined “severe need group populations” based on self-reported risks, gender, race, and age. Those with missing information on some demographics could not be assigned to a severe need population.

Table 21. In Care Respondents by Severe Need Group Membership

Severe Need Group	N	%	Severe Need Group	N	%
Black MSM	4	4%	IDU	10	10%
White MSM	50	52%	Heterosexual Male	4	4%
American Indian	17	18%	WCB	7	7%
Hispanic MSM	3	3%	Females over 50	2	2%

Overall ‘In Care’ Need Rankings

Ninety-nine (99) of 115 In Care respondents selected the 10 most needed services from a list of 24 services including the following: case management, dental care, emergency medical services, emergency financial assistance, food bank, health insurance assistance, home health care, housing, hospice, inpatient medical care, inpatient substance abuse treatment, long term care,

medications, mental health therapy, nutritional services, HIV specialist primary medical care, patient education services, physical rehabilitation, prevention case management, research/ clinical trials, outpatient diagnostic and treatment services, outpatient substance abuse treatment, support services (child care, legal, etc.), and transportation. Of the 24 services to choose from, the following seven services ranked in the top 10 needed services.

Table 22. Top 10 Needed Services for 2006 in Care Respondents

Rank	Service	# of respondents that needed this service	% of respondents that needed this service
1	Medications	91	92%
2	Care Coordination/ Case Management	74	75%
3	Dental Care	70	71%
4	HIV Specialist Primary Medical Care	60	61%
5	Emergency Financial Assistance	52	53%
6	Food Bank	51	52%
7	Mental Health/ Counseling	46	47%

Service Gaps and Service Barriers

The following services were reported to be difficult to access (Service Barriers) and/or perceived as unavailable (Service Gaps) in order of frequency:

- Oral health care,
- Housing,
- Medications,
- Transportation, and
- Third party/Health insurance benefits. Responses were categorized from the open-ended responses.

Dental Care: The majority of respondents listing dental care as difficult to access cited financial and funding issues as barriers to this service. In addition, one person stated that dental services were “not available.” One person reported “Medicare doesn’t pay.”

Housing: Barriers to housing varied by respondent. One individual stated that housing was difficult to access because there needs to be “more money/ services for women with

children/family.” Another stated he had recently been evicted and could not find housing that would accept him. Other barriers included use of “drugs,” “no help available,” and “required to have an income.”

Medications: One client reported that having to fax medication refills from the clinic to the pharmacy was delaying receiving HIV medications, “being without HIV medications for 4 days.” Another client reported that HDAP and Compassionate Care expired and he was not notified in time to fill the prescriptions. Another client stated “Medicare/ Medicaid won’t pay [for medications].”

Transportation: Barriers to transportation include some inefficiency within the system, as well as funding stipulations. One client stated that there are “long waits on the phone.” Another client reported that transportation is “almost always late if on Medicaid.” Obtaining gas vouchers was also a barrier, due to clients having to find someone to drive them, and then later being reimbursed for expenditures. One client stated that transportation providers are “unable to help due to the insurance I have.”

Third Party Benefits: Barriers to obtaining third party benefits included needing more assistance with the application processes, understanding the requirements of third party pay sources, and navigating the third party pay system for uninterrupted services. One client was told by DHS that he qualified for the Advantage program, but he was denied by ADvantage waiver benefits based on the medical requirements of the program. Another client reported that he did not think he could access health insurance assistance if he did not have SSI (Social Security Income).

Severe Need Groups’ Top Service Needs by Service Area

The response from severe need groups differed between the Western Service Area (includes Lawton and OKC MSAs) and Eastern Service Area (includes Tulsa MSA).

The Western Service Area had a proportionately greater response from White MSM and Women of Child-bearing Years than the Eastern Service Area.

The Eastern service area had a proportionately greater response from Black MSM, American Indians, Injection Drug Users (IDUs), and Heterosexual Males.

The largest differences in survey responses based on service location were among White MSM, American Indians, and Injection Drug Users respectively.

(See Table 23 on the following page)

Table 23. Western Service Area Severe Need Groups

Severe Need Group	N	%
Black MSM	2	3%
White MSM	37	59%
American Indian	9	14%
Hispanic MSM	2	3%
IDU	5	8%
Heterosexual Male	2	3%
Women of Child-bearing Years	5	8%
Females over 50	1	2%
Total	63	100%

Table 24. Eastern Service Area Severe Need Groups

Severe Need Group	N	%
Black MSM	2	6%
White MSM	13	38%
American Indian	8	24%
Hispanic MSM	1	3%
IDU	5	15%
Heterosexual Male	2	6%
Women of Child-bearing Years	2	6%
Females over 50	1	3%
Total	34	100%

Comparison of Top Ranking Needs by Severe Need Group and Geographic Location

The top ranking Needs (those with highest percentage of need) were analyzed for each severe need group by location, (except for Hispanic MSM due to small sample size). All SNG top ranking needs were also among the top 10 rankings for the state except for Patient Education reported as a high need by Black MSM in the Eastern Service Area and prevention case management reported as a high need by Black MSM in the Western Service Area. These account for the largest discrepancies when comparing overall state need rankings with rankings by severe need group.

By risk/exposure, 11 (or 69%) were MSM, 1 (or 6%) IDU, and 4 (or 25%) Heterosexual contact. In addition, two respondents preferred not to disclose their risk/exposure. All female respondents with known risk/exposure were heterosexual, whereas the majority of male cases were MSM, followed by heterosexual exposure and injection drug use, respectively. Heterosexual exposure proportions were greater for out of care respondents than in care respondents.

Table 25. In Care Primary Needs by Severe Need Group and Service Area

Severe Need Group	Western Service Area	Eastern Service Area
Black MSM	Prevention Case Management, Medications, & Dental	Care Coordination/ Case Management, Emergency Financial Assistance, Medications, Nutrition, & Patient Education
White MSM	Medications	Medications
American Indian	Care Coordination/ Case Management & Medications	Food Bank
Hispanic MSM*	NA	NA
IDU	Dental & Medications	Dental, Emergency Medical, Food Bank, and Medications
Heterosexual Male	Dental	Medications
Women**	Emergency Financial Assistance, Medications	Dental, Mental Health, & HIV Specialist Medical Care

*Sample size too small to group by service area. Overall statewide primary needs for Hispanic MSM were medications, HIV specialist primary medical care, dental, and care coordination/ case management.

**Women of Child-bearing Years and Women over 50 primary needs were combined due to small sample size.

1. HIV Care and Treatment Service Needs

The majority of the severe need groups reported Medications as being a primary need; however, there were differences in needs between groups as well as geographic locations within the severe need groups. Medications were not listed as a top ranking need for the following groups in the Eastern Service Area: Black MSM, American Indians, and Women. The Heterosexual Male severe need group also do not list medications as a primary need in the Western Service Area. Several groups reported Dental Care as a primary need including Black MSM (Western), IDU (Western and Eastern), Heterosexual Male (Western), and Hispanic MSM statewide also reported Dental Care as a top ranking need.

Although Care Coordination/ Case Management was a high need in overall rankings for the state, only Black MSM in the Eastern Service Area, American Indians in the Western Service area, and Hispanic MSM statewide reported it as the top ranking need. HIV Primary Medical Care was a top need for Women in the Eastern Service Area and Hispanic MSM statewide. The only severe need group that reported Mental Health as a top ranking need was Women in the Eastern Service Area. Emergency Medical Services was only reported by IDU in the Eastern Service area as a top ranking need.

2. HIV Prevention/ Education Needs

Black MSM in the Western Service Area reported Prevention Case Management as a primary need and was the only severe need group to report it as a primary need. Black MSM in the Eastern service area was the only SNG to report Patient Education as a primary need.

3. Other Support Service Needs

Two severe need groups (American Indians and IDU) in the Eastern service area reported Food Bank services as a primary need, while the Western Service Area severe need groups did not report Food Bank as a primary need. Emergency Financial Assistance was a primary need for Black MSM in the Eastern Service Area and Women in the Western Service Area. Black MSM in the Eastern service area was the only group to report Nutritional Services as a top ranking need.

2006 Out of Care Client Survey Response

Demographics of 2006 OOC Participants

A total of 18 individuals reported they did not have at least one viral load, CD4 count, or evidence of ART in the last 12 months. Of these individuals, 15 (83.3%) were male, 2 (11.1%) were female, and 1 (5.6%) were of unknown gender. The mean age of respondents was 41 years of age, ranging from 19 years to 78 years.

Of those with known race/ethnicity, 0 (0%) were Hispanic, 8 (44%) were White, 7 (39%) were Black, and 3 (17%) were American Indian/ Alaska Native. A greater percentage of out of care clients (39%) were Black as compared to 11% of the in care respondents. Table 26 below represents HRSA “severe need group populations” based on self-reported risks, gender, race, and

age. Those with missing information on some demographics could not be assigned to a severe need population.

Table 26. Out of Care Respondents by Severe Need Group Membership

Severe Need Group	N	%
Black MSM	2	12%
White MSM	6	35%
American Indian	3	18%
IDU	1	6%
Heterosexual Male	3	18%
Women of Child-bearing Years	2	12%
Total	17	100%

Twelve (67%) of the OOC respondents were receiving case management services in the OKC MSA, 2 (11%) in the Lawton MSA, and 4 (22%) in the Tulsa MSA. In comparison for those in care, 49% were receiving case management services in the OKC MSA, 12% in the Lawton MSA, and 39% in the Tulsa MSA. Of those out of care with known risk/exposure, 11 (69%) were MSM, 1 (6%) IDU, and 4 (25%) Heterosexual. In addition, two respondents preferred not to disclose their risk/exposure.

All female respondents with known risk/exposure were Heterosexual, whereas the majority of male cases were MSM, followed by Heterosexual exposure and injection drug use respectively. Heterosexual exposure proportions were greater for out of care respondents than in care respondents. ***A greater proportion of out of care clients were Black MSM, Heterosexual Male, and Women of Child-bearing Years than the In Care survey respondents.***

Years since Diagnosis

Out of care respondents ranged from living with HIV/AIDS from 0 to 21 years since diagnosis, with a mean of 9 years living with HIV/AIDS. One client was newly diagnosed within the year.

Referral to Care and Medical Care Access within One Year of Testing Positive

Three clients reported they were not referred for medical care. Of those not referred, none received medical care within a year of testing positive. Two out of the 3 respondents not referred for medical care were Black. Of those who were referred, 69% reported they received medical care within one year of testing positive. There was a significant relationship between being

referred for medical care and accessing medical care within one year of testing positive ($r(13) = 0.61, p = .015$). Reasons for not accessing medical care within one year of testing positive included “didn’t think I needed it” (3), “don’t trust doctors” (1), “locked up” (1), “moved out of state” (1), and “I was depressed” (1).

All severe needs groups except for Heterosexual males and Black MSM reported Transportation as the primary reason for not getting medical care in the past year. In addition, the Black MSM and White MSM severe need groups reported being anxious about going to the doctor/nurse about their HIV and the American Indian severe need group reported “I didn’t think I needed medical care” as a primary reason. “I didn’t want to receive medical care” and “I couldn’t afford medical care” were only reported as primary reasons by the Heterosexual Male severe need group. No clients reported wait lists at clinics as a reason for not getting medical care in the past year. Table 27 depicts the top 5 reasons to explain why clients did not get medical care in the past year, as well as the severe need groups that reported each item as their primary reason for not getting medical care. Clients were allowed to respond to more than one item. Some severe need groups had more than one primary reason for not receiving medical care in the past year. The IDU severe need group did not respond to this item.

Table 27. Primary Reasons for Not Obtaining Medical Care in the Past Year for HIV

Reason	# of Clients N=13	% of Clients	Severe Need Groups Reporting as a Primary Reason
I lacked transportation to get to medical care appointments.	6	46%	White MSM, American Indian, Women of Childbearing Years
I get anxious about going to a doctor/nurse about HIV.	4	31%	Black MSM, White MSM, Heterosexual Male
I did not think that I needed medical care.	4	31%	American Indian, Heterosexual Male
I didn’t want to receive medical care.	3	23%	Heterosexual Male
I couldn’t afford medical care at the time.	3	23%	Heterosexual Male

Reasons for seeking HIV medical care services after being out of care for 12 months or longer

Most severe need groups (with the exception of Black MSM) reported being concerned about their health as the primary reason for seeking medical care after being out of care. Black MSM

reported “I am sick” as being the primary reason for seeking medical care. In addition to being concerned about their health, Heterosexual Males reported knowing medications are available that can help with their HIV as a primary reason for seeking medical care. Although having a place to live and a doctor that respects them were in the top 5 reasons clients are now seeking medical care, no severe need group rated these items as the primary reason for now seeking medical care. The IDU severe need group did not respond to this item.

Table 28. Top 5 Reasons for Now Seeking Medical Care

Reason	# of Clients N=15	% of Clients	Severe Need Groups Reporting as a Primary Reason
I am concerned about my health.	10	67%	White MSM, American Indian, Heterosexual Male, Women of Child-bearing Years
I am sick.	5	33%	Black MSM
I have a place to live.	4	27%	NA
I have a doctor that respects me.	3	20%	NA
I know there are medications that can help me with my HIV.	3	20%	Heterosexual Male

Services that helped you get into medical care for HIV

Most severe need groups reported HIV Case Management/ Care Coordination as the primary service that helped get them into Primary Medical Care; only Black MSM and Women of Child-bearing Years did not report case management as a primary service that got them into medical care.

Black MSM reported Mental Health treatment as the primary service facilitating access to medical care, and Women of Child-bearing Years reported outreach as the primary service getting them into medical care.

In addition to case management as a primary service, the American Indian severe need group also reported HIV Counseling, Testing, and Referral Services, Housing, and Indian Health Services as playing a major role in accessing medical care.

The Heterosexual Male severe need group, in addition to Case Management, reported outreach and “my will to live” as primarily facilitating access to medical care.

The IDU severe need group did not respond to this item.

Table 29. Primary Services that Facilitated Referral and Access to Medical Care

Service	# of Clients N=15	% of Clients	Severe Need Groups Reporting as a Primary Referral Service
HIV Case Management/ Care Coordination	6	40%	White MSM, American Indian, Heterosexual Male
HIV Counseling, Testing, and Referral Services	5	33%	American Indian
Outreach	4	27%	Heterosexual Male, Women of Child-bearing Years
Mental Health Treatment/ Substance Use Treatment	2	13%	Black MSM

Services that will continue to keep you in HIV Primary Medical Care

All severe need groups (except Women of Child-bearing Years) reported HIV Medication Assistance Programs as a primary retention service. In addition, most severe need groups reported HIV Case Management/ Care Coordination as helping them continue their medical care. Black MSM and Women of Child-bearing Years were the only severe need groups that did not indicate HIV Case Management as a primary retention service. Transportation was reported by White MSM and American Indians, HIV Specialist Care by White MSM, Dental and Health Insurance Assistance by American Indians, and Housing by American Indians and Women of Child-bearing Years also as primary services that will help continue to keep clients in medical care. Although Health Insurance Assistance did not rank in the top 5 retention services for all respondents, American Indians reported it as a primary service for retention in medical care. (See Table 30 below and on the following page)

Table 30. Services That Will Help Retain Clients in Medical Care

Service	# of Clients N=15	% of Clients	Severe Need Groups Reporting as a Primary Retention Service
HIV Medication Assistance Programs	10	67%	Black MSM, White MSM, American Indian, Heterosexual Male
HIV Case Management/ Care Coordination	9	60%	White MSM, American Indian, Heterosexual Male

Service	# of Clients N=15	% of Clients	Severe Need Groups Reporting as a Primary Retention Service
Transportation	7	47%	White MSM, American Indian
Housing	6	40%	American Indian, Women of Child-bearing Years
HIV Specialist Primary Medical Care	6	40%	White MSM

Summary of In Care and Out of Care Needs Assessment Results

Based on these results, the In Care Severe Need Groups shared common service priorities, but differences did occur among some Severe Need Groups. Most In Care Severe Need Groups reported Medications as their primary needed service; however, Black MSM had the largest discrepancies in need from the overall need rankings statewide, reporting Patient Education as a high need in the Eastern Service Area and Prevention Case Management (or Comprehensive Risk Counseling Services) as a high need in the Western Service Area. Dental Care services were perceived as unavailable and/or difficult to access statewide for In Care respondents mainly due to lack of financial resources. Respondents also expressed difficulties in understanding third party pay sources and requirements for programs.

Out of Care respondents reported lack of Transportation to medical appointments as the primary reason for being out of care in the last year. There was a significant relationship between being referred for medical care and accessing medical care within one year of testing positive. The majority of Out of Care respondents listed Care Coordination/ Case Management as the service getting them into medical care, and listed Medication assistance programs as the primary service that will keep them in medical care. However, Black MSM reported Mental Health/ Substance abuse services as the primary services promoting entry into medical care. Women of Childbearing Years reported Housing as the primary service that will keep them in medical care.

Based on the findings from the 2005-2006 Needs Assessment Update, the Oklahoma State Department of Health, in collaboration with the newly formed joint planning body, the Oklahoma HIV Planning Council (OHPC), should focus on the following three initiatives:

- 1) Incorporating more education and prevention messages into the medical treatment of those living with HIV/AIDS
- 2) Creating more capacity for navigating and understanding care systems
- 3) Increasing referral and follow-up of services to ensure clients enter and remain in HIV medical care.

The following are options the OSDH and OHPC may want to consider to address these initiatives:

- Provide evidence-based interventions to Severe Need Groups to facilitate initiation and retention in medical care (prevention case management, outreach case management, interventions specific to Black MSM).
- Develop referral protocols and improve communication between HIV CTR, case management, and medical staff to ensure referrals/ follow-ups are provided to newly positive clients.
- Explore all transportation resources and provide education to clients and providers.
- Explore barriers to obtaining dental care services.
- Develop an action plan for ensuring clients have greater access to needs assessments.
- Develop an updated service resource inventory and eligibility requirements of programs.

Comparison to 2003 Needs Assessment Findings

2003 Client Sample: A total of 184 clients completed In Care and Out of Care surveys of which 89% (108) were from Oklahoma City residents, 40% were from Tulsa residents (74), and 2 were from out of state. The In Care respondents divided closely, with a total response of 101, with 54% from the Oklahoma City area (55) and 46% from the Tulsa area (46).

Out of Care respondents were weighted toward Oklahoma City, with 51 out of a total of 83 Out of Care respondents. Oklahoma City had 61% of Out of Care participants (51); Tulsa had 36% (30) and 2 Out of Care respondents were from Out of State but accessing services in Oklahoma (2%). This response rate reflects 3.9% of all People Living with HIV/AIDS (184/4,690 PLWH/A) in Oklahoma.¹

The average age of respondents was 41.25 years, with a wide range from 9 years to 68 years of age. Average annual income was \$11,941, ranging from \$0 to \$120,000.

¹ HIV Prevalence as of May 2002, Epidemiologic Profile, p. 88.

2003 In Care Needed Services: Nine (9) services were listed under ‘needed services’. Rankings were separately analyzed for the Western and Eastern service areas (405/580 vs. 918 area codes).

Table 31. Services Needed and Couldn’t Access - 405/580 Area Code

ALL RESPONDENTS: (n=55)					
Service Category	Need	Use	Barrier	Gap	Gap Rank
Dental Care	32%	40%	15%	11%	6
Primary Medical Care	23%	43%	6%	13%	5
Vision			11%	11%	6
Case Management	19%	23%	4%	23%	1
Mental Health	19%	23%	2%	11%	6
Emergency Medical	11%	15%	6%	13%	5
Substance Abuse	9%	13%	6%	15%	4
Education	6%	11%	2%	13%	5
Nutrition	4%	11%	2%	9%	7
Prevention	4%	9%	2%	21%	2
Meds & Therapeutics	4%	4%	4%		
Inpatient	2%	2%	2%	13%	5
Rehab			2%	11%	6
Hospice			4%	19%	3
Support Services			2%	11%	6
Long Term Care			2%	13%	5

Service Gaps noted in the 2003 survey of 405/580 area PLWHA included Case Management, Prevention, Hospice, Substance Abuse treatment, and Primary Medical Care.

Table 32. Services Needed and Couldn't Access - 918 Area Code

ALL RESPONDENTS (n=46):					
Service Category	Need	Use	Barrier	Gap	Gap Rank
Dental Care	18%	24%	11%	13%	1
Primary Medical Care	11%	35%	4%	7%	4
Vision	26%	26%	7%	7%	4
Case Management	8%	22%	4%	12%	2
Mental Health	13%	26%	9%	2%	6
Emergency Medical	8%	22%	15%	4%	5
Substance Abuse	11%	22%	11%	2%	6
Education	8%	17%	7%	4%	5
Nutrition	13%	24%	4%	4%	5
Prevention	16%	15%	13%	4%	5
Meds & Therapeutics	3%	11%	7%	2%	6
Inpatient	5%	15%	7%	4%	5
Rehab	16%	13%	7%	4%	5
Hospice	3%	15%	11%	2%	6
Support Services	12%	15%	7%	2%	6
Housing	29%	22%	7%	9%	3
Child Care	11%	4%	20%		
Long Term Care	3%	11%	2%	13%	1
Home Health Care	5%	9%	2%	2%	6

Service Gaps noted by the 918 area PLWHA in the 2003 needs assessment process included: Dental care, Long Term Care, Case Management, and Housing services. Dental care was the highest perceived Gap (“need service and can’t access”) in both geographic areas. Transportation ranks among the top four Needs for both geographic areas. Other gaps differ by the two geographic regions, with Case Management in Tulsa perceived as a greater issue in the 2003 Needs Assessment. Both regions listed Substance Abuse as one of the lower ranking Gaps but also did not perceive a high need for this service. Table 33 below indicates the number of referrals for needed services versus the frequency of acceptance or use of the service. *Further exploration of the barriers to existing MH/SA treatment and counseling services is warranted, given the disparity in numbers referred and numbers accepting MH/SA service referrals*

Table 33. Mental Health and Substance Abuse Needs vs. Use

Service	Attend meetings	Do Not Attend	Unknown
Counseling sessions	30.7%	68.7%	0.6%
Stress management	33.9%	65.5%	0.6%
Recommended to therapist or counselor	24.6%	74.8%	0.6%
Taking medications for mental health issues	44.1%	55.3%	0.6%
Told they needed substance abuse services in past year	9.3%	90.1%	0.6%
Received Out-Patient services but believe they need In-Patient services	2.9%	96.5%	0.6%

Unmet Need Estimate

Table 34. HRSA Care Definitions

Care Status	Definition
In Care, In System (green)	Primary Care within the publicly funded system within the last 12 months
In Care, Out of System (yellow)	No primary care within system within the past 12 months but accessed Pharmacy/Meds or accessed primary care in alternate system (private physician, military, other geographic region)
Out of Care (red)	No primary care within the past 12 months
Never In Care	Never accessed care

Unmet Need Framework Table 2007

Population Sizes		Value		Data Source(s)
Row A.	Number of persons living with AIDS (PLWA), for the period of 1/1/2006 thru 12/31/2006	3,001		HARS
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of 1/1/2006 thru 12/31/2006	2,668		HARS
Row C.	Total number of HIV+/aware for the period of 1/1/2006 thru 12/31/2006	5,669		HARS
Care Patterns		Value		Data Source(s)
Row D.	Number of PLWA who received the specified HIV primary medical care during 1/1/2006 thru 12/31/2006	1,848		HARS, VA, Medicaid, ADAP/ Health Insurance Assistance, RW CAREWare (Parts B-D), Chart Review
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during 1/1/2006 thru 12/31/2006	1,099		HARS, VA, Medicaid, ADAP/ Health Insurance Assistance, RW CAREWare (Parts B-D), Chart Review
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during 1/1/2006 thru 12/31/2006	2,947		HARS, VA, Medicaid, ADAP/ Health Insurance Assistance, RW CAREWare (Parts B-D), Chart Review
Calculated Results		Value	Percent	Calculation
Row G.	Number of PLWA who did not receive the specified HIV primary medical care	1,153	38%	Value = A - D. Percent = G/A
Row H.	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	1,569	59%	Value: B - E. Percent: H/B
Row I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	2,722	48%	Value: G + H. Percent: I/C

Estimation methods

To evaluate unmet need for Oklahoma HIV/AIDS cases, the HIV/AIDS Surveillance and Analysis Section completed several activities. For the purposes of analysis, out of care was

defined as no CD4, Viral Load, or evidence of ART from 1/1/2006 thru 12/31/2006. In care was defined as having either a CD4, Viral Load, or evidence of ART from 1/1/2006 thru 12/31/2006. Analysts cross-matched HARS with client-level data sources of care pattern data and death indexes including RW CAREWare, Medicaid, HIV Drug Assistance Program (HDAP), Health Insurance Assistance Program (HIAP), VA, National Death Index, as well as state death certificates. As HARS does not contain treatment variables, the HARS data manager created a custom field to track persons identified as in-care through the use of HAART therapy as identified through RW CAREWare, Medicaid, VA, and HDAP/HIAP databases.

Following the cross-match, field surveillance specialists conducted 965 chart reviews on clients still deemed out of care that were not lost-to-follow up in HARS. These chart reviews were conducted at the last known medical provider site. Oklahoma chose these methods as client level data is available for both care pattern and disease surveillance data, which provides a more accurate picture of unmet need than a random survey or chart review alone. In addition, OSDH conducted a follow-up chart review since data sources were mainly public sources of care pattern data, and the chart review allowed OSDH to account for private care pattern data.

Limitations include the out-migration of clients, which may over-estimate unmet need as care pattern data may be located in another state for a client. The Surveillance and Analysis Unit can accurately track in-state migration but cannot accurately identify all out-of-state migration through the Centers for Disease Control RIDR activity or through contact with the last known reporting provider.

Cross-program collaboration makes the unmet need process possible. During the unmet need process, The Manager of Care Quality Assurance and Data Analysis works regularly with the Surveillance and Analysis Unit on estimating unmet need. The OSDH also has an excellent relationship with the Department of Veterans' Affairs and the Oklahoma Healthcare Authority (who administers the state Medicaid program), and access to these outside data sources provides OSDH with a more accurate estimate of unmet need. In addition, all Ryan White providers in the state (Parts B-D) are using CAREWare, with data for "All Parts" located on a centralized server at OSDH.

Assessment of unmet need

Upon completion of the unmet need estimate and follow-up chart audits with medical providers on cases by field surveillance specialists; the OSDH performed a demographic sub-population analysis on race/ethnicity, gender, and MSA location. This analysis incorporated cross-matched data from the VA, HARS, Medicaid, CAREWare (Parts B through D), HDAP, HIAP, and medical chart reviews.

There has been significant progress made in reducing the level of unmet need in the State (decreasing from a high of 63% in 2003 (83% PLWA) to the 48% in 2007. However, much work remains if Oklahoma is to assure greater parity in access to care by all those Oklahoma residents affected by HIV disease. The following table summarizes the results.

Table 35. Demographics of HIV positive cases in Oklahoma by Care Status, 1/1/2006 thru 12/31/2006.

Characteristic	HIV+/ aware population	Number with Met Need	Number with Unmet Need	% of Unmet Need Population	% of Category with Unmet Need	% of Total HIV+/aware population
	TOTAL	5669	2947	2722	100%	48%
<i>HIV or AIDS</i>						
PLWA	3001	1848	1153	42%	38%	53%
PLWH/non-AIDS*	2668	1099	1569	58%	59%	47%
<i>GENDER</i>						
Male	4751	2475	2276	84%	48%	84%
Female	918	472	446	16%	49%	16%
<i>RACE/ ETHNICITY</i>						
White (non-Hispanic)	3703	1989	1714	63%	46%	65%
Black (non-Hispanic)*	1296	616	680	25%	52%	23%
Hispanic*	275	98	177	7%	64%	5%
Asian/ Pacific Islander	34	12	22	1%	65%	1%
American Indian/ Alaska. Native	354	229	125	5%	35%	6%

Characteristic	HIV+/ aware population	Number with Met Need	Number with Unmet Need	% of Unmet Need Population	% of Category with Unmet Need	% of Total HIV+/aware population
<u>HIV Only AGE</u>						
1 - 12	23	7	16	1%	70%	0%
13 - 19*	124	33	91	3%	73%	2%
20 - 29*	1010	373	637	23%	63%	18%
30 - 39	954	424	530	19%	56%	17%
40 - 49	422	198	224	8%	53%	7%
50 - 59	114	54	60	2%	53%	2%
60 and over	15	7	8	0%	53%	0%
<u>AIDS-Only AGE</u>						
1 - 12	9	6	3	0%	33%	0%
13 - 19	22	12	10	0%	45%	0%
20 - 29*	546	314	232	9%	42%	10%
30 - 39*	1373	808	565	21%	41%	24%
40 - 49	823	558	265	10%	32%	15%
50 - 59	190	123	67	2%	35%	3%
60 and over	35	25	10	0%	29%	1%

MSA						
OKC	2070	1185	885	33%	43%	37%
Tulsa	1364	763	601	22%	44%	24%
Lawton*	182	61	121	4%	66%	3%
Ft. Smith (Sequoyah County)	21	12	9	0%	43%	0%
Non-MSA*	2032	926	1106	41%	54%	36%

*Relative risk of being more likely to be out of care was significant (p<. 05) for these groups as compared to other groups within each demographic category.

HIV-only cases were 53% more likely to be out of care than AIDS cases. Blacks were 12% more likely to be out of care than non-Blacks; Hispanics were 36% more likely to be out of care than non-Hispanics. Cases diagnosed in the Lawton MSA were 54% more likely to be out of care than cases diagnosed in other MSAs. Cases diagnosed in non-MSAs were 28% more likely to be out of care than those diagnosed in MSAs. In addition, 13-19 year old HIV-only cases were 26% more likely to be out of care and 20-29 year old HIV only cases were 12% more likely to be out of care compared to other HIV only age groups. Within AIDS cases, 20-29 year olds were 13% more likely to be out of care, and 30-39 year olds were 14% more likely to be out of care than other age groups.

According to “A Needs Assessment Update: HIV Positive Clients In or Out of Care in Ryan White Facilities (2007), out of care respondents just entering care reported lack of transportation to medical appointments as the primary reason for being out of care in the last year. There was a significant relationship between being referred for medical care and accessing medical care within one year of testing positive. The majority of Out of Care respondents listed care coordination/ case management as the service that facilitated their entry into medical care, and listed medication assistance programs as the primary service that will help them remain in medical care. However, Black MSM reported mental health/ substance abuse as the primary service getting them into medical care, and Women of Childbearing Years reported Housing as the primary service that will keep them in medical care.

The Oklahoma HIV Planning Council (OHPC) utilizes the unmet need framework to inform decisions regarding prioritization of services and funding. The OHPC is comprised of prevention and care stakeholders, so unmet need data is not only used to prioritize care funding, but is also used to set HIV prevention priorities so that counseling, testing, and referral (CTR) services and Prevention for Positives programs can target groups most likely to not enter care once they test positive or who are more likely to drop out of care.

Ryan White Part B funded services have been expanded to specifically target the out of care population. After a successful pilot program in Oklahoma City, outreach case management services to individuals who have been out of care for 12 months have been expanded to include three outreach case managers covering the Tulsa, Oklahoma City, and Lawton areas. **The OSDH allocates funding for medical transportation since the number one barrier to receiving medical care is transportation for out of care individuals.**

In addition, since most barriers to care involve lack of insurance or ways to pay for medical services, the OSDH continues to expand its HDAP and Health Insurance Assistance Programs. Case managers are encouraging clients who qualify for other pay sources for insurance, such as the OEPIC state insurance programs; to apply so that needs other than just medications can be covered. The disease intervention team (Partner, Counseling, and Referral Services) at OSDH has also received training on accessing Ryan White services to make the referral process efficient once a client is informed of his/her HIV positive status.

Prevention needs (listed in order of volume and priority)

These priority areas for primary prevention of HIV transmission and secondary prevention of further HIV transmission by those already infected are based on the latest Epidemiology Profile and segmented by high risk transmission group (in terms of newly diagnosed and currently HIV infected persons), gender and age groups. At the time of this writing, the priority interventions were still under development.

Priority #1 HIV Positive Persons

Males	Females
1.1 African American	1.1 African American
1.2 White/Caucasian	1.2 Hispanic
1.3 Hispanic	1.3 Caucasian
1.4 All other race/ethnicity	1.4 All other race/ethnicity

Priority #2 Males Who Have Sex with Males (MSM)

- 2.1 African American MSM
- 2.2 Caucasian MSM
- 2.3 Hispanic MSM
- 2.4 American Indian MSM
- 2.5 Age 13-24 all race/ethnicity MSM
- 2.6 Rural MSM

Priority #3 Females 13 and over at high risk for HIV through Heterosexual Transmission and/or IDU and other risk behaviors that transmit HIV

3.1 African American

3.2 Age 13-49 all race/ethnicity

3.3 Over 50 all race/ethnicity

Priority #4 Injection Drug Users

4.1 All ages and races/ethnicities

Special recommendation for all IDU programs to include a component of Hepatitis C screening. Note While the OHPC recommends screening for Hepatitis C, we understand the limitations that might be imposed on this activity due to funding limitations.*

Unique Service Delivery Challenges in the Statewide Service Area

Rural Nature of State: Oklahoma is a largely rural state with poor transportation linkages. Without the benefit of a supportive public transportation system, transportation assistance and access to primary medical and other core medical and support services remains a critical challenge for PLWHA in Oklahoma.

Recent Population Changes: The Hispanic population was the fastest growing minority reported in the 2000 Census, and there has been a 200% increase over the last two decades. The Hispanic population includes both legal residents mostly from the western United States, and many illegal aliens especially from Mexico, many of whom are not fluent in the English language, which has presented overwhelming barriers for providing information and treatment to this population.

Health Care Provider Shortage: The 2006 needs assessment survey results evidence improved access to primary medical care services over the 2003 survey findings

Poor Health Rankings: In *America's Health: United Health Foundation State Health Rankings 2008*, Oklahoma's overall health ranking moved up from 47 to 43 in the nation, but the state's residents still lack adequate access to primary care physicians.

- **Ranking:** Oklahoma is 43rd in 2008; it was 47th in 2007.
- **Strengths:** Strengths include a low prevalence of binge drinking at 13.0 percent of the population and strong public health funding at \$99 per person.
- **Challenges:** Challenges include a high prevalence of smoking at 25.8 percent of the population, limited access to primary care with 79.9 primary care physicians per 100,000 population, many poor mental and physical health days per month at 3.9 days and 4.1 days in the previous 30 days, respectively, and a high rate of deaths from cardiovascular disease at 371.0 deaths per 100,000 population.
- **Significant Changes:** In the past year, the percentage of children in poverty decreased from 20.7 percent to 19.0 percent of persons under age 18. Since 1990, the prevalence of

obesity increased from 11.6 percent to 28.8 percent of the population, and the incidence of infectious disease decreased from 34.9 to 14.0 cases per 100,000 population.

Health Disparities: In Oklahoma, low birth weight babies are more common among non-Hispanic Blacks at 13.6 percent than Hispanics at 6.5 percent. **Access to health care varies significantly by race and ethnicity in the state; 56.1 percent of Hispanics lack health insurance compared to 20.8 percent of non-Hispanic whites.**

Impact of co-morbidities: The co-morbidities described earlier have a more significant impact on PLWHA because of the limited healthcare resources available to treat the co-morbidity. Ryan White resources are accessed to address these issues. Qualitative data indicates that those with substance abuse issues, those with SMI, or STI co-morbidities, and the homeless all need relatively more resources in comparison to those without these issues.

To meet the diverse needs of PLWHA, the Ryan White programs are challenged to meet the needs of the homeless, and provide mental health and substance abuse services that are otherwise lacking due to the absence of state funds.

CHAPTER 6: Barriers to Care and Services

One of the key purposes of this integrated SCSN and Comprehensive Plan is to accurately identify the HIV service gaps and barriers and responsively intervene to reduce obstacles to care so that PLWHA may readily access, engage with and remain in high quality primary medical care and support services. The following discussion highlights the most recent needs assessment findings relative to the Statewide service Barriers experienced by PLWHA, as well as the unique barriers to care reported by PLWHA residing in the western and eastern portions of the Oklahoma service area.

2006 In Care Service Barriers

In the most recent 'In Care' survey, the following services were reported to be difficult to access (Service Barriers) and/or perceived as unavailable (Service Gaps) in order of frequency:

- 1) Oral health care,
- 2) Housing,
- 3) Medications,
- 4) Transportation, and
- 5) Third party/Health insurance benefits. Responses were categorized from the open-ended responses.

Dental Care: The majority of respondents listing dental care as difficult to access cited financial and funding issues as barriers to this service. One person reported “Medicare doesn’t pay.”

Housing: Barriers to housing varied by respondent. Reasons included lack of funding, recent eviction, drug use, no income and ‘no help available’. One individual stated that housing was difficult to access because there needs to be “more money/ services for women with children/family.”

Medications: Cited barriers include lag times in obtaining refills through Part C clinics owing to fax delays to and from pharmacies; lags in case manager notification regarding expiration of HDAP and compassionate care meds; and Medicare drug plan doesn’t cover all needed drugs.

Transportation: Barriers to transportation include some inefficiency within the system, as well as funding stipulations. One client stated that there are “long waits on the phone.” Another client reported that transportation is “almost always late if on Medicaid.” Obtaining gas vouchers was also a barrier, due to clients having to find someone to drive them, and then later being reimbursed for expenditures. One client stated that transportation providers are “unable to help due to the insurance I have.”

Third Party Benefits: Barriers to obtaining third party benefits included needing more assistance with the application processes, understanding the requirements of third party pay sources, and navigating the third party pay system for uninterrupted services. One client was told by DHS that he qualified for the Advantage program, but he was denied by Advantage based on medical requirements of the program. Another client reported that he did not think he could access health insurance assistance if he did not have SSI (Social Security Income).

2006 In Care Service Barriers: Western and Eastern Oklahoma

The Service barriers cited by PLWHA respondents residing in the 405/580 area codes in the 2006 needs assessment survey included the following:

- 1) Dental Care (15%)
- 2) Vision Care (11%)
- 3) Primary Medical Care (6%) tied with
- 3) Emergency Medical care (6%) tied with
- 3) Substance Abuse Treatment (6%)

The Service barriers cited by PLWHA respondents residing in the 918 area code in the 2006 needs assessment survey included the following:

- 1) Child Care (20%)
- 2) Emergency Medical Care (15%)
- 3) Prevention services (13%)
- 4) Dental Care (11%) tied with
- 4) Hospice (11%)

Oklahoma HIV planners and providers continue to grapple with the geographic, cultural and racial disparities in treatment and care and strive to overcome these barriers which are heavily characterized by stigma and all of its attendant impacts on the HIV prevention, testing and care efforts across the state. In Oklahoma, as nationally, minorities less likely to receive needed services and procedures than whites, even when controlling for socioeconomic status, age, gender, access, etc. Rural residents are less likely to personalize risk, become tested for HIV or disclose their status if positive, or to travel the long distances to an HIV specialist. And, continuing language barriers and cultural challenges prevent the growing numbers of Hispanics in the state to seek prevention and testing services, to disclose their same sex behaviors to sexual partners, or to accept medical treatment for their disease.

CHAPTER 7: Description of Current Continuum of Care

Ryan White Part B Allocation Plan: Fiscal Year 2008 (April 1, 2008 - March 31, 2009)

FY 2008 RW PART B ALLOCATION PLAN	
Ryan White Part B Base Grant	\$3,804,744
AIDS Drug Assistance Program	\$4,253,231
Carry over from FY 07	\$75,000
ADAP Supplemental	\$1,024,714
Total Ryan White Part B Award	\$9,157,689

FY 2008 ALLOCATION OF PART B FUNDING

Part B Base Grant	\$3,804,744
• Part B Administration (Grantee)	\$294,441
• Evaluation and Planning Activities (Includes \$129,865 Quality Management activities)	\$178,809
• CARE Direct Services	\$1,828,926
• HIV Drug Assistance Program (<i>from base grant to ADAP</i>)	\$ 495,744
• HIV Home Health Program	\$ 25,000
• Health Insurance Assistance Program	\$ 775,600
• Drug Adherence Program	\$ 206,224
AIDS Drug Assistance Program (ADAP)	\$4,253,231
• HIV Drug Assistance Program	\$3,783,161
• ADAP Administration (Grantee)	\$ 283,396
• Quality Management	\$ 186,674
ADAP Supplemental FY 2007 Carryover	\$ 1,024,714 \$75,000
TOTAL Ryan White Part B Grant FY 2008	\$9,157,689

The Ryan White Part B Service Continuum

Eastern Oklahoma – 23 counties	\$731,570.00
Western Oklahoma – 54 counties	\$1,097,356.00

Table 36. Oklahoma Service Category Descriptions

<i>SERVICE CATEGORY</i>	<i>DESCRIPTION</i>	<i>FY 2008 ALLOCATION</i>
<i>Direct services</i>		
Case Management	Three forms of HIV case management are funded, including Medical Case Management, non-medical Case Management, and Outreach Case Management. All CM services include a comprehensive psychosocial assessment to assist the client in identifying service needs, developing a service plan and directly linking	\$800,000

SERVICE CATEGORY	DESCRIPTION	FY 2008 ALLOCATION
	clients to services.	
Medication Assistance	Prescription medications for HIV disease and other related conditions and/or episodic illness, prescribed by a licensed physician.	\$304,670
Specialty Medical Care	Specialty Medical services include reimbursement for specialty medical services including dermatology, neurology, gynecologic procedures, etc.	\$337,000
Dental Care/Oral Health	Routine preventive dental care and restorative dental procedures and appliances.	\$133,630
Mental Health Services and Substance Abuse Services	<i>Professional outpatient mental health services</i> including assessment and professional counseling. <i>Professional substance abuse treatment</i> through the county alcohol and drug addiction services board. Services include detoxification, inpatient residential programs, and outpatient treatment and aftercare services.	\$147,626
Laboratory Testing	Diagnostic laboratory testing on site for HIV related and other indicated conditions including Viral Load, CD4 cell counts, and genotyping to determine medication resistance.	\$74,000
Treatment Adherence	Pharmaceutical education and treatment adherence education and counseling and pill box monitoring.	\$200,000
Transportation	Free transportation to and from medical appointments.	\$32,000

(Source: OSDH, 1/9/2009)

FY 2008 Ryan White Part B	Allocation
HIV Drug Assistance Program (HDAP) FY 2008 GOAL is to provide Statewide medication assistance for a minimum of 1200+ eligible low-income individuals living with HIV disease, including 300 eligible individuals with prescription co-pay assistance. The HIV Drug Assistance Program (HDAP), through a contract with the drug wholesaler, provides specific HIV-related medications to eligible low-income individuals living with HIV disease in Oklahoma. FY 2008 BENEFITS: HDAP clients are eligible for one 30-day supply per month for prescribed medications on the HDAP formulary. Exceptions are Bactrim DS and Dapsone, which is 90 days. Prescription co-pay assistance for drugs on HDAP formulary.	\$4,253,231
Health Insurance Assistance FY 2008 GOAL is to provide approximately 140 eligible low-income individuals living with HIV disease in Oklahoma with assistance on health insurance premiums e.g. Cobra, High	\$ 775,600

Risk Pool Insurance and O'EPIC.	
FY 2008 Ryan White Part B	Allocation
HIV Home Health Program FY 2008 GOAL is to provide home health services to approximately 15 low-income individuals living with HIV disease. The OSDH HIV Home Health Program (HHHP) provides home health services to eligible low-income individuals living with HIV disease in Oklahoma. Services include: Durable medical equipment and supplies (at a cap of \$1,000 per person/per year); Personal and Skilled Care visits limited to 60 visits per program year.	\$25,000

Oklahoma Ryan White Part B Program

Part B of the Ryan White HIV Treatment Modernization Act of 2006 provides funding directly to the fifty states to administer HIV medical and support services in all communities across each state. The state of Oklahoma differentiates the ‘Eastern’ region or the 918 area code (Tulsa) from ‘Western’ region or the 405/580 area codes (Oklahoma City). The eastern side of the state (918 area code) is home to approximately 39-40% of the HIV disease burden in the state and 918 area providers receive approximately 40% of the Part B funding. The western side of the state (405 and 508 area codes) comprises approximately 60% of the HIV disease burden and consequently is granted 60% of the Part B funding. Part B funds are used to fund a number of client based services.

These Part B funded services include Case Management, of which three types are distinguished (clinical, community and outreach); Oral Health services; Laboratory services funding; HIV Medications; Specialty Medical services, Treatment Adherence, Mental Health counseling and Substance Abuse treatment; and Medical Transportation. These services represent Part B Direct services. In addition, The Oklahoma State Department of Health (OSDH) directly administers Home and Community Based Health Care; Health Insurance Assistance Program (HIAP) and Oklahoma’s HIV Drug Assistance Program (HDAP). The University of Oklahoma Health Sciences Center (OUHSC) in Oklahoma City and Oklahoma State University-Center for Health Sciences-College of Osteopathic Medicine (OSU-CHS-COM) in Tulsa receive Part C funding to provide early intervention services with regards to HIV disease.

Statewide Agencies involved in supporting Other Services for PLWHA

The **Department of Human Services (DHS)** funds 6 FTEs to provide HIV Care Coordination in Oklahoma through its **AIDS Care and Information System division (ACIS)**. Care Coordinators are equally split between Oklahoma City and Tulsa and maintain caseloads with no income eligibility. ACIS care coordinators link PLWH/A to various entitlement programs.

The **Department of Human Services (DHS)** also administers the ADvantage Medicaid Waiver program, which provides home and community-based services for elderly and disabled persons, including PLWA, with the goal of averting nursing home or other institutionalized care.

The **Department of Mental Health and Substance Abuse Services (DMHSAS)** is the provider of inpatient substance abuse treatment at their Norman Alcohol and Drug Treatment Center.

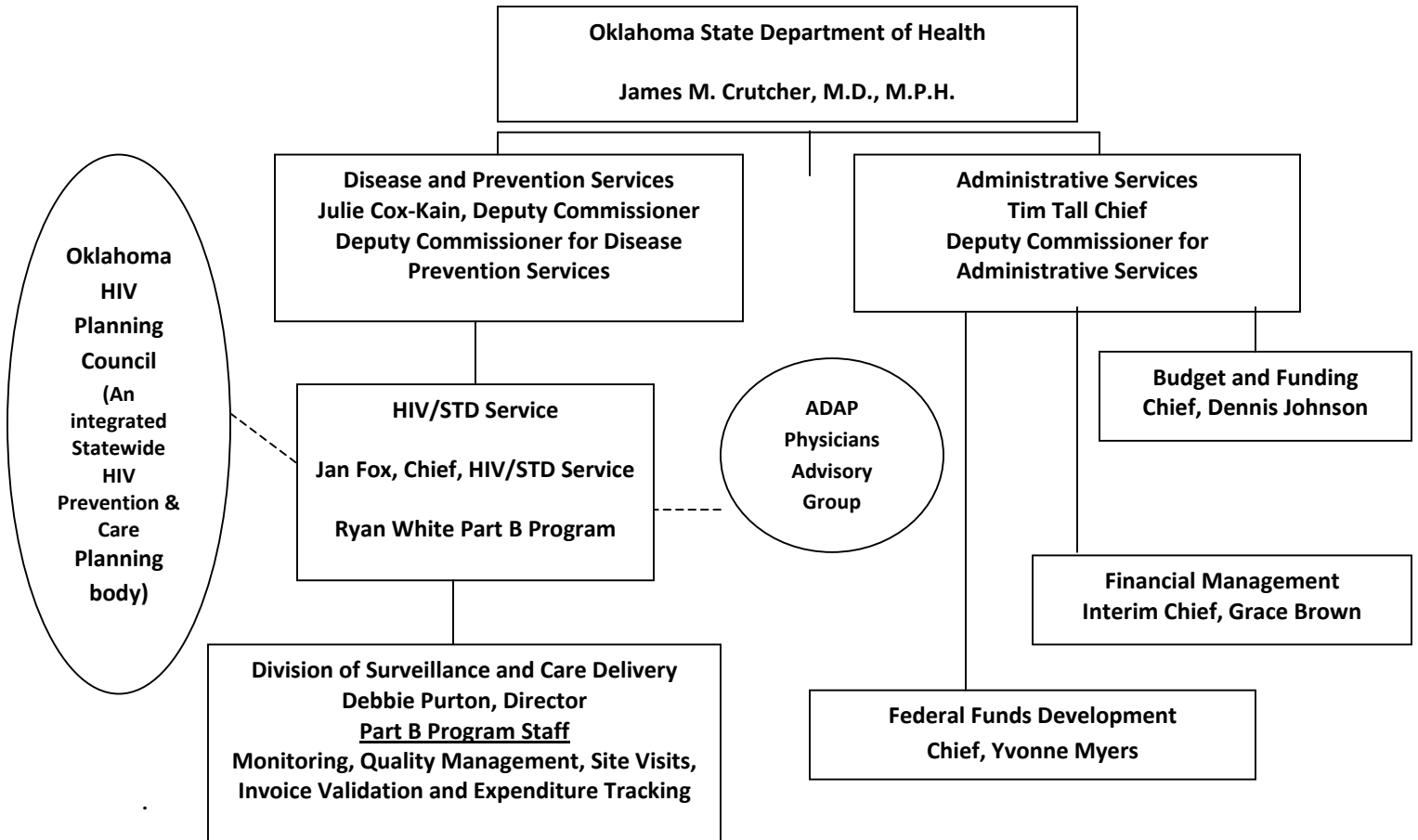
The **Oklahoma Healthcare Authority (OHCA)** is the state’s Medicaid agency, maintaining linkages to OHPC through their Exceptional Needs Coordinator. This linkage allows continual updating of changes in the state’s Medicaid system as well as managed care. **OHCA** also administers the OEPIC Program, a new program which addresses the health insurance needs of uninsured Oklahomans.

The **Oklahoma Housing Finance Agency** is a public trust that administers **HOPWA** funds or *Housing to Persons With AIDS*.

The **Department of Corrections** provides HIV testing, care and services to the incarcerated.

The **Veterans Administration** in Oklahoma City provides HIV outpatient and inpatient medical care to qualified veterans.

Figure 2: Statewide Providers Administering Part B Program at OSDH



CHAPTER 8: Resource Inventory

Development of the Service Resource Directory

A comprehensive Resource Directory focused specifically on HIV Treatment and Care Services, including Part B Providers, provides information by county about the availability of HIV-related services and non-HIV related services. The directory is updated annually. This allows clients and providers to access the most current resource information available.

The OSDH and OHPC recognize the need to develop a smaller regionally-based and more client friendly version of the Resource Inventory/Services Guide for PLWHA.

Table 37. Total HIV Funding in Oklahoma

Total HIV/AIDS Federal Funding, FY2007		
	OK \$	US \$
CDC HIV/AIDS Funding	\$3,383,118	\$531,101,751
HOPWA Funding	\$943,000	\$256,162,000
SAMHSA HIV/AIDS Funding	\$0	\$107,503,426
OMH HIV/AIDS Funding	\$200,000	\$11,322,893
Ryan White Program Funding	\$11,115,532	\$2,050,220,880
Total	\$15,641,650	\$2,956,310,950

(Source: KFF State Health Facts, 2007)

Availability of Other Resources

Other resources available to cover health care costs of eligible individuals and families with HIV disease are outlined below.

Housing: RAIN--OK, the Part B provider for Western Oklahoma, has accessed federal grants from the Department of Housing and Urban Development, Special Housing Project, the Department of Rehabilitative Services, and HOPWA. These monies are available for additional ancillary care, social care and non-formal assisted care expenses. **Tulsa CARES**, the Part B non-

medical case management provider on the eastern side of the state receives HOPWA funding to support short and long-term housing assistance for PLWHA residing in the 918 area code.

Medicare and Medicaid (Third Party/Governmental Payers): Medicare and **Medicaid** programs HHS' Centers for **Medicare & Medicaid Services (CMS)** is the largest payer of care provided to persons living with AIDS in the U.S. Medicaid alone pays for more than 50 percent of care to persons with AIDS, and provides care to 90 percent of children with AIDS.

State of Oklahoma Medicaid Plan: To be eligible for Medicaid, an applicant must first qualify for a category of Medicaid established by federal regulations. Each category has requirements concerning citizenship, resources (assets), and monthly income. Medicaid eligibility is determined each month for each individual. Each person applying for Medicaid must qualify under one of the following categories:

- Age 65 or older
- Legally disabled or blind
- Pregnant women
- Child under age 18
- Parent or caretaker of a child under age 19
- Women with breast or cervical cancer

Full Medicaid benefits are available only to U.S. citizens and legal residents. Federal regulations limit an individual's resources to \$2,000. For a family, the limit starts at \$3,000. Federal regulations also require the state to set monthly income standards which vary based on the category of Medicaid.

A person who does not qualify for a category of Medicaid is considered for the Primary Care Network (PCN) Program. The PCN Program serves individuals age 19 and above with incomes under 150% of the federal poverty level who are not otherwise eligible for Medicaid through the State Plan and who are eligible only through a waiver of federal Medicaid requirements approved by the federal Centers for Medicare and Medicaid Services.

An applicant who has monthly income which is more than the monthly income standard, but less than the amount needed to pay his or her medical bills may be considered for the Medicaid Medically Needy program. The program is also referred to as the "spend-down" program. To qualify for Medicaid coverage of medical bills, the person agrees to "spend down" his or her monthly income to the Medicaid income standard. The person may choose to either pay "excess" monthly income to the state or to pay a portion of his or her monthly medical bills directly to the medical provider. A person who is not a citizen or a legal resident may qualify for Emergency Services Program. This program limits benefits to emergency medical services only.

Medicare Part D Drug Plan

PLWHA who are eligible by work history and disability may be eligible for enrollment in the recently enacted Medicare Part D drug benefits plan. Part B funds may be used to support the co-

pays for Medicare Part D prescription coverage for PLWHA who meet the income criteria. PLWHA who are Medicaid eligible are automatically assigned a drug coverage plan.

ADvantage Waiver Program for Home & Community Based Care: This program provides federal and state funded in-home services to older Oklahomans and adults with physical disabilities who are medically and financially eligible to receive nursing facility care under Medicaid guidelines. Services include: Adult day health care, home delivered meals, comprehensive home care, case management, skilled care, medications, specialized equipment and supplies, environmental modifications and advanced supportive restorative assistance.

Veterans Administration Program Benefits: There are two (2) Veteran's Affairs Medical Centers in Oklahoma—the VAMC in Muskogee (50 beds) and VAMC in Oklahoma City (169 beds). Both offer a full complement of mental health and substance abuse treatment programs, in addition to outpatient clinics. The Part C Infectious Disease Physicians also provide HIV care through the VA clinics and hospitals in Oklahoma City.

High Risk Insurance Pool

The state of Oklahoma makes available health insurance to all persons who meet the income and other eligibility requirements and have no other source of health benefits. The Part B funds are used to support health insurance premiums and co-pays for PLWHA who are eligible to participate in the High Risk Insurance Pool.

The High Risk Pool was created to serve those who are considered medically uninsurable or high risk (people who have been denied health insurance due to a serious health condition). In certain cases, it also applies to those who have been quoted very high premiums, again due to a serious health condition.

To be eligible, individuals: 1) Must have lived in Oklahoma at least one year; 2) Must have been rejected for health insurance by two companies or have been quoted very high premiums; and 3) Cannot be institutionalized in a penal, drug or alcohol facility.

Oklahoma Employer/Employee Partnership for Insurance Coverage (Insure Oklahoma-OEPIC), administered by OHCA is a program assisting adults, 19 to 64 years of age, who do not exceed 185% of the federal poverty level, with either (1) a portion of their private health plan premiums, or (2) the purchase of a state sponsored health plan operated under the state Medicaid program. Insure Oklahoma is designed and intended to assist in the purchase of health coverage. Oklahomans can participate in two ways:

- ✓ Insure Oklahoma/O-EPIC ESI, Employer Sponsored Insurance, designed to assist small business owners in providing their employees and their employees' families with health insurance, and

- ✓ Insure Oklahoma/O-EPIC IP, Individual Plan, designed to assist sole proprietors (self employed), certain unemployed individuals, and working individuals who do not have access to small group health coverage.

State of Oklahoma Children’s Health Insurance Program: The Children's Health Insurance Program (CHIP) is a medical assistance program for children who do not have other health insurance and who meet the eligibility criteria. A child may qualify when three conditions are met:

- The child is 18 years or younger
- Family income is below 200% of the federal poverty level (FPL) and the child is not eligible for Medicaid.
- There is no other insurance plan available, either from employer or individual.

Continuum of Care and Service Priorities

Process for Establishing a Client-Centered Continuum of Care

The continuum of care in Oklahoma is inconsistent throughout the state due to large geographic stretches in which few Oklahomans reside. The majority of Oklahomans living with HIV/AIDS live around the Oklahoma City area and the Tulsa metropolitan areas. The state population totals 3,450,654, with twelve of its 77 counties deemed ‘frontier’, so rural that no single community has a population equaling 2,500. 60.8% of the state’s residents live in just five metropolitan statistical areas: Oklahoma City (1,083,346); Tulsa (803,235); Lawton (114,996); Enid (57,813); and Sequoyah County (38,972) – residents included in Fort Smith, AK MSA.

Ryan White Part B Continuum of Care

Under Ryan White Part B, States may use funds for the following purposes:

- 1) Home and community-based health care and support services**
- 2) Continuation of health insurance coverage**, through a Health Insurance Continuation Program (HICP);
- 3) Pharmaceutical treatments**, through the HDAP Program;
- 4) HIV care direct** that assess needs, organize and deliver HIV services in consultation with service providers, and contract for services; and
- 5) Direct health and support services.**

Part B funded services include comprehensive outpatient core medical and support services for individuals with HIV disease that include, but are not limited to:

1. *Essential core medical services such as:*

- medical, nursing, and dental care
- diagnostics
- monitoring
- medical follow-up services
- prescription assistance
- mental health services
- home health and hospice care
- medical case management services
- substance abuse treatment/counseling

2. *Essential medical support services which impact medical outcomes such as:*

- counseling (other) performed by a non-licensed counselor, includes nutritional counseling and treatment adherence counseling
- direct emergency financial assistance
- food bank/home delivered meals/nutritional supplements
- housing referral services
- health education/risk reduction
- outreach to identify those with HIV disease and connect them to care
- referral services that link those with HIV disease to additional resources
- transportation
- interpretation, translation services

Process for Establishing Service Priorities

One of the main goals in the 2006-2008 Comprehensive Plan was to reduce the level of unmet need and bring the out of care into care. The OHPC has continuously been involved in activities to accomplish this goal, which remains a major directive in the new 2009-2011 plan. One of the accomplishments has been to duplicate the Oklahoma City outreach case management project in Lawton and Tulsa to target out of care individuals with high intensity case management and get them into primary medical care. There has been a decrease from around 63% of individuals out of care to 48% based on the most recent unmet needs analysis. In addition, primary care programs have been expanded through Part B funding in Oklahoma to assist with the greater financial needs of providers to accommodate an increasing number of individuals getting into primary medical care. Another goal was to establish evidence-based outcomes. The new Quality Committee was established to correlate quality of care in Oklahoma to the public health service guidelines recommendations, and is now in the process of revising its quality improvement plan and training providers on indicator development and measuring outcomes. In addition, the OSDH is implementing a new client level data system for case management as well as

converting CAREWare data to a 'real time' data system for more timely access to outcome measures.

The OHPC, Oklahoma's Public Advisory Planning Body meets regularly (six times per year) with OSDH staff, consumers, stakeholders, and community leaders regarding Ryan White activities, unmet needs, needs assessment, contractual/ financial issues with programs. The OHPC has been very involved in getting individuals who are out of care into care by educating providers on unmet needs and strategies to get people into care. They also provide a great networking opportunity for providers and consumers to discuss the comprehensive plan and progress toward its goals. In addition, the OHPC consists of both new and seasoned members as the group has recently been merged into a prevention and care planning body. The OHPC and OSDH has been incorporating education and training in the areas of comprehensive planning, needs assessment, and unmet needs analysis for the new group. In addition, the Manager of Quality Assurance and Data Analysis has conducted interactive and group trainings for the OHPC on Quality Management expectations of Ryan White providers and basic quality improvement principles, which can be applied to strategic planning and the comprehensive plan.

The OHPC completed a review of documents and resources during the Fall 2008 planning processes that served to inform the Statewide Part B funded services plan in relation to other HIV services with different funding sources. The following documents were reviewed:

- 1) FY 2006 Needs Assessment Survey Results
- 2) Mid-year data from service provider reports on client utilization and expenditures
- 3) 2007 State of Oklahoma Epidemiologic Data
- 4) 2008 Unmet Need Study
- 5) Report of community-based services and resources that are not funded by Ryan White
- 6) Clinical Case Management with Multiple Diagnosed Clients
- 7) Oklahoma HIV Direct Programs Client Utilization Report
- 8) HDAP Client Utilization Report
- 9) HIAP Client Utilization Report
- 10) HHHP Client Utilization Report
- 11) Updated Resource Inventory

In January, 2008, the OHPC convened a participatory day-long statewide planning meeting to review the comprehensive needs data and refine the goals and objectives for the 2009-2011 SCSN and Comprehensive Plan.

Service Costs and Utilization

For Fiscal Year 2008 (April 1, 2007 through March 31, 2008) the total Part B services costs per client totaled \$902.00. A table of Service Costs & Utilization for the Part B program and a matrix of currently contracted providers by funded Service Category is provided below.

TABLE 38. RYAN WHITE PART B COST & UTILIZATION BY SERVICE CATEGORY

FY08 Services Cost and Utilization Report: Part B Direct Cost Utilization Report*

Reporting Period: April 01, 2007 through March 31, 2008

Report Criteria:

Provider(s): OSU-CHS-COM, OUHSC, RAIN OKC, RAIN Lawton, Red Rock BHS, Tulsa CARES

Funding Source: Ryan White Part B

Part B Base Service	Clients	Units	Visits	Expenditures	Cost/Unit	Cost/Service	Cost/Client
Outpatient/ Ambulatory Medical Care	660	5,887	4,426	\$ 497,268.00	\$ 84.47	\$ 112.35	\$ 753.44
Oral Health Care	50	642	310	\$ 122,137.00	\$ 190.24	\$ 393.99	\$ 2,442.74
Mental Health Services	296	4,329	1,320	\$ 81,312.00	\$ 18.78	\$ 61.60	\$ 274.70
Case Management (non-medical)	841	19,850	7,935	\$ 366,622.00	\$ 18.47	\$ 46.20	\$ 435.94
Medical Case Management	934	12,070	7,094	\$ 333,223.00	\$ 27.61	\$ 46.97	\$ 356.77
Local AIDS Pharmaceutical Assistance	452	41,449	2,748	\$ 196,859.14	\$ 4.75	\$ 71.64	\$ 435.53
Medical Transportation Services	295	2,381	809	\$ 21,673.00	\$ 9.10	\$ 26.79	\$ 73.47
Total--All Services	1,795	86,608	24,642	\$ 1,619,094.14	\$ 18.69	\$ 65.70	\$ 902.00

(Source: CAREWare, 12/23/08)

CHAPTER 9: Profile of Ryan White Funded Providers by Service Category

Ryan White Providers and Services

Agency	Primary Medical Care/Labs	Specialty Medical Care	Substance Abuse/Mental Health	Dental	Case Management	Transportation	Local APA	TX Adherence	Outreach CM
Red Rock BHC			X						
RAIN OK				X	X	X			X
RAIN Lawton					X				X
Tulsa C.A.R.E.S.			X		X				
OUHSC-IDI	X	X	X		X		X	X	
OSU CHS-COM	X	X		X	X	X	X		X
<i>Total</i>	3	2	3	3	5	2	2	1	3

The state has two primary “hubs” of service providers—Oklahoma City and Tulsa. Each city has a Part C clinic as well as Part B providers.

Description of Oklahoma City Part B Providers

- The University of Oklahoma Health Sciences Center-Infectious Disease Unit provides comprehensive HIV specialty medical care and coordinated access to health care treatment and support services for infected children, adolescents, men and women with HIV/AIDS, and their affected families residing in the 405/580 area codes (through a combination of Part B, C, and D funding). Part B funded services include laboratory, specialty medical care, medical case management, mental health services, local APA, and treatment adherence. OUHSC also promotes HIV prevention, education, and counseling and testing. These programs link those HIV positive persons who are out-of-care into medical treatment and support services, and decrease the acuity level of these persons.
- The Regional AIDS Intercommunity Network (RAIN Oklahoma) was formed by the January 2005 merger of the Regional AIDS Interfaith Network and CarePoint. Both organizations have been actively engaged in providing services to Oklahomans impacted by HIV/AIDS for well over a decade (RAIN was founded in 1991 and CarePoint in 1993). The merged agency operates from offices in Oklahoma City, Tulsa and Lawton, and provides a continuum of services including HIV prevention education, testing, outreach case management and non-medical case management, housing assistance, nutritional services, and volunteer care teams to clients Statewide. Part B funds outreach case management and non-medical case management in the Oklahoma City and Lawton RAIN offices.

- Red Rock North Behavioral Health Services provides mental health care and the continuum of care for HIV-positive individuals.

Description of Tulsa Area Part B Providers

- The Oklahoma State University-Center for Health Sciences-College of Osteopathic Medicine's Internal Medicine Specialty Services Program is responsible for providing comprehensive, integrated HIV prevention, primary medical and specialty care and care coordination services for individuals living with HIV/AIDS residing in the 918 area code (through a combination of Part B, Part C and CDC funding). Part B funded services include laboratory, specialty medical, medical case management, local APA, dental and medical transportation services.
- The Tulsa Center for AIDS Resources, Education and Support (Tulsa C.A.R.E.S.) provides services to meet the special needs of those affected by HIV and AIDS. The case management program forms the hub of the direct care service delivery system in the 918 area code. Part B funds support non-medical case management.

Coordination and Linkage with Other HIV Programs

Ryan White Part A: No Part A Eligible Metropolitan Area (EMA/TGA) exists in Oklahoma.

Ryan White Part B: The Part B service providers are RAIN Oklahoma, RAIN Lawton, Tulsa C.A.R.E.S., Red Rock Behavioral Health Services and OUHSC and OSU-CHS-COM.

Ryan White Part B funding is also being used for the HIV Drug Assistance Program (HDAP), the Home Health Care Program and the Health Insurance Assistance Program (HIAP).

Ryan White Part C: Two (2) Part C programs exist in Oklahoma. The University of Oklahoma Health Sciences Center (OUHSC) is the only program in the 54-county Western region of Oklahoma. Oklahoma State University Center of Health Sciences College of Osteopathic Medicine is the Part C grantee for the 23 counties in the Eastern region of the state.

Ryan White CARE Act Part D: OUHSC is the Part D grantee.

AETC: OUHSC is the AETC grantee.

Part F: The dental reimbursement program is administered by OUHSC College of Dentistry.

HIV Prevention: The Oklahoma State Department of Health (OSDH) receives funding for HIV Prevention services from the Centers for Disease Control and Prevention (CDC).

Other:

- HUD-SHP (Housing and Urban Development – Supportive Housing Program)
- HOPWA (Housing Opportunities for People With AIDS)
- Department of Rehabilitative Services

CHAPTER 10: Demographics of Part B Clients

Table 39: Comparison of 2007 HIV/AIDS Prevalence & 2007 Part B PLWHA Clients

2007 Epi Profile			2007 Part B Clients		
Demographic Group/ Exposure Category	PLWHA as of 12/07		Demographic Group/ Exposure Category	PLWHA as of 12/07	
<i>Gender</i>	#	% of Total	<i>Gender</i>	#	% of Total
Male	5011	83.45%	Male	1,458	81.2%
Female	994	16.55%	Female	330	18.4%
Transgender	-	-	Transgender	6	0.3%
Total	6,005	100%	Total	1795	100.0%
<i>Race/ Ethnicity</i>	#	% of Total	<i>Race/ Ethnicity</i>	#	% of Total
White, not Hispanic	2,669	44.45%	White, not Hispanic	1001	55.8%
African-American, not Hispanic	892	14.85%	African-American, not Hispanic	356	19.8%
Hispanic	218	3.63%	Hispanic	149	8.3%
Asian/PI	0	0%	Asian/PI	8	.5%
American Indian/A.N.	250	4.16%	American Indian/A.N.	127	7.1%
Multi-race	0	0%	Multi-race	131	7.3%
Unknown	1,974	32.87%	Other/Unknown	23	1.3%
Total	6,005	100%	Total	1795	100.0%

2007 Epi Profile Demographic Group/	PLWH A as of 12/07		2007 Part B Demographic Group/Exposure	PLWHA as of 12/07	
<i>Age at Diagnosis (Years)</i>	#	% of Total	<i>Age at Diagnosis (Years)</i>	#	% of Total
<13 years	48	0.80%	<13 years	2	0.11%
13-24 years	794	13.22%	13-24 years	58	3.23%
25-34 years	2,245	37.39%	25-34 years	314	17.49%
35-44 years	2,035	33.89%	35-44 years	735	40.95%
45-54 years	720	11.99%	45-54 years	572	31.87%
55-64	140	2.33%	55-64	101	5.63%
65+	23	.38%	65+	13	0.72%
Total	6,005	100%	Total	1795	100%
<i>Adult/Adolescent Exposure Category</i>	#	% of Total	<i>Adult/Adolescent Exposure Category</i>	#	% of Total
MSM	3,019	50.3%	MSM	978	54.5%
IDU	714	11.9%	IDU	165	9.2%
MSM/IDU	662	11%	MSM/IDU	158	8.8%
Hemo/Coagulation Disorder	21	.35%	Hemo/Coag Disorder	4	0.2%
HET	679	11.3%	HET	409	22.8%
Blood Transfusion	42	0.7%	Blood Transfusion	7	0.4%
Risk Not Specified	816	13.6%	RNS/Other	69	3.9%
Total	6,005	100%	Total	1795	100%

Table 39: Underrepresented Populations in Ryan White Funded Primary Medical Care

Special Population	Overall % in PLWHA	Comparison to 'In Care' Population %	Estimated Composition in Out of Care Group
1) African Americans	New AIDS 26% New HIV 32% PLWH 15.3 % PLWA 15%	19.8% Part B 22.5% Part C	52%
2) Youth, 13-24 years & 20-29 years	New HIV 32.3% (among Youth ages 20-29 yrs) PLWH 22% (among Youth, ages 15-24 yrs)	Youth, ages 13-29 comprise 10.3% of Part B clients Youth, ages 13-24 yrs comprise only 2.9% Part C clients	PLWH: 13-19 yrs: 73%; 20-29 yrs: 63% PLWA: 13-19 yrs: 45%; 20-29 yrs: 42%
3) Hispanics	New AIDS 10.5% New HIV 7.1% PLWA 3.8% PLWH 3.4%	8.3% Part B clients 7% of Part C clients	64%
4) IDU	*New AIDS 22% New HIV 17% *PLWA 25% *PLWH 21%	18% of 'combined' Part B 18% of 'combined' Part C	unk
5) Rural PLWHA	Unknown	16% Part B Clients Est. 20% Part C	54%

- Proportion of IDU total when combine IDU and MSM/IDU (Source: Column B: OK HARS data, 2007; Column C –2007 CAREWare Data; Column D: 2008 Unmet Needs Assessment)

African American PLWHA

In 2007, Blacks comprised 32% of the new HIV cases, yet there were only 19.8% African American PLWHA in the Ryan White Part B program's Primary Medical Care service category. (2007 Ryan White CADR)

Out of Care/Unmet Need: The level of Unmet Need among African Americans is 2nd among race/ethnic groups at 52%, behind Hispanics at 64%, per a 2008 Oklahoma study.

Barriers to Care Entry: Barriers to care entry include the stigma associated with HIV infection, issues with disclosing risk behavior, concerns about funding of care, and historical misperceptions about antiretroviral therapy.

PLWHA Youth

In 2007, there were 10.3% Youth PLWHA (ages 13-29 years) in the Ryan White Part B program's Primary Medical Care service category. (Oklahoma 2007 Ryan White CADR)

Out of Care/Unmet Need: Youth evidenced a substantially increased rate for being out of care in 2007, at 42%-73%, depending on HIV or AIDS status and age range (13-19 years versus 20-29 years) according to a 2008 Oklahoma Unmet Need study.

Barriers to Care Entry: Barriers listed by Youth include stigma, perception that they aren't 'sick', and fears related to HIV medications. These fears appear contradicted by their statements that HIV medications can resolve their infection despite delayed entry into treatment.

Hispanic PLWHA

In 2007, there were 8.3% Hispanic PLWHA in the Ryan White Part B program's Primary Medical Care service category, while Hispanics comprised 10.5% of all new AIDS cases. (Oklahoma 2007 Ryan White CADR)

Out of Care/Unmet Need: Hispanics recorded the highest percent of unmet need or election to stay out of care among all races/ethnicities despite an HIV-positive diagnosis at 64% in 2007.

Barriers to Care Entry: Reasons for the decision not to enter care include undocumented citizenship status, lack of financial resources, stigma related to HIV, and issues surrounding the desire to remain non-disclosed to their spouse and/or family about disease/same-sex relations.

IDU

In 2007, there were 9.2% IDU and 8.8% MSM/IDU (for a total of 18%) in RW funded Part B services, yet IDU and MSM/IDU comprised 17% of HIV incidence, 22% of AIDS incidence, 25% of AIDS prevalence and 21% of HIV prevalence in 2007.

Barriers to care Entry: Barriers for IDU and substance abusers include continued substance use/abuse and fear of legal entanglements.

Rural PLWHA

In 2007, Rural PLWHA comprised 16% of the Part B funded service delivery system.

Out of Care/Unmet Need: Rural PLWHA, residing in non-MSA localities throughout the state, comprised 54% of the out of care population (compared to the state average of 48%).

Barriers to care Entry: Many barriers act as obstacles to care for Rural PLWHA including transportation difficulties, stigma, and fears of disclosure and lack of confidentiality.

Males, Females, MSM, Heterosexual and American Indians are all ‘In Care’ in proportions that reflect their proportionate representation in the local epidemic.

SECTION II. WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?

Introduction to Section II:

The OHPC plans to focus its actions and those of its partners over the next three years on the further refinement of an ideal continuum of care for all PLWHA in Oklahoma. Efforts to achieve this ideal will result in a continuum that shortens the time between diagnosis and entry into care, facilitates earlier testing and treatment and reduces transmission of the virus to others, lengthens the time between entry into care and transition to AIDS-defined status, reduces the number and severity of complications and episodes of illness and, finally, lengthens the time between HIV diagnosis and death from the virus. Through careful consideration of Oklahoma PLWHAs’ environment, population characteristics, history, needs, care resources, service gaps and barriers to care, the OHPC has developed an ideal continuum of care.

CHAPTER 11: Continuum of Care for High Quality Core Services/Shared Vision & Values

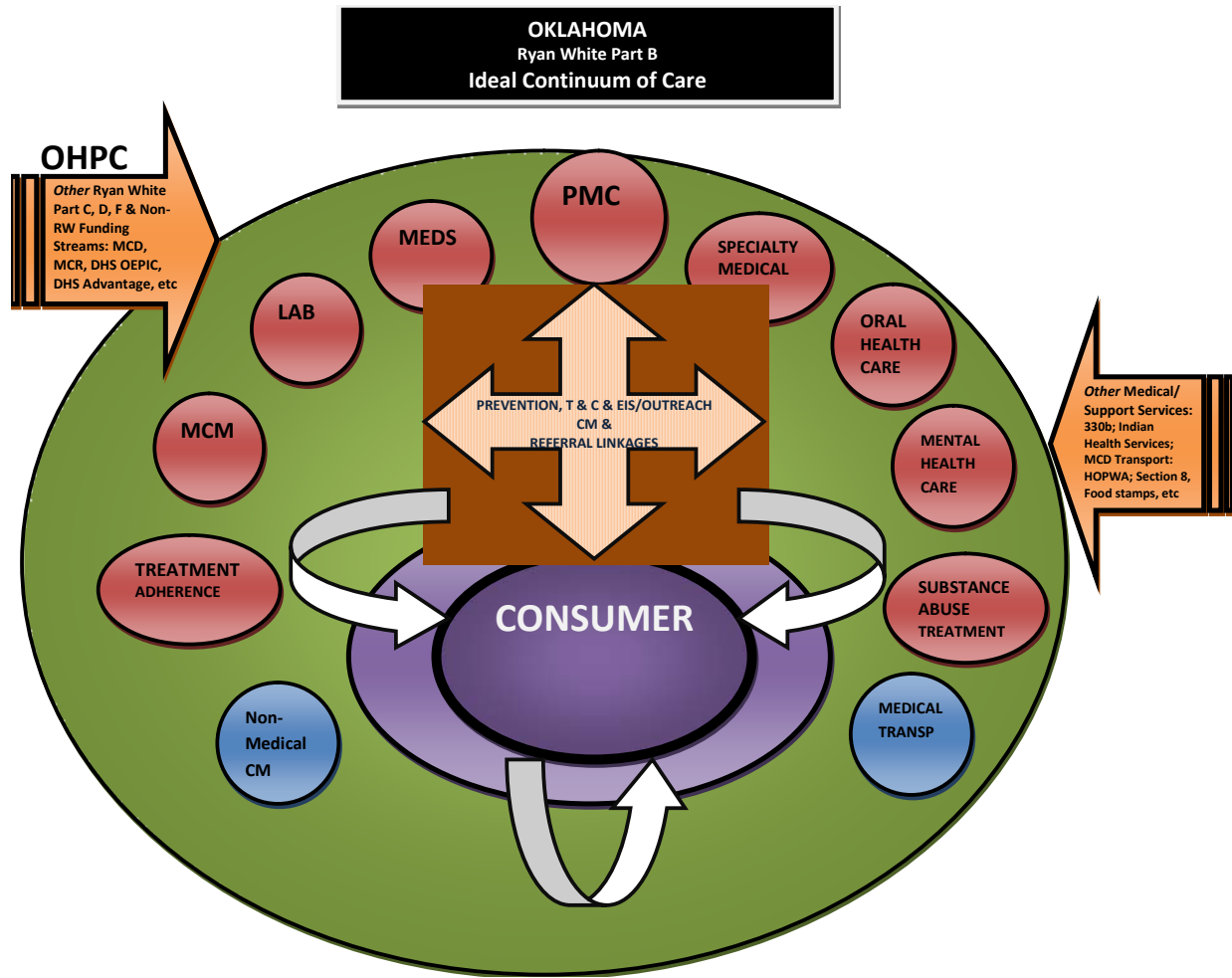
The Mission of the Statewide Coordinated Statement of Need (SCSN): is to identify epidemiological trends, common unmet needs and barriers for persons living with HIV/AIDS throughout Oklahoma and to promote a shared vision for effective planning and coordination of treatment and care services across the state.

OHPC Vision Statement: Over the next three years, the community will enhance (or increase access to) a coordinated system of HIV/AIDS care (treatment) and prevention in order to improve the quality of life for people living with HIV/AIDS in Oklahoma.

The continuum of care in Oklahoma is defined by those services directly linking newly diagnosed and people living with HIV and AIDS to primary medical care and support services. Services with the highest ranking throughout the prior three-year strategic plan timeframe relate directly to primary medical care entry and retention. (Core Medical Services ranked 1 through 5 in priority). Medical and social support services ranked 6-15 are services determined to facilitate entry into and retention in care based on findings of the 2006 triennial needs assessment.

Mission of the Oklahoma HIV Planning Council: To ensure active, diverse and substantive input and involvement of persons living with HIV and AIDS (PLWHA) in the HIV prevention and care planning processes for the State of Oklahoma.

The Oklahoma HIV Planning Council is an important statewide advisory planning body of physicians, community leaders, State agency representatives, service providers, and consumers. Working in partnership with the Oklahoma State Department of Health, HIV/STD Service, they developed the goals of the SCSN and Comprehensive Plan, make recommendations as to the best utilization of the Ryan White Part B funds, and help to develop and maintain a comprehensive continuum of care for those living with HIV disease. After analyzing needs assessments, service barriers, and gaps in services, they submit an HIV service delivery plan for Oklahoma and evaluate these services for cost effectiveness and efficacy of meeting consumer needs. It is the policy and mission of the OHPC to ensure active, diverse and substantive input and involvement of persons living with HIV/AIDS (PLWHA) in the planning process. PLWHA have a unique understanding of service needs, which make them essential participants in the planning and oversight of services.



SECTION III: HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF AND ACCESSIBILITY TO CORE SERVICES?

CHAPTER 12: Planning within the State of Oklahoma

The purpose of this section is to provide a road map that will refine and continuously improve the Oklahoma HIV care and support services delivery system. The proposed care system has been created to be responsive to the changing needs of the epidemic and fill the service gaps of PLWHA who know their status and are not in care. The Plan effectively responds to HRSA/HAB's over-arching goals 'to increase access to care to 100% and reduce outcome disparities to 0%'. It provides guidance as to how our system needs to change to assure availability of and accessibility to core medical and other support services.

As the continuum of care in Oklahoma continues to evolve, core values and shared visions are utilized to guide and direct the service delivery planning process for PLWHA. Utilizing these guiding principles (Mission and Shared Vision) and other pertinent information such as the HRSA planning requirements, the Statewide Coordinated Statement of Need (SCSN), and results from the regional and statewide needs assessments, the OHPC formulated the following goals and objectives for the next three years. The following sections will include:

- A narrative description of the goals of the SCSN and Plan, and
- A summary table of each goal, accompanied by objectives and actions with specified timeline and responsible party.

The central purpose of the Ryan White Part B funding is facilitating PLWHA access into and retention in care and ensuring that they are supported in adhering to their medical regimens. Therefore, at the core (center) of the model are both medical care and the supportive services that help PLWHA to engage with and remain in care.

Because it is important that these various medical and support services be delivered in a coordinated and consistent manner, the care circle is surrounded by services that facilitate or arrange access to medical and supportive services. This core of medical, supportive, and coordination services exists in the context of goals that promote access to care for all those living with HIV/AIDS and ensures that high-quality services are provided in a cost-effective manner. The entire continuum of care is specifically designed to result in improved health outcomes.

Extensive planning contributed to development of the updated comprehensive plan, with Ryan White and other service provider, community involvement and PLWHA input. Developing goals for the integrated 2009-2011 SCSN and Comprehensive Plan was a data-driven process. The preliminary goals presented in this document were developed based on consumer and provider input; epidemiologic and other data from the Oklahoma State Department of Health; detailed In Care and Out of Care consumer survey results from the 2006 Needs Assessment, and preliminary

results from the 2009 prevention prioritization process. Additional data sources include information from the last Statewide Comprehensive Statement of Need and Statewide Comprehensive Prevention Plan, with final input from the Planning Council.

The OHPC members and invited guests spent a day-long planning session to review and refine the short-term and long-term goals for the integrated SCSN and Comprehensive Plan. The Oklahoma HIV Planning Council is responsible for assuring that the plan's goals are met with the suggested objectives and tasks assigned. In addition, in collaboration with OSDH, the *Care Committee* is responsible for:

- 1) Implementing the specific tasks required to meet the goals;
- 2) Monitoring the tasks required to meet the goals using measurable indicators; and
- 3) Performing outcomes evaluation on the goals in the plan.

Cross Cutting Issues

Cross-cutting issues identified in the day-long statewide planning process and common to all Ryan White Program Parts across the State include extreme poverty, high levels of un-insurance, substantial co-morbidity, drug use, lack of transportation, lack of affordable housing, lack of knowledge about services available, stigma, discrimination, fears of disclosure and lack of confidentiality. Also noted was the continued high level of unmet need, the rising cases of HIV/AIDS among Youth, and the disproportionate impact among Blacks.

In addition to the findings already mentioned, several needs, gaps and challenges were also Identified, as follows:

- 1) The need for integrated, interdisciplinary and co-located approaches to care and support services;
- 2) Multi-cultural, multi-disciplinary teams that integrate to the extent possible medical care, including specialty care, with mental health, substance use treatment, case management and other HIV- related support services can best manage the complex medical and social issues faced by PLWHA and their affected families. Ideally, services are co-located or, at a minimum, stronger working relationships are forged between programs.
- 3) The need for case management training in performing expanded behavioral risk assessment and risk reduction education that is age appropriate and culturally competent
- 4) The increased complexity of care and costs associated with multiple co-morbidities diagnoses (MH, SA, Hepatitis, STDs, diabetes and heart disease) which translates into an on-going need for cross-training of staff, co-location of services wherever feasible, and frequent case consultation.
- 5) Long distances to travel for rural PLWHA combined with weak public transportation infrastructure creates access barriers for rural PLWHA.
- 6) Shortage of dentists who accept Medicaid and need for expanded oral health services.
- 7) The need for stronger linkages between prevention and care – referrals and retention in care.
- 8) The need for community-based social marketing efforts to reduce stigma and inform consumers of benefits of testing, treatment and care.
- 9) The need for ongoing Provider staff education in cultural competency.

- 10) The need for greater CM training in accessing all available third party resources.
- 11) The need for RW and non-RW provider training in facilitating client access to all available medical and support services.
- 12) The need for continued training in Data management systems and Quality Management & Evaluation

Conclusion

The steady expansion and changed demographics of the HIV epidemic, as well as improved survival time for people living with AIDS are placing increased stress on state and local health care systems. The State of Oklahoma, through this integrated SCSN and Comprehensive Plan document, outlines the need for collaboration among all Ryan White grantees. This collaboration is based on needs assessment findings, goals and objectives of the Oklahoma HIV Planning Council and evaluation/monitoring of HIV/AIDS providers. The overarching goal for all Ryan White Parts is to link/re-engage in primary medical care those individuals who know their positive HIV status. As all of the Ryan White funded entities respond to the numerous challenges in delivering quality HIV care for an expanding patient population, the collaborative focus on reducing health care disparities, bringing the out of care in to care while maintaining a comprehensive continuum of care is critical. Only through 'all Part' collaboration can these challenges be overcome.

Narrative Summary of 2009 Service Delivery Goals

Goal 1: Improve Access to Health Care

An ideal, comprehensive care system ensures that geographical, socioeconomic, or infrastructure obstacles that prevent PLWHA from accessing that system are minimized or eliminated. A variety of regional and Statewide collaborative strategies, along with targeted marketing, outreach and early intervention programs are designed to overcome barriers to care, including PLWHA not knowing how or where to obtain care, not knowing what services are available through Ryan White, or lacking the knowledge or skills in how to navigate the benefits and services available in Oklahoma. EIS case management staff also serve those out of care by addressing their concerns about stigma and other issues that may keep them from seeking care. Outreach is strongly linked to early intervention services, with the goal of facilitating earlier access to care and shortening the interval between testing and care entry.

Only 52% of Oklahoma's PLWHA have a met need for HIV primary medical care. Ensuring access to all needed core medical services, including adequate levels of Oral Health Care, acceptable and accessible Mental Health and Substance Abuse treatment services, and providing the necessary transportation assistance to access needed services represent top goals for the new plan. The measures of the efficacy of this HRSA strategy include the increasing number/percentage of the HIV-positive population (including each of the special populations) who are entering care each year, encouraging earlier entry into care and reducing time from

testing to care, and effectively retaining in care all special populations living with HIV disease in Oklahoma.

Goal 2: Eliminate Health Disparities

African Americans, Hispanics, Males, MSM, and Youth evidence an increasing and disproportionate impact of HIV/AIDS in Oklahoma. (*Oklahoma Epidemiologic Profile, 2008*). The level of Unmet Need, or the percent of PLWHA not in care that know that they are HIV-positive, is highest for African Americans, Hispanics, Youth and Rural residents per a study conducted in 2008 by the Oklahoma State Department of Health. The Statewide level of unmet need is approximately 48% for 2007 (*Oklahoma Unmet Need Study, 2008*). The OHPC reviews these reports and other sources of information (such as needs assessments and information from the community), and issues directives aimed at eliminating health disparities. Ensuring urban and rural parity in access to core medical and support services and the co-location and high level collaboration between providers to jointly manage PLWHA's HIV disease management and other co-morbidities facilitates successful engagement and retention in care for all the underserved populations in Oklahoma.

Implementing best practice strategies which result in more 'youth-friendly', women-friendly' and 'minority-friendly' care environments encourages entry into and retention in care. The measures of the efficacy of this HRSA strategy include the increasing number/percentage of the urban and rural underserved populations who are entering into and receiving care, combined with steady reductions in the level of unmet need, especially among the special populations.

Goal 3: Improve the Quality of Health Care

Higher-quality core medical care and support services are more effective at interrupting the progression of HIV disease and in preventing/reducing complications of the disease while contributing to quality of life and reducing the further spread of the disease. The Continuous Quality Management Program will monitor provider performance against PHS standards of care and provide training and technical assistance to all Part B providers as needed.

The OHPC in 2009 will review the quality improvement service category reports, and consider consumer needs and category performance and history as well as other funding streams available to a category when making allocation and reprogramming decisions. The measure of the efficacy of this HRSA strategy is evidenced by: 1) the integration of quality management processes and standards of care for all Part B funded services; 2) the increasingly knowledgeable and informed Part B providers and Consumers who are involved in continuous quality improvement activities; 3) compliance with public health standards; and 3) continuous performance improvements in key health indicators annually.

Goal 4: Assure Cost Effectiveness

The expenditure of Part B funds must occur after all other resources are exhausted and must assure the maximum possible impact for each dollar expended. The OHPC and its committees review expenditure and service delivery reports to assess trends in utilization of funds, services

provided, and costs per service category/units of service. OSDH provides expenditure and service reports to the OHPC regularly throughout the year. Where funds in a service category are under-expended, the OSDH re-programs the under-spent funds to other categories that have demonstrated need.

The Oklahoma HIV Planning Council collaborates with other funding streams to assess any duplication of services, and strives to reduce/prevent unnecessary duplication in funding streams. The measures of cost effectiveness include: 1) a PSRA process which documents use of Part B funds to fill service area gaps; 2) demonstrated maximal use of other funding streams to support the continuum of care while achieving reductions in costs per service category uses; and 3) a system of care that continues to expand access to meet the increasing demand, evidenced by a continuously expanding Part B client population in care.

Goal 5: Improve Health Outcomes

This goal sums up the overall effectiveness of both the Ryan White Part B program, and the effectiveness of all partners who serve HIV-positive consumers in the Oklahoma planning area. Outcomes for the specific service categories are interim measures of effectiveness. Outcome measures selected for measurement and reporting in the upcoming fiscal year include numerous indicators of importance to the men, women and youth to be served, including the number/percent of PLWHA with CD4 cell counts below 200 who are appropriately prescribed PCP prophylaxis and the number/percent of PLWHA on ART who achieve and maintain an undetectable viral load during the project year. Other outcome measures include the increasing number/percent of female PLWHA who receive annual Pap smears and pelvic exams and appropriate referrals; the increasing number/percent of PLWHA who receive TB testing each year, and are appropriately treated for latent and active Tuberculosis; and the decreasing number/percent of the client population that develop an AIDS diagnosis during the project year.

The ultimate health outcome measures include a reduction in emergency room and hospitalization rates and increasing survival rates/reduction in death rates due to AIDS. Improvements in quality of life outcomes to be tracked and reported include reported increases in overall health and reports of increased employment among HDAP clients.

These goals form the basis for the triennial comprehensive plan, with emphasis on the following four core themes:

- 1) Reduced Unmet Need, effectively moving the out of care into HIV primary medical care;
- 2) Increased access to care, especially among the emerging and special populations;
- 3) Reduced disparities in health care access and outcomes for the emerging and historically underserved populations; and
- 4) Continuous quality improvement, including its direct relationship to client level data and provider performance data, and positive impact on health outcomes.

CHAPTER 13: Goals, Objectives, and Activities

This chapter identifies the Oklahoma Part B goals, and the plans to accomplish those goals during the 2009-2011 time frame, through specially developed strategies and action steps that are responsive to the state’s current situation and statewide assessment of needs, in order to meet the measurable objectives of the stated plan. This plan was developed in keeping with the HRSA guidance at the forefront, and will provide guidance to the OHPC over the next three years. The implementation plan orchestrates numerous strategies and implements new and continuing initiatives, based upon the considered needs of Oklahoma PLWHA in achieving the ideal continuum of care. All of the proposed activities include consideration of cost effectiveness and quality, so that the health outcomes of those served may continue to evidence the desired improvements.

2009 HRSA Expectations for Comprehensive Plan

Table 40. 2009 HRSA COMPREHENSIVE PLAN EXPECTATIONS
1. Ensure the availability and quality of all core medical services within the service area.
2. Eliminate disparities in access to core medical services and support services for individuals with HIV among disproportionately affected sub-populations and historically underserved communities.
3. Specify strategies for identifying individuals who know their HIV status but, are not in care, informing them about available treatment and services, and assisting them in the use of those services.
4. Include a discussion of clinical quality measures.
5. Include strategies that address the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system.
6. Provide goals, objectives, timelines and appropriate allocation of funds (as determined by the needs assessment).
7. Include strategies to coordinate the provision of services programs for HIV prevention, including outreach and early intervention services.
8. Include strategies for the prevention and treatment of substance abuse.

Short Term Goals and Long Term Goals of the 2009-2011 Oklahoma Part B Comprehensive Plan

a. Chart of Short Term Goals, Objectives, Timelines and Responsible Parties

The OHPC, in collaboration with OSDH, has identified the following 6 goals, 14 objectives and 44 activities as its action plan aimed at developing the ideal continuum of care in Oklahoma.

1	Goal # 1: Improve Access to Health Care Services		
	Objective 1.1: Increase access to care by 10% annually for PLWHA populations by creating more capacity for navigating and understanding care systems and other resources for services. (Baseline: 2008 New & Returning Part B Clients=1,795; Target 180 New Part B Clients with 36 new AA; 15 new Hispanic; 19 new Youth; 33 new Female; 29 new Rural and 32 new IDU clients)	Timeframe	Responsible Person(s)
	Activity #1.1.1. Create and widely disseminate an updated PLWHA Resource Guide to all points of entry, including C/T, outreach, primary medical and specialty providers & other key providers & locations.	Q 1-2, Update Annually	OHPC & Committees
	Activity #1.1.2. Develop referral protocols and improve communication between HIV CTR, case management, and medical staff to ensure referrals/ follow-ups are provided to newly positive clients.	Q 1, 2, 3 ,4	OSDH
	Activity #1.1.3. Encourage RW Part B/C PMC, CM & MH/SA providers to implement ‘opt out’ HIV testing as an element of routine care.	Quarterly/ Annually	OSDH
	Activity #1.1.4. Explore evidence-based interventions, support proposals and pilot innovative alternative models for engaging SNG clients in care.	Bi-Annually	OSDH
	Objective #1.2: Reduce lag time from testing to care by 5% annually to speed entry into care for all newly diagnosed PLWHA populations and especially SNGs (Establish Baseline: 2008 Delays in Months from Testing to Care, by special population, through cross-match of PEMS and CAREWare data bases)	Timeframe	Responsible Person(s)
	Activity #1.2.1. Confirm ‘Points of Entry’ & Strengthen Testing/Counseling & Referrals to Care linkages; ensure follow-up tracking strategies for referral confirmation.	Q 1-2	OSDH

Activity #1.2.2. Perform 'Late to Care' study as part of comprehensive 2009 In Care Needs Assessment; evaluate results and implement strategies to reduce identified barriers to care.	Q 1-4	OSDH OHPC
Activity #1.2.3. Explore best practice peer advocacy/support models to facilitate earlier care entry & enhance care engagement among underserved populations.	Q 1-2	OHPC
Activity #1.2.4. Explore various client-centered models of care, & best practices, with emphasis on increasing 'women', 'youth-' and 'minority-friendly' care environments.	Q 1-2	OHPC
Activity #1.2.5. Strengthen coordinated linkages with non- RW providers across the life span to facilitate mutual referrals and increased cross-collaborations, including IHS.	Q 2-3	OSDH
Activity #1.2.6. Explore barriers to obtaining dental care services, and implement solutions to address access issues.	Q 2-3	OSDH OHPC

2 Goal # 2: Reduce Health Care Disparities		
Objective #2.1: Reduce Level of Unmet Need by at least 2.5% Annually. (Baseline: 2008 Unmet Need=48%or 2,722: Target 90 OOC annually for total of 270 or 10% reduction in unmet need over next three years)	Timeframe	Responsible Person(s)
Activity #2.1.1. Complete an Unmet Study surveying the Out of Care populations.	Q 1-2	OSDH OHPC
Activity #2.1.2. Address OOC Service Gaps & Barriers.	Q 3-4	OSDH OHPC
Activity #2.1.3. Develop and implement target messages to overcome SNG barriers to care entry, and particularly for AA MSM.	Q 3-4	OHPC
Activity #2.1.4. Require bi-annual provider assessments of those who are out of HIV primary care and require providers to contact them and facilitate re-entry into care.	Q 2-4	OSDH
Activity #2.1.5. Increase utilization of peer mentors to strengthen access, engagement & retention in care among SNGs.	Q 2-4	OSDH OHPC

Activity#2.1.6. Continually assess demographic profile of Part B clients to assure that disproportionately affected subpopulations and historically underserved communities are accessing core medical services.	Quarterly, Ongoing	OSDH OHPC
Objective #2.2: Evaluate Barriers to MH/SA Services and Address HIV Disease and Co-Morbidity Management among New and Returning Part B clients.(Baseline: Part B Clients assessed as needing MH/SA services compared with # of confirmed referrals)	Timeframe	Responsible Person(s)
Activity #2.2.1. Identify and implement best practice CM & PMC models to overcome the barriers to MH/SA services and improved protocols to retain mentally ill clients in care.	Q 1-2	OSDH OHPC
Activity #2.2.2. Provide CM trainings directed toward increasing skills in accurately assessing, screening and appropriately referring clients for needed MH/SA services.	Q 2-3	OSDH
Activity #2.2.3. Identify and engage potential partners for the provision of expanded oral health, transportation, and in-patient and out-patient MH/SA treatment services.	Q 2-3	OHPC
Objective #2.3: Ensure parity of urban/rural service delivery, including assurance of access to services by non-MSA and rural residents.	Timeframe	Responsible Person(s)
Activity # 2.3.1 Ensure access to core medical and key support services for rural residents through increased coordination of RW and non-RW service providers, including IHS and 330b referrals and collaboration.	Q 2-3	OSDH
Activity #2.3.2 Explore all available transportation resources; explore innovative approaches to transportation assistance and provide resource information/education to clients and providers, to ensure enhanced access to care.	Q 2-3	OSDH OHPC
Objective#2.4 Increase by 5% annually the number of Part B Clients retained in Primary Medical Care (Baseline: Proportion of 2007 Part B Clients retained in care in 2008)	Timeframe	Responsible Person(s)
Activity#2.4.1 Assess cultural competency technical assistance and training needs of Part B providers and deliver TA to increase capacity to effectively serve/retain in care the disproportionately affected populations.	Ongoing	OSDH OHPC

Activity 2.4.2. Engage AETC in the provision of CM and PMC provider trainings on resources available and increasing mutual referrals and collaborations with RW & non-RW providers and systems of care.	Q 2-4	OSDH OHPC
Activity 2.4.3. Explore and implement evidence-based interventions directed toward Severe Need Groups to facilitate initiation and retention in medical care (prevention case management, outreach case management, interventions specific to African American MSM).	Ongoing	OSDH OHPC
Objective #2.5 Reduce the further spread of HIV infection through enhanced primary & secondary prevention efforts in case management and primary care settings.	Timeframe	Responsible Person(s)
Activity #2.5.1. Assess the TA needs of providers and ensure each has the skills and resources to integrate effective and continuous sexual and drug use risk assessments and risk reduction counseling services for PLWHA clients and their sex and drug using partners.	Ongoing	OSDH OHPC
Activity #2.5.2. Incorporate more education and prevention messages into the medical treatment of those living with HIV/AIDS.	Annually	OSDH OHPC
Activity #2.5.3 Develop an action plan for ensuring clients have greater access to needs assessments.	Ongoing	OSDH OHPC
Activity#2.5.4 Ensure 'Voice of the Consumer' in OHPC representation and inclusion in program planning and evaluation activities.	Ongoing	OHPC Committees

3	Goal # 3: Improve the Quality of Services	
Objective #3.1: Implement 2009 Quality Management Plan inclusive of all indicated Provider and Consumer CQI Trainings by December 2009	Timeframe	Responsible Person(s)
Activity #3.1.1. Implement and evaluate the comprehensive QM Plan and results for all Part B services.	Q 1,2, 3, 4	OSDH OHPC
Objective #3.2:Strengthen Medical Case and Non-Medical Management Care and Systems	Timeframe	Responsible Person(s)

Activity #3.2.1. Conduct quality improvement trainings with Part B providers and consumers, complete performance audits of all CM providers, and implement CQI TA activities to address performance improvement issues.	Q 1,2,3,4	OSDH
Objective #3.3:Ensure Adequate Levels of Medical & Non-Medical Case Management Services to Support Access to & retention in Care	Timeframe	Responsible Person(s)
Activity #3.3.1. Conduct assessment of CM provider capacity and capability and use findings to inform system improvements.	Q 2-3	OSDH
Objective #3.4:Implement and Evaluate System-wide Client Level Data Reporting	Timeframe	Responsible Person(s)
Activity #3.4.1. Implement the system-wide strategy to collect, track and report HRSA client level data.	Q 1-4	OSDH
Activity #3.4.2. Analyze piloted results, refine strategies and evaluate first year client level data collection and reporting efforts for ways to continue to improve the process.	Q-2-4	OSDH

4	Goal #4 : Ensure Cost Effectiveness of Service Delivery	
Objective #4.1:Ensure Effective Utilization of Part B Funds to fill Service Gaps and Reduce Disparities in Care	Timeframe	Responsible Person(s)
Activity #4.1.1. Compile and assess all services funding streams and encourage funds diversification to maximize utilization of Part B funds and optimize the further expansion of the Oklahoma continuum of care.	Annually	OSDH OHPC
Activity #4.1.2. Evaluate core and support funding splits and evaluate unit costs for services across providers and service categories, to inform cost effectiveness considerations, and ensure the most appropriate expenditure of Part B funds.	Annually	OSDH OHPC

Activity #4.1.3. Provide ongoing 3 rd party reimbursement resource acquisition and benefits trainings to all CM providers to ensure maximal use of all other available resources.	Ongoing	OSDH
Activity #4.1.4. Review service utilization data to ensure appropriate allocation of funds and expenditure of funds with no carry-over.	Quarterly	OSDH OHPC
Activity #4.1.5. Perform annual priority setting/resource allocation process based on multiple programmatic and fiscal data sets.	Annually	Care Committee

5 Goal # 5: Improve Health Outcomes		
<i>Objective #5.1: Increase by 10% annually Part B achievement of improvements in key health outcome indicators, as evidenced by individual level client data and aggregate provider data (Baseline: 2007/2008 QM Results)</i>	<i>Timeframe</i>	<i>Responsible Person(s)</i>
Activity #5.1.1. Evaluate effectiveness of 2009 priority CQI activities (directed toward PCP prophylaxis, Oral health visits and CM visit documentation improvements) and their impact on clinical performance measures & health outcomes.	Quarterly Annually	OSDH
Activity #5.1.2. Implement key CQI projects to address low scoring performance measures.	Q 3-4	OSDH
Activity #5.1.3. Develop systems to track and report health outcome improvements including 1) reduced deaths due to AIDS/increased survival rates; 2) increases in quality of life as measured by increases in HDAP clients reports of improved health and return to employment.	Q 2-4	OSDH
Activity #5.1.4. Utilize the CAREWare system to generate client level health outcome indicator reports, disseminate findings, and use data to inform system improvements.	Bi-annually	OSDH

6	Goal #6: GOAL: To Improve the Service Delivery System in the State		
Objective 6.1: Ensure the planning process has wide community participation and is consumer driven	Timeframe	Responsible Person(s)	
Activity 6.1.1. Conduct a full In Care/Out of Care/Late to Care needs assessment triennially (“Voice of the Consumer”) with special studies in between.	Q1 2009, 2010 & 2011	OHPC	
Activity 6.1.2. Ensure the OHPC is reflective of the epidemic and develop strategies to receive regular and in-depth input from consumer-based and regional community-based groups.	Q2, 2009	OHPC	

LONG-TERM GOALS AND OBJECTIVES (Over 3-year period: FY 2009 – 2011)

STRATEGIES/ACTIVITIES	Timetable			Responsible
	FY '09	FY '10	FY '11	
I. INCREASE ACCESS TO CARE				
A. Increase Access to Care by 10% Annually Among All Population (N=180) and 10% each of Special Populations/SNGs (Baseline: 2008 Part B Clients)				
Conduct community-wide services and funding Inventory & Develop/Distribute Consumer Resource Guide	■			Grantee
Strengthen outreach & HIV testing/counseling and early intervention services & referral linkages in urban/rural venues targeting high risk & aware/not in care	■	■		Grantee Council
Encourage & support PMC , CM & other core medical providers to implement 'opt out' HIV testing		■	■	Grantee
Explore and Support Proposals/pilot innovative strategies to increase client engagement in care/Increase use of Peer mentors	■	■	■	Grantee
B. Encourage earlier Care Entry & Reduce Lag Time from Testing to Care by 5% Annually for all Newly Diagnosed PLWHA				
Confirm 'points of entry' and strengthen Testing/Counseling to Care linkages	■	■		Grantee Council
Explore best practices and pilot innovative models of care that encourage earlier entry and retention in care for youth, men, women and minorities, and particularly AA MSM.	■	■		Council
Strengthen coordinated linkages with non-RW providers of services across the lifespan to increase mutual referrals and care sources	■	■	■	Council

STRATEGIES/ACTIVITIES	Timetable			Responsible
	FY '09	FY '10	FY '11	
II. REDUCE HEALTH CARE DISPARITIES				
A. Reduce Level of Unmet Need by at least 2.5% Annually				
Conduct 'Out of Care' study, analyze findings and use priority setting process to implement changes in Service Delivery System	■	■		Council
Continuously assess demographic profile of Part B clients to assure that disproportionately impacted and historically underserved are accessing services	■	■	■	Grantee Council
B. Evaluate Barriers and Address HIV Disease and Co-Morbidity Management among New and Returning Clients				
Conduct study of barriers to usage of existing MH/SA services and explore best MCM/CM & PMC practices to jointly address MH and SA needs among Part B clients	■	■		Council
Identify and engage state & CBO partners for the provision of expanded transportation, oral health, and outpatient and inpatient MH & SA services	■	■	■	Grantee Council
C. Ensure Parity of Urban/Rural Service Delivery, including Assurance of Transportation/Oral Health services for Urban and Rural Residents				
Increase collaboration and coordination of RW and non-RW providers, and expand transportation assistance to create more parity between urban/rural care resources	■	■	■	Council
D. Increase by 5% Annually the number of Part B Clients Retained in Primary Medical Care				
Refine coordination & linkage of Outreach, Case Management and Primary Medical Care	■	■	■	Grantee Council
Evaluate and implement numerous strategies to positively impact PLWHA retention in care	■	■	■	Grantee

STRATEGIES/ACTIVITIES	Timetable			Responsible
E. Reduce the Further Spread of HIV Disease through Enhanced Primary & Secondary Prevention Linkages and Programs	FY '09	FY '10	FY '11	
Assess and address TA needs of providers to ensure competency in performing serial risk assessments and providing risk reduction education and counseling for PLWHA and their sex and drug using partners	■	■	■	Grantee
Incorporate more education and prevention messages into the medical treatment of those living with HIV/AIDS	■	■	■	Grantee
III. IMPROVE QUALITY OF SERVICES				
A. Strengthen & Refine Medical and Non-Medical Case Management Services and Systems				
Conduct CM Trainings and implement improvements	■	■	■	Grantee
B. Implement 2009 CQI trainings and performance audits of MCM and non-medical CM providers.				
Implement TA activities to address performance improvement issues	■	■	■	Grantee
C. Ensure Adequate levels of Medical and Non-Medical Case Managers to support Access and Retention in Care				
Conduct assessment of CM provider capacity and use findings to inform the system changes/improvements	■	■	■	Grantee Council
D. Implement and Evaluate System-Wide Client Level Data Reporting				
Implement, evaluate and continuously refine client level data reporting system and provide TA and guidance as indicated.	■	■	■	Grantee

STRATEGIES/ACTIVITIES	Timetable			Responsible
IV. ENSURE COST EFFECTIVE SERVICE DELIVERY	FY '09	FY '10	FY '11	
A. Ensure Effective Utilization of Part B Funds to fill Service Gaps and Reduce Disparities in Care				
Assess all funding streams, encourage maximize utilization of Part B funds and expand continuum of care.	■	■	■	Grantee Council
Review funding split between core and support services	■	■	■	Council
Analyze accessibility/quality/utilization of core services in service delivery system	■	■	■	Council
Conduct priority setting/resource allocation process	■	■	■	Council
V. IMPROVE HEALTH OUTCOMES				
A. Increase by 10% Annually in Part B Provider Improvements in Key Health Outcome Indicators, as Evidenced by Client Level Data Sets				
Review/Refine Standards of care for Part B funded Case Management services, perform chart audits, compare findings to HRSA performance expectations, and implement corrective plans	■	■	■	Grantee
Utilize CAREWare system to generate client level health outcomes indicator data, disseminate findings, and use the data to inform system improvements	■	■	■	Grantee
Ensure OHPC is consumer-driven and reflective of epidemic Ensure widespread consumer and provider input	■	■	■	Grantee Council
Utilize multiple sources of data for evaluation and planning	■	■	■	Grantee Council

STRATEGIES/ACTIVITIES	Timetable			Responsible
VI. IMPROVE SERVICE DELIVERY	FY '09	FY '10	FY '11	
A. Ensure the planning process has wide community participation and is consumer driven				
Assure mechanism to involve Part B Clients in Needs Assessment Activities	■	■	■	Grantee Council
Conduct a full needs assessment triennially ('Voice of the Consumer') with special studies in between	■	■	■	Grantee Council
Ensure the OHPC is reflective of the epidemic and develop strategies to receive regular and in-depth input from consumer-based and regional community-based groups.	■	■	■	Grantee Council

SECTION IV. How will we monitor our progress?

Introduction to Section IV: Multiple persons and many agencies have a role in implementing the goals of the 2009-2011 SCSN and Oklahoma Comprehensive Plan. The primary responsibility for ensuring that the plan is implemented, and for monitoring its implementation, falls to the OHPC's Care Committee, in collaboration with the Oklahoma State Department of Health. However, the planning and implementation of the three-year plan requires the full cooperative effort of all Ryan White and other planning and provider partners across the state.

CHAPTER 14: Implementation, Monitoring and Evaluation Plan

Implementation Processes

The Oklahoma HIV Planning Council (OHPC) uses several processes to accomplish the various strategies identified in the action plan. These processes are identified below.

OHPC Leadership Activities

Although the Planning Council performs most of its work through a committee structure, council leadership is responsible for spearheading collaborative activities with OSDH partners.

OHPC Committee Activities

Each OHPC committee has ongoing responsibility for one or more HRSA- and/or CDC--mandated activities. Within these mandates, committees target their activities to accomplish plan strategies.

The **Executive Committee** is comprised of the Community Co-Chair, OSDH Co-Chair, Two Ex-Officio members of the HIV/STD Service staff (Director of Prevention and Intervention and Director of the Division of Surveillance and Care Delivery) and the Chairs of the OHPC Committees.

- The **Membership Committee** focuses its council membership recruitment efforts toward engaging wide consumer involvement and the necessary talent and leadership required to fill the voting seats and encourage their full participation in council activities.
- The **Assessment and Evaluation Committee** monitors special needs assessment studies and reviews reports it has requested. This committee is responsible for evaluating the needs for HIV prevention and care in Oklahoma and for tracking current and future trends in HIV infection. This committee also tracks and evaluates care funded services and expenditures and reviews quality of care reports, making recommendations for improvements.

- The **Policy Committee** develops and recommends policies for the operations of the OHPC, including but not limited to Conflict of Interest, Grievance, and Confidentiality policies, as well as developing various operating and other procedures.
- The **Care Committee** is responsible for assisting in the planning and reviewing of Ryan White funded services and assisting OSDH with the development of the Comprehensive Strategic Plan and Statewide Coordinated Statement of Need. The Care Committee's planning processes include the analysis of multiple data sources including consumer assessments of need, service expenditures by category, service utilization and quality improvement data. The Care Committee also contributes a portion of the Comprehensive HIV Prevention Plan which pertains to accessing all available care and services.
- The **Prevention Committee** is responsible for the prioritization of HIV prevention target populations and a set of prevention interventions for each target population, as well as the presentation of this information to the OHPC. The committee also completes a portion of the Comprehensive Strategic Plan that addresses these items.

Provider Contracting and Contract Monitoring Process

OSDH establishes contract conditions of award and monitors Part B contract performance. Some planning council directives are included among the conditions of award, and are subsequently monitored. Monitoring is performed both by review of documents submitted by providers and by OSDH site visits to providers.

The Oklahoma Part B site-visitation process is comprehensive and occurs at least bi-annually to:

- 1) Review the agency's/program's capacity and effectiveness in delivering HIV care and services according to the Part B legislation and guidance;
- 2) Review the program's effectiveness of service implementation in accordance with the goals and objectives specified in the grant application/contract;
- 3) Assess consumer satisfaction and level of involvement in the program;
- 4) Identify areas of strengths and areas of needed improvement(s) in service delivery;
- 5) Identify best-model practices;
- 6) Ensure compliance with the all Part B *Standards of Care*; and
- 7) Make recommendations for technical assistance aimed at improving the quality of care and services and continued compliance with Part B funding guidelines.

Monitoring and Evaluation

The OHPC is the body primarily responsible for the development of this plan and, in collaboration with OSDH will ensure the plan's implementation, monitor its components and evaluate the proposed goals, objectives and strategies.

CHAPTER 15: Improving Client Level Data

The Quality Committee is fully implementing the new client level data system collection which started in January 2009. The OSDH has been using CAREWare since 2001 to track services and client information, so providers are very accustomed to collecting and reporting client level data to OSDH. Challenges currently revolve around collecting more detailed clinical information in CAREWare from medical providers. OSDH did incorporate the performance measures into their most recent contracts with medical providers, and the Manager of Care QA and Data Analysis has been reinforcing the importance of clinical documentation in CAREWare. Missing data reports are available to providers and with providers being centralized on the main server at OSDH, the Manager of Care QA and Data Analysis can create reports and copy them to providers to run as needed to improve data quality. In addition, Performance Measures Groups 1 and 2 are available to all providers in CAREWare to perform at any time at the click of a button. The grantee provided training to all providers on the RDR and RSR systems in January and reviewed with each the required data elements and new clinical information required. The Manager of Care QA and Data Analysis (in addition to data quality staff from a large medical provider) participated in the RDR/RSR training from HRSA.

The OSDH will use CAREWare to generate an export file that can be directly uploaded to the RSR system. Currently all medical and non-medical providers use CAREWare to enter service data so uploading medical and non-medical case management provider and client data is not an issue. OSDH's focus will be on ensuring data completeness and accuracy, especially focusing on screenings and detailed clinical information that is needed.

Currently, the OSDH has conducted baseline analysis of performance measures and has identified areas for improvement using the Performance Measures Module in CAREWare or RDR. Data is incomplete for some clinical variables so the QC will work with providers to improve the data completeness. These measures will provide evidence of performance over time and assist the grantee with identifying areas for improvement with services and quality of care. Overall, the performance measures are consistent with the client level data that needs to be uploaded to HRSA with the RSR, so monitoring the performance measures in CAREWare will assist the grantee with preparation for the RSR collection that began in January of 2009.

A QI formal meeting process has now been in place for over a year and provides a structured environment for the discussion of quality improvement issues. The Quality Committee meets monthly and minutes are recorded. In addition, the Manager of Quality Assurance and Data Analysis continues to utilize the skills gained from the Train-the-Trainer Program from the National Quality Center, and has conducted four quality improvement trainings to date. All members of the Quality Committee (QC) have been trained in PDSA, QI Theories and Principles, Performance Measurement, RW Quality Expectations, and Leadership for Quality Improvement.

Although performance measures have always been tracked, the quality management plan was primarily the responsibility of the Manager of Quality Assurance and Data Analysis and attention was more focused on measurement rather than process. With the implementation of

quality committee meetings, other staff have become involved in the process and are trained in quality improvement activities as well so that formal PDSA cycles and improvement projects are not the responsibility of one or two individuals. This has also created a sense of teamwork and allows staff to present concerns so that the group can process possible solutions. Based on the work and feedback from the QC, technical assistance requests for case management are efficient and providers are satisfied with the training they are receiving.

Medical case management quality improvement visits are assisting case managers with performance improvement. During 2008, each medical case management site received a report detailing areas of strength and areas for improvement in CAREWare documentation, medical case management chart documentation, preparation for the RDR and RSR, and client satisfaction. The Coordinator of Case Management Services, Director of Care Delivery, Contract Monitor, and Manager of Care QA and Data Analysis have been conducting these team visits along with CDC funded prevention quality assurance staff. The team has been a great asset to assist case managers with evaluating their services and providing recommendations for improvement. The QC also partnered with a pharmaceutical company in December of 2008 to conduct medication adherence behavioral change training for case managers and medication adherence staff. This training was a great opportunity for case managers to improve motivational interviewing skills.

Clinical quality progress reports and results of QI studies are presented to the Oklahoma HIV Planning Council's Evaluation and Assessment Committee for review. In addition, the Manager of Quality Assurance and Data Analysis has provided quality improvement training to the OHPC on Quality Management Expectations of Ryan White Grantees and Client Satisfaction. Performance measure data has been an integral piece to the collaboration of Ryan White Parts B, C and D in Oklahoma. Since all Parts use CAREWare and data is stored centrally by the OSDH, performance measures are calculated for clients receiving Parts B through D statewide. OSDH is also currently collaborating with a Part C and D clinic to establish a Statewide "Consumers for Quality Group" that will report to the Quality Committee. Based on QM data statewide on the increasing caseloads of medical case managers, OSDH increased Part B funding to support more medical case managers at the Part C clinics in Oklahoma City and Tulsa.

Planned Quality Activities

Goals and Objectives for FY 2009

1. Goal: Improve performance measure data and clinical client data documentation in CAREWare.
 - Objective: By April of 2009, provide training on performance measures, RDR reporting, and RSR data collection.
2. Goal: Improve efficiency and completeness of client level data reporting/ application process for the HIV Drug Assistance Program and Health Insurance Assistance Program.

- Objective: By March of 2010, have online case management system in place that will include an online application process.
3. Goal: Complete data collection and analysis on quality improvement projects.
- Objective: By March of 2010, conduct quality improvement projects (dental care exams and updated care plans) using Plan, Do, Study, Act methodology and implement positive changes.
4. Goal: Implement a consumer advisory process for Part B services to assist with quality improvement activities.
- Objective: By March of 2010, conduct quality improvement training for consumers and form committee of Consumers for Quality that reports to the overall Quality Committee.
5. Goal: Improve treatment adherence outcomes of new HIV Drug Assistance Program clients.
- Objective: By March of 2010, conduct evaluation of adherence counseling and education program with clients of HIV Drug Assistance Program.
6. Goal: Update and improve current case management standards.
- Objective: By March of 2010, establish workgroup, process and timeline for revising case management standards.
7. Goal: Update and improve current provider quality management plans.
- Objective: By March of 2010, conduct at least 1 site visit per agency to review quality management plans and make recommendations for improvements.

CHAPTER 16: Using Data for Evaluation

Using Data to Improve or Change Service Delivery in the State

A comprehensive system of program data tracking and program evaluation has been developed and will continue throughout the next project period to capture and report the required administrative and clinical program data. Both formative (monthly/quarterly) and summative (biannual) evaluations will continue to be performed in compliance with the goals and objectives of the comprehensive plan. Annual budget period renewal applications, delineating progress toward the stated goals and objectives will be submitted each year, and the Data Reports will be submitted each year, according to HRSA/HAB's requirements.

OSDH has developed a thoughtful, planned and systematic process for monitoring and evaluating the quality, comprehensiveness, accessibility and clinical outcomes of the Ryan White Part B funded service categories. Performance progress data is collected monthly according to a

service-specific (i.e., EIS/case finding, primary medical care, medical case management and treatment adherence, referrals, etc) management information system that, together, captures all relevant program services data on an ongoing basis. These data reports form the basis for the annual OHPC planning activities, OSDH narrative progress reports and the annual data reports.

Multiple sources of data are used to evaluate the State's level of progress toward achievement of the five key Health Resources and Services Administration (HRSA) goals: 1) improve access to care, 2) eliminate health disparities, 3) improve the quality of care, 4) assure cost effectiveness, and 5) improve health outcomes. Examples of the types of data to be used to evaluate attainment of these goals include the following:

Improving access to care and reducing access disparities: Individual level client data will be gathered and tracked regarding testing/referral source and length of time between testing and care entry. Each provider will track and report the number of new and returning patients by demographic profile, compared to the evolving profile of the local epidemic to evaluate the level of access and whether access is increasing, especially among the underserved and hard-to-reach populations in the urban and rural portions of the state.

Needs assessment data will be analyzed for the generation and testing of new interventions and strategies to reduce the stated barriers to access and retention in care among PLWHA. Provider and PLWHA-identified service gaps will be addressed through the annual planning processes, with ongoing monitoring of the state's level of success in reducing gaps in the core medical and key supportive services. Individual level client data and aggregate provider data by service category will be tracked and analyzed to determine the degree to which Oklahoma is reducing access disparities among each of the special populations.

Individual level client data will be tracked and evaluated for the number and proportion of PLWHA who are present and retained in primary medical care (evidenced by making and keeping at least one primary medical care visit during the initial six month time period and achieving at least one PMC visit during the second six month period of each project year) as a key measure of retention in care. Routine analyses of the Medical and non-Medical Case Manager's initial and annual client assessments of support service needs compared to level and extent of confirmed referrals and service usage will be used to examine the extent of confirmed access to medical services and the degree to which the supportive services are contributing to PLWHA engagement with and their sustained retention in care.

Reducing level of unmet need: Individual level client data will be tracked regarding dates of previous testing, previous medical care and length of absence from care upon entry into care and upon re-entry into HIV medical care. OSDH will perform a cross-match of PEMS data to CAREWare data to evaluate length of delays from testing and entry into care. Multiple strategies are outlined to aggressively reduce the high level of unmet need in the state of Oklahoma and expand services to assure all PLWHA of access to core medical services and key supportive services to maximize utilization of services and retention in care. The OSDH will utilize data from multiple sources to evaluate progress in reducing the out of care fraction in Oklahoma.

Ensuring cost-effectiveness of services delivery: Key data elements that are tracked and analyzed on a monthly, quarterly and annual basis include provider reports of cost expenditures by client and by service category; continual evaluation of the other local resources available; maximal use of non-Ryan White sources of care and funding to support the Oklahoma continuum of care; and analysis of individual client level data for evidence of duplicative service delivery, with actions taken to prevent or reduce any unnecessary duplication.

Improving the quality of the care and services delivered: A robust quality management system ensures the continued progress toward achieving the highest level of quality possible, according to HRSA/HAB performance measures, as discussed at length in the following chapter.

Improving the health outcomes of individual PLWHA: The plans to utilize client level data along with aggregate provider data, by service category, in order to demonstrate how Part B funded services are improving HIV-related clinical health outcomes, are comprehensively discussed in the following chapter.

CHAPTER 17: Clinical Quality Management

CQM Program Structure

Purpose, Vision, Mission

The purpose of the Quality Management (QM) Program is to set forth a coordinated approach to ensuring Part B clients have access to high quality services that are consistent with Public Health Service Guidelines for the treatment of HIV/AIDS. The mission of the QM Program is to improve the quality and availability of health care and support services to eligible individuals and families living with HIV disease. Quality Improvement (QI) principles will be utilized as a basis for improvement of care and services. The QM Program strives to continuously improve the quality of care and services in a multidisciplinary team approach and are consistent with the overall commitment to quality within the Oklahoma State Department of Health and HIV/STI Service.

Overall Goals and Objectives

A systematic, program-wide process for planning, designing, measuring, assessing and improving performance will include the following components:

- A. Develop a planning mechanism incorporating baseline data from external and internal sources (list data sources) and input from department leadership, staff and clients. Clinical, operational and programmatic aspects of client care will be reviewed.

- B. Emphasize design needs associated with new and existing services, patient care delivery, work flows and support systems which maximize results and satisfaction on the part of the clients and their families, providers and staff.

- C. Evolve and refine measurement systems for identifying trends in care and sentinel events by regularly collecting and recording data and observations relating to the provision of client care across the continuum.
- D. Employ assessment procedures to determine efficacy and appropriateness and to judge how well services are delivered and whether opportunities for improvement exist.
- E. Focus on improving quality in all of its dimensions by implementing multidisciplinary, data driven, project teams and encouraging participatory problem solving.
- F. Promote communication, dialogue and informational exchange across the department and throughout the organizations reporting structure, with regard to findings, analyses, conclusions, recommendations, actions and evaluations pertaining to performance improvement.
- G. Strive to establish collaborative relationships with diverse community and healthcare agencies for the purpose of collectively promoting the general health and welfare of the community served

FY 2008 Part B funds allocated to clinical quality management

Oklahoma allocated 3.5% of its FY08 Part B funds to quality management.

QM Program Roles and Responsibilities

The *department's leadership group*, Director of Care Delivery, Contract Monitor, Manager of HIV Drug Assistance, Health Insurance Assistance, and Home Health Programs, Coordinator of Health Insurance Assistance, Manager of Quality Assurance and Data Analysis, Coordinator of Case Management Services, and HDAP Enrollment Coordinator, is *accountable, responsible and answerable* for planning, directing, coordinating and improving healthcare services in the Ryan White Part B Program. This leadership group approves the performance improvement plan, and reviews quality improvement activities during its regular meetings.

The leadership group has formed a Quality Committee (QC), under the direction of the Director of Care Delivery. The QC, Director of Care Delivery, and HIV/STI Service Chief oversee the allocation of resources to quality management activities. The Manager of Quality Assurance and Data Analysis serves as the QC leader and coordinates the QC activities and agenda topics, including establishing the quality management program and coordinating the QI plan and improvement projects. The Director of Care Delivery serves as the QC facilitator, providing support and feedback to the QC leader. QC member responsibilities include suggesting problem-solving tools, offering ideas and active participation in improvement projects, respecting meeting ground rules, reviewing QI plan goals and indicators, regular meeting attendance, and rotating meeting minute responsibilities.

The Oklahoma HIV Planning Council (OHPC) members (providers and consumers) provide ongoing quality improvement feedback through the Evaluation and Assessment Committee. The Manager of Quality Assurance and Data Analysis reports quality activities to this committee and provides quality training to OHPC members, QC members, and contracted providers. In addition, the Manager of Quality Assurance and Data Analysis reports member recommendations and concerns to the QC. Through the Division of Care Delivery, the QC also provides ongoing QI reports to the HIV/STD Service Chief and HIV community and medical providers.

Process for Evaluation of QM Program and Activities

Once an opportunity for improvement has been identified, a multidisciplinary improvement project team will be convened to analyze the process and develop improvement plans. These teams will include those staff members closely associated with the process under study. Every attempt will be made to include individuals from other areas who may be impacted by changes made by the team and to help promote collaboration between agencies.

Continuous Quality Improvement Methodology will be utilized and will include but not be limited to the following:

- PDSA (Plan/Do/Study/Act) • Flow Chart Analysis • Cause-and-Effect Diagrams • Brainstorming • Observational Studies/patient flow • Activity Logs

Quality Committee/Team Meeting Record Improvement Plans will be developed and implemented by the teams. Improvements may include:

- System Redesign • Education or Technical Assistance (Internal or Provider Staff/Patients) • Clinical Guidelines review, revision or development • Procedure and policy changes • Form development or revision

All improvement plans will be communicated to all staff and to providers/ clients if deemed appropriate. Meetings, e-mails, memos, and informal verbal communications are all considered appropriate methods to communicate the team's activities and improvement plans, as long as all parties are included in the process.

Specific Indicators Being Monitored for Core Medical Services and Data Collection Strategy

The QC will be monitoring core medical services in accordance with the HAB performance measures for core medical, Groups 1, 2, and 3. Once approved Group 3 (in draft form) performance indicators (HDAP, Case Management, and Dental) will be measured as well. OSDH also measures indicators associated with satisfaction and health status. Indicators will be analyzed using data from Ryan White CAREWare, EMR, the new Ryan White Services Report, HDAP/HIAP enrollment database, medical case management chart reviews, and client satisfaction surveys.

The QC will monitor progress toward indicators by reviewing data quarterly. The QC has established baselines for the core medical performance measures deemed critical by HAB

(Group 1). Complete data for 2007 was not available in CAREWare for PCP prophylaxis, and will be a measure the QC and medical providers will work toward standardizing for data collection procedures as an improvement project.

Performance indicators include the following for 2009. Baseline data is included with dates of reporting period and data source.

Table 41: 2009 Performance Indicators

Indicator	Baseline Percentage	Reporting Period	Data Source
Percentage of clients with HIV infection who had two or more CD4 t-cell counts performed in the measurement year.	73%	1/1/2007 thru 12/31/2007	CAREWare
Percentage of clients with AIDS who are prescribed HAART.	100%	1/1/2007 thru 12/31/2007	RDR, CAREWare
Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.	86%	1/1/2007 thru 12/31/2007	RDR, CAREWare
Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm3 that were prescribed PCP prophylaxis.	Insufficient Data	1/1/2007 thru 12/31/2007	CAREWare
Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy.	95%	1/1/2007 thru 12/31/2007	RDR, CAREWare
Percentage of women with HIV infection who have a Pap screening in the measurement year.	77%	1/1/2007 thru 12/31/2007	RDR, CAREWare
Percentage of clients with HIV infection for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV infection.	18%	1/1/2007 thru 12/31/2007	RDR, CAREWare
Percentage of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	38%	1/1/2007 thru 12/31/2007	CAREWare
Percentage of adult clients with HIV infection who had a test for syphilis performed in the measurement year.	60%	1/1/2007 thru 12/31/2007	RDR, CAREWare
Percentage of clients with HIV infection who received testing with results documented for latent tuberculosis infection since HIV diagnosis.	52%	1/1/2007 thru 12/31/2007	RDR, CAREWare

Indicator	Baseline Percentage	Reporting Period	Data Source
Percentage of HIV positive clients satisfied with Ryan White medical case management services in the measurement year.	89%	1/1/2008 thru 12/31/2008	Case Management Client Satisfaction Survey
Percentage of HIV-infected medical case management clients who had a medical case management care plan documented and updated two or more times in the year.	71%	1/1/2008 thru 12/31/2008	Medical Case Management Chart Review
Percentage of HIV-infected medical case management clients who had 2 or more medical visits in an HIV care setting in the measurement year.	49%	1/1/2007 thru 12/31/2007	CAREWare
Percentage of HDAP applications approved or denied for HDAP enrollment within 2 weeks of HDAP receiving a complete application.	99%	4/1/2007 thru 3/31/2008	HDAP/HiAP enrollment/ chart review
Percentage of clients enrolled in HDAP or Health Insurance Assistance that rate their health as good or very good in the measurement year.	68%	4/1/2007 thru 3/31/2008	HDAP/HiAP enrollment
Percentage of HDAP or Health Insurance Assistance clients stating their health had improved after being on ART for a year or more in the measurement year.	76%	4/1/2007 thru 3/31/2008	HDAP/HiAP enrollment
Percentage of HDAP or Health Insurance Assistance clients that had undetectable viral loads in the measurement year.	73%	4/1/2007 thru 3/31/2008	HDAP/HiAP enrollment

✓ Annual Quality Goals

Based on last year’s performance rates, the quality committee prioritizes the following 2009 quality projects. Quality improvement project teams will be initiated in order to improve the following:

1. Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm³ prescribed PCP prophylaxis. Data entry issue in CAREWare. Goal is 90%.
2. Percentage of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year. Possible data entry issue. Goal is 50%.

3. Percentage of HIV-infected medical case management clients who had a medical case management care plan documented and updated two or more times in the measurement year. Documentation issue in case management charts. Also need to record in CAREWare for RSR. Goal is 80%.

✓ **Regular review of data for performance measures from a variety of sources will occur quarterly.** The Manager of Quality Assurance and Data Analysis will coordinate these activities. Data reports will be presented for review to Quality Committee and designated teams. Data sources will include but will not be limited to:

- *Clinical Measures utilizing RW CAREWare*
- *Client Satisfaction Survey results*
- *Demographic data, visit frequency, referral data from CAREWare*
- *Drug utilization pattern, adherence, and pharmacy data from OU College of Pharmacy system.*
- *Quality of Life data from HIV Drug Assistance Program and Health Insurance Assistance Program enrollment data.*
- *Chart Audit data from case management and mental health.*

Data collection will be implemented utilizing appropriate sampling methodology and will include both concurrent and retrospective review.

Assessment and Evaluation

Assessment and evaluation of the data will be performed by various existing teams (Contracts and Administration, HDAP/HiAP, Quality Assurance and Data Analysis, Senior Management, OHPC Assessment and Evaluation Committee) who will determine if the data warrants further evaluation. Based on this ongoing review, priorities will be set and opportunities for improvement identified.

Multidisciplinary Team and Development of Improvement Plan

Once an opportunity for improvement has been identified a multidisciplinary team will be convened to analyze the process and develop improvement plans. These teams will include those staff members closely associated with the process under study. Every attempt will be made to include individuals from other areas who may be impacted by changes made by the team and to help promote collaboration between agencies.

Continuous Quality Improvement Methodology will be utilized and will include but not be limited to the following:

- PDSA (Plan/Do/Study/Act)

- Flow Chart Analysis
- Cause-and-Effect Diagrams
- Brainstorming
- Observational Studies/patient flow
- Activity Logs

Quality Committee/Team Meeting Record Improvement Plans will be developed and implemented by the teams. Improvements may include: • System Redesign • Education (Staff/Patients) • Clinical Guidelines review, revision or development • Procedure and policy changes • Form development or revision

All improvement plans will be communicated to all staff and to providers/ clients if deemed appropriate. Regular meetings, e-mail, memos, and informal verbal communication are all considered appropriate methods to communicate the team's activities and improvement plans, as long as all parties are included in the process.

F. Sustaining Improvements

Regular feedback regarding improvement projects is critical to its success in sustaining improvements over time. Once an improvement plan has been successful a regular monitoring schedule will be implemented to determine whether the plan remains successful over time.

Description of HDAP Quality Management Program

Improvements and changes needed in program service delivery can be determined based on review of data. The Advisory Committee's primary purpose is to make HDAP formulary recommendations and uses guidelines for formulary changes. These guidelines include a review of clinical information, cost consideration of the drug, and program budget implications. The grantee takes into consideration the cost neutrality of the drug as compared to other drugs already in the existing class of drugs and data, if available, to project program utilization and cost. This committee consists of Infectious Disease physicians, HIV specialists and clinical pharmacists involved in the care of HDAP patients, including physicians connected with the Part C clinics. This committee has managed effectively by meeting electronically and by conference call on an as needed basis. If further communication is needed, meetings can be scheduled. This process has helped to expedite the addition of new FDA approved antiretroviral drugs to the program formulary.

The grantee is linked with AETC who provides workshops for Ryan White providers including HDAP prescribing physicians. The information presented in these workshops is continually updated with the latest guidelines. Members of the Advisory Committee are also part of the AETC as consulting physicians for health care practitioners statewide. The HDAP manager also presents jointly with AETC staff to health care providers on HDAP.

APPENDICES

Oklahoma State Department of Health 2009-2011 Comprehensive Plan

Demographic Group/Exposure Category	AIDS Incidence		AIDS Prevalence		HIV (not aids) Prevalence	
	01/01/06 to 12/31/07		as of 12/31/07		as of 12/31/07	
	<i>AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.</i>		<i>AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.</i>		<i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.</i>	
Race/Ethnicity	Number	% of Total	Number	% of Total	Number	% of Total
White, not Hispanic	229	51.3	1,532	47.9	1,137	40.5
Black, not Hispanic	116	26.0	462	14.5	430	15.3
Hispanic	47	10.5	122	3.8	96	3.4
Asian/Pacific Islander	3	0.7	0	0.0	2	0.1
American Indian/Alaska	32	7.2	151	4.7	99	3.5
Multi- Race	19	4.3	0	0.0	0	0.0
Unknown	0	0.0	928	29.0	1,046	37.2
Total	446	100.0	3,195	100.0	2,810	100.0
Gender	#	% of Total	#	% of Total	#	% of Total
Male	370	83.0	2,738	85.7	2,273	80.9
Female	76	17.0	457	14.3	537	19.1
Total	446	100.0	3,195	100.0	2,810	100.0
Age at Diagnosis (Years)	#	% of Total	#	% of Total	#	% of Total
<13	1	0.2	11	0.3	37	1.3
13-14	1	0.2	2	0.1	2	0.1
15-24	24	5.4	180	5.6	610	21.7
25-34	108	24.2	1,120	35.1	1,125	40.0
35-44	177	39.7	1,302	40.8	733	26.1
45-54	109	24.4	474	14.8	246	8.8
55-64	20	4.5	92	2.9	48	1.7
>=65	6	1.3	14	0.4	9	0.3
Total	446	100.0	3,195	100.0	2,810	100.0

Demographic Group/ Exposure Category	AIDS Incidence: 01/01/06 to 12/31/07 <i>AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.</i>		AIDS Prevalence as of 12/31/07 <i>AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.</i>		HIV (not aids) Prevalence as of 12/31/07 <i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.</i>	
	Number	%	Number	%	Number	%
Adult/Adolescent AIDS Exposure Category						
Male-to-male sexual contact	197	44	1,674	53	1,345	49
Injection drug use	57	13	384	12	330	12
Male-to-male sexual contact and injection drug use	40	9	412	13	250	9
Hemophilia/coagulation disorder	1	0	14	0	7	0
Heterosexual contact	58	13	343	11	336	12
Receipt of blood, components, or tissue	2	0	22	1	20	1
Perinatal exposure, HIV diagnosed >= 13	0	0	0	0	0	0
Other risk factor reported	0	0	0	0	0	0
Risk not specified	88	0	331	10	485	17
Total	443	100	3,180	100	2,773	100
Pediatric AIDS Exposure Categories	Number	%	Number	%	Number	%
Hemophilia/coagulation disorder	0	0	1	9	4	11
Mother with/at risk for HIV infection	1	100	9	82	27	73
Receipt of blood, components, or tissue	0	0	0	0	0	0
Other risk factor reported	0	0	1	9	6	16
No identified risk factor (NIR) ^f	0	0	0	0%	0	0%
No risk factor reported (NRR) ^g	0	0	0	0	0	0
Total	1	100	11	100	37	100

State of Oklahoma Implementation Plan – Oklahoma State Department of Health

Ryan White Part B - FY 2009 (April 1, 2009 – March 31, 2010)

Part B Program Area: Part B Base					
Total Number of Contractors/Providers Funded in FY 2009: 5					
Service Goal Statement: To link eligible Persons Living With HIV/AIDS in Oklahoma to appropriate outpatient medical care and support services to improve health status.					
Objective/s: List quantifiable and time-limited objectives relating to the Program Area named above. Where appropriate, list multiple objectives that are required to implement a new service, or to continue an existing service.	Service Unit Definition: Provide the name and definition of the unit of service to be provided (e.g. a one-hour face-to-face encounter, one round-trip bus ride).	Quantity: Provide the number of people to be served and service units to be provided during the grant year.		Time Frame: Indicate the estimated duration of activity relating to the objective listed.	FY 2009 Funds: Provide the approximate amount of Part B funds to be used to provide this service. Where possible, divide funding among individual objectives.
		Number of People to be Served	Total number of Service Units to be Provided		
1. Identify and link to primary medical care HIV+ individuals statewide who know their HIV status but are not in care.	One face to face outreach case management visit	120	300	Apr 09 – Mar 10	\$135,000 Comanche County \$45,000 Oklahoma City \$45,000 Tulsa \$45,000
2. Coordinate medical care through clinical case management at Part C EIS clinics utilizing an interdisciplinary medical model.	One face to face clinical case management visit	1,000	2,000	Apr 09 – Mar 10	\$390,000: \$230,000 Oklahoma City \$160,000 Tulsa
3. Coordinate medical and social support services through community case management.	One community case management face to face visit	720	1,440	Apr 09 – Mar 10	\$315,000: \$135,000 OKC MSA \$135,000 Tulsa MSA \$45,000 Comanche County
4. Provide eligible Part B clients with HIV medications not covered on the ADAP formulary.	One prescription	500	3,500	Apr 09 – Mar 10	\$304,670 statewide: \$182,802 western Oklahoma \$121,868 eastern Oklahoma

Part B Program Area: Part B Base					
5. Provide eligible Part B clients with transportation services to medical appointments.	One bus token, cab voucher, or volunteer driver service	450	900	Apr 09 – Mar 10	\$35,000 statewide: \$25,067 western Oklahoma \$6,933 eastern Oklahoma
6. Provide eligible Part B clients with dental care services for diagnostic, prophylactic and therapeutic Class 1, 2, and 3 oral health care needs.	One dental visit	450	450	Apr 09 – Mar 10	\$133,630 statewide: \$80,462 western Oklahoma \$53,168 eastern Oklahoma
7. Provide eligible Part B clients with laboratory services in order to monitor HIV disease.	One laboratory service	550	1,050	Apr 09 – Mar 10	\$74,000 statewide: \$44,400 western Oklahoma \$29,600 eastern Oklahoma
8. Provide outpatient mental health and substance abuse services through individual therapy, group therapy, or professional counseling.	One individual, group, or professional counseling session	250	1,200	Apr 09 – Mar 10	\$147,626 statewide: \$97,626 western Oklahoma \$50,000 eastern Oklahoma
9. Provide specialty primary care services to eligible Part B clients.	One laboratory, dental, or medical specialty service	150	1,200	Apr09- Mar10	\$337,000 \$224,000 western Oklahoma \$113,000 eastern Oklahoma

Part B Program Area: ADAP (HIV Drug Assistance Program)					
Total Number of Contractors/Providers Funded in FY 2009: 3					
Service Goal Statement: To ensure access to HIV/AIDS therapies consistent with PHS guidelines for all eligible Persons Living With HIV/AIDS in Oklahoma.					
Objective/s:	Service Unit Definition	Quantity:		Time Frame:	FY 2009 Funds Total = \$4,278,905 (does not include Administration, Quality Management, Planning and Evaluation): ADAP Earmark \$3,795,618 Part B Base \$480,287
		Number of People to be Served	Total number of Service Units to be Provided		
1. Continue statewide HIV prescription assistance program through the state's AIDS Drug Assistance Program	One prescription for medication on the program formulary	570	15,321	Apr 09 - Mar 10	\$3,869,405
2. Continue prescription co-pay assistance for medications on the state's AIDS Drug Assistance Program	One prescription that receives co-pay assistance	300	5,100	Apr 09 - Mar 10	\$409,500
3. Provide clinical adherence services to ADAP clients in the Oklahoma City Part C clinic	One service of either initial assessment, follow-up and routine clinical visit and refill monitoring.	660	2472	Apr 09-Mar 10	\$204,224

Part B Program Area: Health Insurance Assistance Program					
Total Number of Contractors/Providers Funded in FY 2009: 1					
Service Goal Statement: To ensure access to continued health insurance coverage for all eligible Persons Living With HIV/AIDS in Oklahoma.					
Objective/s:	Service Unit Definition	Quantity:		Time Frame:	FY 2009 Funds
		Number of People to be Served	Total number of Service Units to be Provided		
1. Continue statewide health insurance assistance through the state's Insurance Assistance Program.	One monthly insurance premium payment	160	1,440	Apr 09- Mar 10	\$775,600

Part B Program Area: HIV Home Health Program					
Total Number of Contractors/Providers Funded in FY 2009: 1					
Service Goal Statement: To ensure access to continued health insurance coverage for all eligible Persons Living With HIV/AIDS in Oklahoma.					
Objective/s:	Service Unit Definition	Quantity:		Time Frame:	FY 2009 Funds
		Number of People to be Served	Total number of Service Units to be Provided		
1. Continue statewide HIV Home Health Program.	One skilled nurse visit, personal care visit or DME	15	100	Apr 09 - Mar 10	\$25,000