Wisconsin HIV/AIDS Strategy

2012 - 2015

September 2015 Edition
The United States will become a place where new HIV infections are rare and, when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to quality, life-extending care, free from stigma and discrimination.

National HIV/AIDS Strategy
July 2010

The Wisconsin HIV/AIDS Strategy (WHAS) can be viewed and downloaded from the web-based library of the Wisconsin HIV/AIDS Community Planning Network website. Further information regarding the WHAS and the Wisconsin HIV Community Planning Network or the Statewide Action Planning Group can be obtained by contacting Barbara Nehls-Lowe, Wisconsin HIV Community Planning Network Coordinator, at 608-890-4653 or bnehlslowe@dcs.wisc.edu.

September 2015
# Wisconsin HIV/AIDS Strategy

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I. Introduction and Background

The Wisconsin HIV/AIDS Strategy (WHAS) is a living document that addresses the dynamic and ever changing nature of HIV-related services and activities in Wisconsin. It is a planning document that is required as a condition of funding by two federal agencies, the Health Resources and Services Administration (for Part B of the Ryan White CARE Grant) and the Centers for Disease Control and Prevention (under Program Announcement PS12-1201: HIV Prevention Cooperative Agreement).

The purpose of the WHAS is to identify priority needs for HIV-related prevention and care services in Wisconsin for the period 2012-2015 and to address the three major goals of the National HIV/AIDS Strategy (NHAS) which are directed at:

1. Reducing HIV incidence.
2. Increasing access to care and optimizing health outcomes.

The WHAS is consistent with the priorities of the State health plan Healthiest Wisconsin 2020 and is aligned closely with State health plan focus areas, particularly those involving:

- Access to high quality health services.
- Alcohol and drugs.
- Communicable diseases.
- Health disparities.
- Reproductive and sexual health.
- Social, economic, and educational factors that influence health.

The WHAS is intended to expand the capacity of Wisconsin’s HIV care and prevention service systems to implement high quality, scientifically sound, culturally competent services that reach individuals at highest risk and those disproportionately affected by HIV infection. While HIV prevention and care services are provided by a diverse group of organizations and individuals in Wisconsin, the WHAS addresses those services and activities that are primarily overseen and coordinated by the Wisconsin AIDS/HIV Program in the Division of Public Health, Wisconsin Department of Health Services.

The organizing framework for the WHAS is the Prevent-Test-Link-Treat model of community planning and service delivery which captures the critical activities, functional areas, and integrated nature of HIV-related public health services in Wisconsin.

Over the past several years, this planning document has evolved as a comprehensive combined plan for HIV prevention and care services. The WHAS addresses the changing demographics of the HIV epidemic and the inclusion of new technologies in service delivery. It also integrates key concepts that reflect philosophical shifts in program planning and service delivery such as the following:

- Early Identification of Individuals with HIV/AIDS and Linkage to Care -- resources increasingly focus on identifying individuals who are unaware of their HIV status, linking HIV positive individuals to care and supporting retention in care, and referring HIV negative individuals into services that assist in keeping them free of HIV.

- Targeting Resources to Persons Disproportionately Affected by HIV
The majority of Wisconsin’s cases are located in the southeastern region of the state. Young Black gay and bisexual men in Milwaukee are the populations most affected by HIV in Wisconsin. Over 60% of HIV funds awarded by the Department of Health services are directed to agencies in southeast Wisconsin.
Scalability of Activities -- interventions are directed to select priority populations in ways that are efficient and effective in order to maximize limited resources. Examples include the delivery of an effective, science-based behavioral intervention to male-to-female transgender persons and targeted condom distribution to gay, bisexual and other men who have sex with men.

Expanded Engagement with Partners and Stakeholders -- emphasis is placed on stronger collaboration and coordination of HIV prevention, care, and treatment as well as expanded engagement of partners and stakeholders in program planning, implementation, and evaluation.

Coordinated Implementation of the Patient Protection and Affordable Care Acts (ACA) -- the ACA is expected to bring large numbers of uninsured persons, including persons living with HIV, into the health care system. As more individuals engage in health care services as a result of the ACA, there will be increased demand for accessing and coordinating HIV-related prevention and care services.

Monitoring Health Outcomes and Quality Services -- the Institute of Medicine (IOM) report Monitoring HIV Care in the United States: Indicators and Data Systems identified critical data and indicators related to continuous HIV care and access to supportive services. The report emphasized the need for consolidating data and measures of health indicators that can assist in monitoring the impact of the NHAS and ACA on improvements in HIV care.

Many individuals and organizations contributed to the development of this planning document through their dialogue and participation with the Statewide Action Planning Group (SAPG). The SAPG members recognize the providers and consumers of HIV prevention and care services and their affiliates and advocates who, on a daily basis, are actively engaged in and committed to quality HIV services in Wisconsin.
II. Wisconsin HIV/AIDS Data Trends

Confidential, name-associated reporting of confirmed HIV infection and AIDS to the Wisconsin AIDS/HIV Program is required by Wisconsin statute (s. 252.15). Case reports are submitted to the Wisconsin AIDS/HIV Program from private physicians, hospitals, clinics, ambulatory care facilities, sexually transmitted disease clinics, the Wisconsin correctional system, family planning clinics, perinatal clinics, tribal health clinics, blood and plasma centers, military entrance processing stations, HIV testing sites, and laboratories performing HIV testing.

Once collected, surveillance data is analyzed to define the demographics of the epidemic in Wisconsin, to identify disease trends, to provide essential data for program planning and resource allocation, and to assist in the evaluation of HIV-related prevention and care services and health outcomes. On an annual basis, the AIDS/HIV Program releases a comprehensive analysis of state HIV surveillance data for the preceding year and cumulative data reported since the beginning of the HIV epidemic in Wisconsin.


The annual Wisconsin HIV/AIDS surveillance review presents cases of HIV newly diagnosed during 2014, prevalent cases as of December 31, 2014, and deaths through 2012 among Wisconsin residents. Reporting annually on HIV surveillance data is important for policy makers, program planners, HIV service providers and the public to enable effective planning of HIV prevention and care services and ensure efficient use of resources. For planning HIV prevention, testing and linkage strategies, it is important to focus on cases newly diagnosed in Wisconsin—those infections that might have been prevented or identified earlier within the state. When planning care and treatment services, the focus should be on prevalent cases—those currently living with HIV in Wisconsin—irrespective of where they were first diagnosed.

NEW DIAGNOSES

Trend: During 2014, 226 new cases of HIV infection were diagnosed in Wisconsin. Between 2005 and 2014 both the number and the rate of new infections remained stable. The number of new diagnoses over the last decade ranged from a low of 224 in 2012 to a high of 285 in 2009, with an average of 250 new diagnoses per year. The HIV diagnosis rate in Wisconsin is 11th lowest among the 50 states.

Sex: Five times as many males as females were diagnosed with HIV during 2014 (192 males and 34 females). Between 2005 and 2014, the HIV diagnosis rate was stable among older males (ages 30-59) and younger females (ages 13-29). Over the same time period, the HIV diagnosis rate increased among younger males and declined among older females.

Gender: Since 1983, 31 known transgender individuals have been diagnosed with HIV in Wisconsin. During 2005–2014, there were 25 new HIV diagnoses in this population. Twelve of the 25 were Black, and 17 of the 25 were under age 30 at the time of diagnosis.

Racial/ethnic groups: HIV infection disproportionately affects racial/ethnic minorities. During 2014, 67% of new diagnoses were among racial/ethnic minorities, despite minorities making up just 17% of Wisconsin’s population. For males, the 2014 HIV diagnosis rate was more than 16-fold higher among Blacks and 7-fold higher among Hispanics compared to Whites. For females,
the HIV diagnosis rate was 34-fold higher among Blacks and more than 9-fold higher among Hispanics compared to Whites.

**Age:** The median age at HIV diagnosis was 32 years in 2014 but varied considerably by risk exposure group. The median age at diagnosis was 29 years for men who have sex with men (MSM) overall, 43 years for those with high-risk heterosexual contact, and 53 years for those with a history of injection drug use. Among MSM, the median age was 25 years for Blacks and Hispanics and 36 years for Whites.

**Risk:** After adjusting for unknown risk, MSM accounted for 78% of new diagnoses in 2014, including the 3% of diagnoses among men who MSM who also injected drugs. High-risk heterosexual contact and injection drug use (not including MSM/PWID) accounted for the other 15% and 7% of new diagnoses, respectively. HIV diagnoses more than doubled in young Black MSM between 2005 and 2014. The number of diagnoses attributed to high-risk heterosexual contact and injection drug use was stable.

**Geography:** During 2014, HIV cases were diagnosed in 26 of the 72 counties in Wisconsin. However, the distribution was uneven: Milwaukee County cases accounted for 58% of new diagnoses, Dane County for 11%, Racine for 5%, and Outagamie for 4%. The Department of Corrections and all other counties each accounted for fewer than 4% of diagnoses.

**Disease status at diagnosis:** Between 25% and 30% of all cases first diagnosed with HIV infection in Wisconsin during 2011-2014 had already progressed to AIDS by the time of diagnosis. An additional 4% to 8% of cases diagnosed during 2011-2013 progressed to AIDS within 12 months of being diagnosed with HIV infection. These cases represent individuals living for several years with undiagnosed HIV infection, which may lead to poorer health outcomes and increasing opportunities for disease transmission.

**Diagnosed outside of Wisconsin:** In addition to the 226 cases diagnosed in Wisconsin in 2014, 173 individuals previously diagnosed with HIV infection moved to Wisconsin from another state.

Of the 226 new cases of HIV infection diagnosed in Wisconsin during 2014:

- 78% were attributed to men who have sex with men including those who also injected drugs.
- 15% were attributed to high-risk heterosexual contact.
- 7% were attributed to injection drug use.

Reflecting national trends, young Black MSM in Wisconsin continue to be the population most affected by HIV in Wisconsin. During 2014:

- Young Black MSM accounted for almost one-quarter (22%) of all new diagnoses in Wisconsin.
- Diagnoses in young Black MSM more than doubled from 2005 to 2014.
PEOPLE LIVING WITH HIV INFECTION
As of the end of 2014, 6,899 individuals reported with HIV or AIDS were presumed to be alive and living in Wisconsin. Three-quarters (75%) of these were first diagnosed in Wisconsin; the others were initially diagnosed elsewhere. The Centers for Disease Control and Prevention (CDC) estimates that 14% of people living with HIV (PLHIV) are unaware of their HIV status. Thus, an estimated 1,125 in the state are unaware of their HIV infection, so the total number of PLHIV in Wisconsin is estimated to be 8,024.

HIV prevalence varies by demographic group. Nearly one in three (30%) Black MSM is estimated to be living with HIV, compared to 9% of Hispanic and 2% of White MSM. Less than 1 in 1,000 females and non-MSM males in Wisconsin is HIV-positive. Within the non-MSM groups, the rate is highest among Blacks—about 10 in 1,000.

Nearly half (49%) of all PLHIV reside in Milwaukee County. Dane County has the second highest proportion (12%), followed by Brown County (4%). Kenosha, Racine, and Waukesha counties each have 3% of the state’s prevalent cases. The Wisconsin Department of Corrections, Rock, La Crosse, and Outagamie counties each have 2%. All other counties have 1% or fewer cases.

Deaths
Deaths due to any cause among people reported with HIV infection have declined markedly since the early 1990s. Deaths peaked in 1993 (373 deaths). In 2012, the most recent year with complete data, 127 deaths among people with HIV are known to have occurred in Wisconsin, consistent with the average of 127 deaths each year between 2004 and 2011. HIV as the underlying cause of death is also on the decline—75 of the 127 reported deaths in 2012 were due to non-HIV-related causes, while 52 had HIV indicated as the underlying cause of death. The median age of death rose from age 37 in 1990 to age 42 in 2002 to age 51 in 2012, indicating that people are living longer with HIV.

IMPLICATIONS

HIV diagnoses
Trends in recent cases first diagnosed in Wisconsin should guide planning for HIV prevention. The steep rise in diagnoses in young black MSM and the young median age at diagnosis suggest that young Black MSM should be the top priority for HIV prevention efforts in Wisconsin. The young median age at diagnosis may reflect both acquisition of HIV at a younger age and diagnosis closer to the time of infection, suggesting that recent efforts to better target HIV testing in young MSM have met with some success.
Maintaining prevention efforts in those with high-risk heterosexual behaviors and those who inject drugs is also important. While the number of new cases of HIV in PWID continues to decline, increases in cases of hepatitis C and heroin overdoses in young adult PWIDs in rural parts of Wisconsin underscore the risk that HIV cases could increase in PWIDs. Thus it is important to provide effective prevention services to PWID to prevent both HIV and hepatitis C.

**HIV prevalence**

HIV prevalence data should guide HIV care and treatment services. At the end of 2014, 6,899 people were reported with HIV and presumed to be living in Wisconsin. The fact that 44% of the PLHIV in Wisconsin are age 50 or older indicates that HIV care providers must attend to patients’ health conditions related to aging as well as their HIV disease.

**For additional information**

The AIDS/HIV Program website (http://www.dhs.wisconsin.gov/aids-hiv/Stats/index.htm) includes annotated PowerPoint slides and county-level summary reports. Other reports regarding HIV are also available on this site.


General information about HIV prevention and care services in Wisconsin:
http://www.dhs.wisconsin.gov/aids-hiv/

Information about hepatitis C:
https://www.dhs.wisconsin.gov/viral-hepatitis/hcv-program.htm
III. Needs Assessment and Services Gaps

The Wisconsin AIDS/HIV Program identifies HIV service priorities through needs assessments and gap analyses, conducted both formally and informally through multiple venues. Identification of needs and service gaps is obtained through ongoing surveillance, epidemiologic investigations, surveys, special studies, community dialogues, contract monitoring, feedback from service providers and consumers, and input from individuals and communities at risk for HIV or related health disparities. The AIDS/HIV Program collaborates with community partners in identifying and prioritizing service needs and planning interventions to address service gaps.

A. Needs Assessment

The AIDS/HIV Program conducts many activities that address the five primary components of a comprehensive needs assessment, as defined by HRSA:

- An epidemiologic profile and monitoring of trends in HIV infection.
- Assessment of service needs, including barriers to receiving needed services.
- Assessment of resource capacity, including available services and number of clients served.
- Assessment of service accessibility, availability and appropriateness for persons living with HIV and AIDS.
- Assessment of unmet needs and service gaps.

The following table highlights the activities conducted by the AIDS/HIV Program or in collaboration with partners to assess needs and identify service gaps.

<table>
<thead>
<tr>
<th>Category</th>
<th>Data source/activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveillance &amp; Epidemiology</td>
<td>HIV surveillance data</td>
<td>Collection, analysis, and dissemination of HIV case data.</td>
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<tr>
<td></td>
<td>Hepatitis C, STD, TB</td>
<td>Collection, analysis, and dissemination of data for co-morbid diseases.</td>
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<tr>
<td></td>
<td>Cluster investigations</td>
<td>Special investigations of clusters of HIV, syphilis, and hepatitis C (6 cluster investigations 2009-2012 to date).</td>
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<tr>
<td></td>
<td>Milwaukee EpiAid</td>
<td>Investigation by CDC in Milwaukee regarding increasing rates of HIV in young Black MSM.</td>
</tr>
<tr>
<td></td>
<td>Geocoding, GIS</td>
<td>Geographic analysis of data and comparison to data on social determinants of health.</td>
</tr>
<tr>
<td>Other special studies</td>
<td>Native American needs assessment</td>
<td>Structured key-informant interviews with 11 tribal coordinators regarding HIV prevention and care issues for tribal members.</td>
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<tr>
<td></td>
<td>PrideFest</td>
<td>HIV counseling and testing and structured surveys on key topics such as the home test kit.</td>
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<td></td>
<td>in+care campaign</td>
<td>Grantee assessment of clinical retention in HIV care.</td>
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<tr>
<td></td>
<td>Recent diagnoses</td>
<td>Review of the first 50 cases of HIV diagnosed from 6/1/11: in care status and health outcomes; evaluation of linkage to care service system.</td>
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<tr>
<td></td>
<td>Community Readiness Assessment</td>
<td>Assess readiness of Black community in Milwaukee to address anti-gay discrimination in preparation for Acceptance Journeys social media campaign.</td>
</tr>
<tr>
<td>Category</td>
<td>Data source/activity</td>
<td>Description</td>
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<tr>
<td>Center for AIDS Intervention Research</td>
<td>Various HIV prevention and care research and evaluation studies.</td>
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<tr>
<td>EvaluationWeb</td>
<td>Client-level counseling &amp; testing and prevention data services data; aggregate data for condom distribution, capacity-building, and harm reduction.</td>
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<tr>
<td>Partner ServicesWeb</td>
<td>Client-level partner services data.</td>
<td></td>
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<tr>
<td>Laboratory</td>
<td>Client-level laboratory data.</td>
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<tr>
<td>AIDS Drug Reimbursement Program</td>
<td>Client-level ADAP utilization data.</td>
<td></td>
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<tr>
<td>Insurance</td>
<td>Client-level data for clients whose insurance premiums are covered by AIDS/HIV Program funds.</td>
<td></td>
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<tr>
<td>Medicaid</td>
<td>Claims data for HIV positive individuals.</td>
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<tr>
<td>PeriDataNet</td>
<td>Client-level data regarding births to HIV positive women.</td>
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<tr>
<td>CareXML</td>
<td>Ryan White service utilization data.</td>
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</tbody>
</table>

### Databases

<table>
<thead>
<tr>
<th>Category</th>
<th>Data source/activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Action Planning Group</td>
<td>HIV consumers and providers meet for day-long meetings 5-6 times per year to provide input to the Wisconsin AIDS/HIV Program; meeting notes and documents prepared for the group’s review.</td>
<td></td>
</tr>
<tr>
<td>Topic-specific</td>
<td>Meetings focused on specific topics such as the linkage to care grant, HIV cluster and coordination of services for young Black MSM (YBMSM).</td>
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</tr>
<tr>
<td>Geographic area-specific</td>
<td>Periodic meetings in the Madison, Appleton, and La Crosse areas to foster coordination among providers.</td>
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<tr>
<td>Black Health Coalition</td>
<td>Task force meetings – PLWHA and community members.</td>
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<tr>
<td>ENDHIV</td>
<td>Planning process led by Diverse &amp; Resilient, resulting from EpiAid regarding HIV in YBMSM in Milwaukee.</td>
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</tr>
</tbody>
</table>

### Community meetings and forums

<table>
<thead>
<tr>
<th>Feedback from grantees and other service providers and their clients</th>
<th>Data source/activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV case managers</td>
<td>Quarterly meetings of HIV case managers</td>
<td></td>
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<tr>
<td>CBOs providing HIV prevention services</td>
<td>Periodic meetings of HIV prevention service providers.</td>
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<tr>
<td>Public counseling and testing site providers</td>
<td>Annual meetings of counseling and testing providers and social networks testing staff.</td>
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<tr>
<td>HIV partner services (PS)</td>
<td>Annual meetings and trainings of PS providers.</td>
<td></td>
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<tr>
<td>Linkage to Care grantees</td>
<td>Story boards prepared by LTC grantees; regular meetings of LTC grantees.</td>
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<tr>
<td>Client satisfaction surveys, implemented by grantee agencies</td>
<td>Identification of issues from client perspectives.</td>
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<tr>
<td>Consumer Advisory Boards</td>
<td>Consumer input and advisories for direct service organizations.</td>
<td></td>
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<tr>
<td>HIV Treaters Meetings</td>
<td>Case presentations and discussions evaluating clinical best practice.</td>
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</tbody>
</table>
B. Client Needs and Service Gaps
Based on the needs assessment mechanisms described above, high priority barriers and service gaps were identified and are described below. The responsible parties for carrying out activities to address each gap are identified and a general timeline for addressing these large scale barriers is provided in Addendum VI.

Unaware of HIV infection
The CDC estimates that 16% of individuals infected with HIV do not know that they are infected. Data suggest that the percentage of individuals unaware might be even greater in some populations, specifically MSM and MSM of color. This is also true in Wisconsin, as evidenced by the high proportion of individuals concurrently diagnosed with HIV and AIDS or progressing to AIDS within one year of HIV diagnosis. Contributing factors for being unaware of HIV infection include the lack of adoption and implementation of the CDC’s routine HIV testing recommendations by some providers and the under-representation of MSM in some testing programs (e.g. social networks testing) despite an increasing number of infections in this population.

Increasing HIV transmission among young MSM of color
Reported cases of HIV infection among young Black MSM have tripled over the past decade and an estimated one-in-three Black MSM is HIV positive. Contributing factors include complacency and continued risk behavior among MSM and difficulty reaching young MSM of color for prevention interventions and certain testing strategies (as mentioned above). In addition, several providers lack knowledge about the scope of Partner Services activities and are not re-engaging Partner Services when patients identify risk behaviors or new partners.

Social barriers to HIV prevention, testing and care
The rate of HIV infection and the prevalence rate in Milwaukee County are more than three times that of the statewide rates. Most cases of HIV infection among young Black MSM are also
from Milwaukee County. Contributing factors to high rates of HIV infection in Milwaukee include anti-gay discrimination (especially in the Black community), patient fear of disclosure and distrust of providers, immigration concerns, and low health literacy.

**Improved linkage to HIV care**
An estimated 86% of individuals newly diagnosed with HIV infection during 2012 were linked to HIV care within three months of diagnosis (based on the presence of laboratory data), which is slightly above the 85% linkage to care benchmark established in the NHAS. However, the presence of laboratory data does not necessarily mean that the individual followed through with the clinical appointment. Contributing factors to failed linkages to care include low prioritization of HIV medical care by the individual, long wait time prior to the initial appointment, inability among publically funded test sites to link individuals to care when they do not return to the test site for the confirmatory test results, limited providers in rural areas, and lack of knowledge of referral resources among low volume, non-clinical test sites.

**Improved retention in HIV care**
Among prevalent HIV cases in Wisconsin as of the end of 2012, only 51% had the recommended two HIV care visits during 2013, meaning that retention in care is poor. Retention is even worse among some subgroups. Poor retention in care is a result of both client-level and system-level barriers. Client barriers include lack of transportation, lack of resources to cover the costs of care, alcohol and drug abuse, mental health issues, fear and distrust of medical providers, homelessness. Systems barriers include lack of health insurance, limited resources for those who are under-insured, lack of youth-focused facilities, lack of “off peak” clinic hours, and lack of transportation. Current systems are also inadequate for identifying people who are at risk of falling out of care, identifying people who have fallen out of care, and for finding and re-engaging individuals in care. Of note, many states have found that individuals who appear to be out of care are in fact deceased, living in another state or are actually in care. Therefore retention in HIV medical care in Wisconsin may actually be higher than the 51% reported here.

**Limited access to ancillary services**
Patient and provider input indicates difficulty in accessing certain services, such as mental health, alcohol and drug abuse, dental, and housing services. Access issues include workforce shortfalls (described below), lack of providers accepting medical assistance (especially dental care and psychiatric services), lack of insurance coverage for needed medications, and lack of transportation. In addition, a lack of regular screening for other service needs (e.g. regular mental health and AODA screenings) has also become a barrier to accessing services.

**Workforce shortfalls**
There are workforce shortfalls in the areas of clinical care, dental care, mental health, and AODA services. Some shortfalls are characterized by an actual lack of providers or provider types (e.g. psychiatrists), especially in rural areas. Other provider shortfalls are characterized by a lack of cultural competence, especially bilingual providers and those competent in issues unique to HIV, minorities with HIV, and lesbian, gay, bisexual and transgender (LGBT) health.

**Incarceration**
Incarceration in county jails, short-term detention centers, or state correctional institutions presents a barrier to continuity of care. While HIV care in state correctional institutions is a covered service, transition to community care after discharge can be difficult. Individuals who are difficult to locate often have unstable housing and competing priorities. Due to the short-term nature of county jails, access to and coordination of care is difficult.
**Health disparities**

Based on analyses of 2007-2011 Youth Risk Behavior Survey, there are significant disparities in the health and wellness of LGB youth, including higher likelihood of mental health and AODA issues, partner violence, early initiation of risk, and lower likelihood of protective factors, such as feeling supported by family. While HIV infection was not addressed in these surveys, the high risk activities reported by LGB youth put them at higher risk for HIV infection. Health outcomes also vary by demographic group. Overall, 40% of prevalent cases of HIV infection in Wisconsin have suppressed viral load. However, this number is lower among certain subgroups, including those with unknown risk and male and female PWID of color. Other groups with traditionally worse health outcomes include those with low socioeconomic status, communities of color, immigrants and refugees, persons with disabilities, and those living in very rural areas.

**Health literacy**

Health literacy, the degree to which individuals can understand basic health information and services needed to make appropriate health decisions, is key to one’s ability to understand risk and make decisions about needed behavior change. Persons with limited education, limited literacy skills, and whose primary language is other than English may be challenged in several ways, especially in understanding the complexities of HIV infection, HIV-related risks behaviors and risk reduction methods, the medical management of HIV, and ways to access needed HIV-related health and support services.

**Increase of hepatitis C among young people**

During 2011 there were two cluster investigations of hepatitis C (HCV) infection among individuals under age 30 that were conducted by the AIDS/HIV Program and the CDC. The results of these cluster investigations highlighted a growing HCV epidemic among young adults, especially in rural areas of the state, due to an increase in injection drug use, a lack of HIV testing, and a knowledge gap about community HCV resources.

**C. Update on 2014 Needs Assessment Planning Activities**

In 2014, the Wisconsin AIDS/HIV Program identified needs assessment as a priority activity to be undertaken in 2014 and 2015, in anticipation of updated revision of the Wisconsin HIV/AIDS Strategy (WHAS) in 2016. A focus paper examining the topic of needs assessment activities and the WHAS was developed by the AIDS/HIV Program and distributed for discussion among AIDS/HIV Program staff and the Statewide Action Planning Group (SAPG). The Ryan White Grant Coordinator presented an overview of plans for needs assessment activities at the SAPG meeting in February 2014.

The HIV Care Continuum will be used as a guiding framework for focusing needs assessment activities. Priority populations for the needs assessment include:

1. HIV positive persons who are unaware of their status.
2. HIV positive persons who have never been linked to medical care.
3. HIV positive persons who have lapsed from medical care or are at risk of falling from care.
4. HIV positive persons who are eligible for health insurance but have not enrolled in coverage.

In 2014, an AIDS/HIV Program workgroup is examining and analyzing internal data sources that capture key epidemiologic and service utilization data regarding the needs assessment priority populations. Data analysis activities are expected to identify characteristics of the priority populations, trends in service utilization, and other variables that will inform the development of tools and methods needed to conduct the next phase of needs assessment in 2015. Additional information regarding the needs assessment and timetable targeted for completion of the needs assessment is included in the needs assessment focus paper in Addendum XI, page 125.
IV. Planning

The Wisconsin AIDS/HIV Program has a long history of involving the people of Wisconsin in the planning process for HIV prevention and HIV care services. In keeping with expectations of federal funding sources, for over two decades the Program has sought input from Wisconsin’s many communities through multiple planning groups and interaction with AIDS/HIV service providers.

HIV community planning reflects an open, participatory, and engagement process in which the community, providers, and the state health department identify and prioritize prevention and care services to meet the needs of Wisconsin residents. The process honors differences in cultural and ethnic backgrounds, perspectives, and experiences. Persons at risk for HIV infection and persons living with HIV infection play key roles in identifying local prevention, care and treatment needs and in fostering public support to prevent further transmission of HIV infection.

Wisconsin HIV Community Planning

Wisconsin has a formal and integrated statewide community planning process for HIV prevention and care services. Beginning in 2007, Wisconsin HIV Community Planning assumed the planning activities formerly conducted by the Wisconsin Ryan White Consortium and the Wisconsin HIV Prevention Community Planning Council. Wisconsin HIV Community Planning includes Community Engagement and the Statewide Action Planning Group (SAPG) that assists local communities and the Wisconsin AIDS/HIV Program in the development, implementation, and prioritization of HIV prevention and care services in Wisconsin.

Community Engagement

Community engagement requires a collaborative interactive process that results in identifying specific strategies to ensure a coordinated and seamless approach to accessing HIV prevention, care, and treatment services for the highest risk populations. This requires ongoing communication and interaction with key stakeholders, HIV service providers and consumers of HIV care, including those not part of SAPG who can best inform and support the goals of the HIV planning process.

Statewide Action Planning Group (SAPG)

The SAPG consists of twenty-five to thirty ambassadors who facilitate communication and expanded engagement in the five regions of the state; participate in developing a joint HIV prevention and care services plan; and advise the Wisconsin AIDS/HIV Program on the development, implementation and prioritization of HIV prevention and care services in Wisconsin.

SAPG members are selected through an annual, open and competitive application process using criteria established by the SAPG and the AIDS/HIV Program. Applications for membership are distributed to all HIV prevention and care providers through mailings, at meetings, and through postings to a dedicated HIV community planning website. Members are appointed for rotating, multi-year terms that begin in January of each year. Approximately one-quarter of the membership is replaced annually.

The SAPG focuses on expanded engagement of consumers, providers, and other key stakeholders in the recruitment of new SAPG members, in community dialogues, and in deliberations with consumers and service providers. The purpose of expanded engagement is to strengthen collaborative efforts across prevention and care service providers, to better coordinate services, and to minimize service duplication.
Planned, proactive recruitment of new members ensures that differences in cultural and ethnic background, perspective and experience are valued and continue to be reflected in SAPG membership. The SAPG actively recruits new members who represent the population characteristics of the current and projected epidemic, including populations at greatest risk for HIV infection; persons living with HIV infection; representatives of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics including varying educational backgrounds, professions, and expertise.

Wisconsin’s commitment to include individuals with various types of experience is reflected in recruitment that is based, in part, on expertise in the following areas:

- HIV Prevention
- HIV Care
- Men who have sex with men (MSM)
- People Who Inject Drugs (PWID)
- Alcohol/Drugs (AODA)
- Sexually Transmitted Diseases (STDs)
- Living with or caring for people who are HIV positive
- Women who are HIV positive
- Youth
- Medical Clinical Services
- Mental Health
- Public Health
- Health Education
- School-based Education
- Community Education
- Social Services
- Corrections
- Advocacy
- Community Planning
- Behavioral Science
- Evaluation or Research

Current membership of the SAPG is listed in Addendum V.

As part of new member orientation and ongoing internal assessment of the SAPG membership, members participate in activities which highlight each member’s interests, experience and expertise. Activities are planned to help members get to know each other and the important perspectives and expertise each member brings to the community planning process.

New members receive a thorough orientation to the Wisconsin community planning process. A mentor is assigned to new members to provide further guidance and ongoing support to the community planning process. Orientation includes descriptions and discussions of:

- The purpose and authority for HIV community planning.
- The history of community planning in Wisconsin.
- Wisconsin HIV Community Planning Network Model.
  - Vision
  - Guiding principles
  - Policies and procedures
  - Roles and responsibilities of SAPG members
- HIV prevention priorities and interventions.
• HIV care priorities and expectations.
• Prevention and care programs.
• Planning, funding and evaluation processes and timelines.

Each meeting provides opportunities to increase knowledge about specific HIV content, build skills of members to actively participate in the planning process and decision-making activities.

The SAPG explores HIV topics and issues using the Prevent-Test-Link-Treat framework for HIV planning and service delivery. Products developed by the group and the Wisconsin AIDS/HIV Program are informed by the NHAS, federal funding requirements, the overarching goals of the Wisconsin AIDS/HIV Program, and the purview of the SAPG. The SAPG includes input from providers, consumers, informed experts and the community-at-large in its deliberations and recommendations.

As required under CDC’s funding announcement PS12-1201 (Comprehensive HIV Prevention Programs for Health Departments), the SAPG reviews the WHAS to ensure that the plan for prevention services allocates resources to the areas and populations with the greatest HIV disease burden. The SAPG documents this activity through a letter of concurrence (Addendum IX) which is submitted to the CDC.

Ryan White Statewide Coordinated Statement of Need and Comprehensive Plan
A condition of funding under Part B of the federal Ryan White HIV/AIDS Program requires states to develop a Statewide Coordinated Statement of Need (SCSN) and a Comprehensive Plan in order to:
• Identify and address significant HIV care issues.
• Monitor progress in addressing HIV care issues.
• Maximize coordination, integration, and effective linkages across the legislative parts of the Ryan White HIV/AIDS Program and other federal, state and local resources.

In Wisconsin, all providers who receive Ryan White funding other than Part B also receive Part B funding. In addition to regular and ongoing communication with these agencies, the AIDS/HIV Program solicits input and facilitates collaborative planning with agencies funded under other legislative parts of the federal Ryan White HIV/AIDS Program through membership and invitational participation in SAPG meetings and through periodic Ryan White All Grantee Meetings.

In addition to the structured planning activities of the SAPG, planning is an ongoing collaborative process conducted by the AIDS/HIV Program with grantees and community and academic partners, through one-on-one meetings and large group meetings and trainings. The following section on Collaboration and Coordination includes examples of ongoing collaborative planning and intervention.

V. Collaboration and Coordination

For over 25 years, the Wisconsin AIDS/HIV Program in the Wisconsin Department of Health Services has coordinated Wisconsin’s public health response to the epidemic of HIV infection. The Program’s approach to the epidemic has emphasized collaboration and coordination among human service providers and disciplines, public and private agencies, individuals and communities at risk for HIV infection, and persons living with HIV infection.

The Wisconsin AIDS/HIV Program has established strong working relationships with community partners (academic, governmental, and private nonprofit organizations) through ongoing
collaborations, consultation, training, and financial support of competitive grants and contractual agreements. The AIDS/HIV Program maintains collaborative partnerships with traditionally funded agencies, state agencies, local health departments, and non-traditional community-based agencies, organizations, and institutions. The AIDS/HIV Program has a long history of successful collaborations in supporting and developing the capacity of ethnic minority and sexual and gender minority groups to respond to the HIV epidemic in their communities.

The AIDS/HIV Program implemented the Prevent-Test-Link-Treat framework for service delivery to ensure that all aspects of client and provider needs are addressed along the HIV spectrum. This format allows Program staff to:

- Monitor program progress.
- Identify client needs.
- Identify service gaps.
- Develop policies and practices that address needs and gaps.
- Improve the health and quality of life of persons living with HIV/AIDS.
- Improve overall public health.

Responsibilities for these activities are varied and shared. The AIDS/HIV Program is responsible for:

- Maintaining communication with federal funders to ensure compliance with all grant requirements and expectations.
- Staying current on testing and treatment protocols to ensure that the most current practices are implemented and utilized by contracted providers.
- Issuing and monitoring provider contracts.
- Providing technical assistance to ensure efficient, effective, and culturally competent services are provided to clients.
- Analyzing data from the EvaluationWeb reporting system and other sources to assess provider progress towards the Program's HIV Prevention goals.
- Fostering relationships between all state providers.
- Conducting regular contract monitoring activities including annual site visits.

Contracted agencies are responsible for:

- Hiring qualified and culturally competent staff.
- Deploying testing initiatives and testing targets.
- Linking clients to care and support services.
- Retaining clients in care.
- Delivering effective, efficient, and culturally competent care and support services.
- Timely and accurate completion of all federal and state reporting requirements.
- Conducting client satisfaction surveys.
- Completing state sponsored training sessions.
- Completing all state and federal required reports.
- Abiding by all contractual terms.

Coordination of HIV-related governmental public health services and functions occurs through ongoing collaborations with local health departments, the Wisconsin Medicaid Program, the Wisconsin State Laboratory of Hygiene, the Wisconsin Department of Corrections, the Wisconsin Department of Public Instruction, Wisconsin Department of Administration, Division of Housing, and other organizational units within the Wisconsin Department of Health Services that are responsible for overseeing and coordinating services related to communicable disease control (including sexually transmitted diseases, hepatitis, and tuberculosis), alcohol and drug use, Medicaid, and state health plan development.
The Wisconsin AIDS/HIV Program collaborates with partners locally, statewide, and nationally to support research and academic inquiry that builds knowledge and expands the understanding of HIV disease and the HIV epidemic. These partnerships guide the development of best practices in preventing HIV infection and in the clinical management of HIV disease. Academic/government partnerships are established between the AIDS/HIV Program and Medical College of Wisconsin (MCW), the Center for AIDS Intervention Research at MCW, the University of Wisconsin School of Medicine and Public Health, and the University of Wisconsin – La Crosse Master of Public Health in Community Health Education Program. These collaborations have resulted in expanded educational opportunities for graduate and postdoctoral students, collaborative evaluation and research activities, and joint academic training and continuing education of health and human service providers.

Successful Collaboration and Coordination

Collaboration and coordination are ongoing activities between the AIDS/HIV Program and its grantees and community and academic partners. Examples of initiatives with a major focus on program collaboration and coordination include the following:

Provider Training

To ensure that clients receive the most up to date care, the AIDS/HIV Program conducts and sponsors provider trainings throughout the year. The Wisconsin HIV/AIDS Training System at the University of Wisconsin – Madison hosts approximately 25 trainings each year. These trainings are directed to front-line staff, to keep them current with Program policies, treatment guidelines and protocols, and certification expectations and licensure credentials. Topics range from a basic HIV 101 class, to HIV testing and service delivery, to HIV counseling skills. While trainings have historically been conducted face-to-face, some trainings are transitioning to an online system for providers to complete and use as refresher material year round. More information about offered trainings can be found at [http://wihiv.wisc.edu/trainingsystem/](http://wihiv.wisc.edu/trainingsystem/).

The Wisconsin site of the Midwest AIDS Training and Education Center (MATEC) provides HIV and AIDS clinical training and support to health care professionals. MATEC’s mission is to enhance the capacity of HIV clinical services and improve quality services for people living with HIV. Programs are developed for, or in conjunction with, clinics or health care organizations to meet their specific needs, including offering programs for individual health care professionals. Collaborating partners include community health centers, tribal health centers, academic medical centers, the Wisconsin Department of Corrections, the Wisconsin Department of Health Services, health care professional societies, and other health care organizations.

Community Prevention Efforts Directed to Young Black MSM

The AIDS/HIV Program is collaborating with a range of community partners in a community engagement, planning, and evaluation process in responding to the HIV epidemic in young Black MSM (YBMSM). Activities include planning intensive HIV prevention interventions targeting YBMSM in the city of Milwaukee, linkage to care services for newly-diagnosed HIV-positive individuals, and social media campaigns targeting providers and community groups serving young Black males. Community partners include Diverse & Resilient, Inc; the Milwaukee City Health Department; Center for AIDS Intervention and Research (CAIR) at the Medical College of Wisconsin; Black Health Coalition of Wisconsin Inc; Pathfinders; and United Migrant Opportunity Services (UMOS).
**Linkage to Care**
In Fall 2011, the Wisconsin AIDS/HIV Program was awarded a 4-year HRSA Special Project of National Significance (SPNS) grant to develop innovative models of linkage to improve access to and retention in quality HIV medical care. This initiative supports the federal focus on early identification of individuals living with HIV/AIDS and the AIDS/HIV Program’s efforts to target high risk populations, especially young MSM of color. The Linkage to Care project is invested in community partnerships that are committed to collaborative learning, planning, implementation and evaluation. Based on epidemiologic data, the initiative is being deployed in the southern and southeastern regions of Wisconsin.

**Medical Home**
The federal Patient Protection and Affordable Care Act (ACA), signed into law in March 2010, enabled states to opt to provide coordinated care through a health home for individuals with chronic conditions. In April 2010, Wisconsin passed legislation to create an HIV-specific medical home that will allow Medicaid certified providers to collect reimbursement for care coordination. The AIDS/HIV Program has collaborated closely with the Wisconsin Medicaid Program and the two state-designated AIDS service organizations (AIDS Resource Center of Wisconsin and AIDS Network) to develop the HIV Medical Home model and negotiate the terms of the State Plan Amendment approved by the Centers for Medicaid and Medicare Services in January 2013.

**Cluster Investigations**
The AIDS/HIV Program coordinates collaborative planning and disease investigation efforts in response to clusters of reported cases of HIV and hepatitis C infection. In the past several years, cluster investigations have been conducted successfully in several areas of the state through AIDS/HIV Program staff (surveillance, testing, partner services, and evaluation staff) collaborating closely with staff from local health departments and community-based organizations in planning and implementing disease investigation activities and interventions.

**PrideFest and other community events**
Throughout the past several years, AIDS/HIV Program grantees have provided educational outreach, condoms and HIV testing at the annual LGBT Pride celebrations held across the state. The largest of these is Milwaukee’s annual PrideFest held the first weekend in June. Other annual events have included FruitFest in Madison, and PrideAlive in Appleton and Green Bay. Program staff frequently participate in planning meetings for these events, to ensure diverse representation among providers, high quality testing services and linkage to care for those who test HIV positive. The AIDS/HIV Program has provided condoms and/or HIV rapid tests for these events and supports confirmatory testing as needed. Typically, 400-600 people are tested in conjunction with Pride events, with approximately 3 to 7 individuals testing positive.

**HIV Awareness Days**
There are several HIV awareness day observances throughout the year. Community-based agencies and service providers assume leadership in promoting community awareness in a variety of formats and venues. This results in interagency collaborations and joint efforts in sponsoring HIV awareness day activities such as lectures, memorials services, community social exchange, and targeted HIV education and testing efforts.

A summary table of current contractual relationships with public and private nonprofit agencies and institutions is located in [Addendum III](#).
VI. Monitoring, Quality Management, Evaluation, and Surveillance

Monitoring, quality management (QM), evaluation, and surveillance activities in the Wisconsin AIDS/HIV Program occur at multiple levels.

Monitoring and Quality Management
The services provided by public and private nonprofit grantees receiving state and federal HIV funding through the AIDS/HIV Program are closely monitored by the Program. As part of the contracting process, staff review, negotiate, and approve grantee intervention plans, work plans, and budgets. Staff monitor monthly expenditure reports to ensure the optimal utilization of funds and regularly monitor and provide feedback on data submitted by grantees and contractors. In addition, the number of clients served is also monitored regularly to ensure that service targets are met and provide technical assistance if necessary. At site visits, conducted at a minimum annually, staff evaluate grantee performance and give feedback, provide recommendations and/or identify required changes. For agencies supported with Ryan White funds, these site visits also include a fiscal and client chart review to ensure compliance with contract requirements and HRSA monitoring standards.

Quality management and quality assurance are also critical activities in ensuring that individuals receive high quality prevention and care services. The AIDS/HIV Program has developed QM plans, policy and procedures manuals, and performance priorities and measures to ensure high quality internal activities and to guide quality assurance of funded services. These documents and measures are periodically updated. Grantees and contractors are required to address evaluation and QM as part of their intervention plans, work plans, and assessment of client need for and satisfaction with services. Additional quality assurance activities specific to prevention and care grantees are summarized below.

Components of the AIDS/HIV Program’s HIV Prevention Unit evaluation approach include:

- Input, review and approval by AIDS/HIV Program contract monitors of grantees’ intervention plans that guide prevention and testing services and reporting.
- Quarterly review of data entered by grantee agencies into EvaluationWeb, the web-based data management system, to assess the extent to which grantees are meeting targets identified in their intervention plan.
- Detailed quality assurance monitoring of counseling and testing data prior to submission to CDC.
- Frequent review of data entered by Partner Services (PS) providers into Partner ServicesWeb, a web-based data management system, to monitor PS performance measures, such as lag time between assignment of cases and percent of partners tested.
- Annual site visits of grantees funded for HIV prevention services.
- Annual meetings and trainings of PS field staff.
- Periodic, contract monitoring telephone calls and emails, as needed.

The AIDS/HIV Program’s Ryan White QM activities include, but are not limited to:

- Annual site visits to assess grantee progress and discuss the need for quality initiatives.
- Semi-annual review of grantee progress toward work plan performance measures, including those released by the federal Health Resources and Services Administration HIV/AIDS Bureau.
- Semi-annual review of utilization data to identify service gaps.
- Annual review of agency QM plans and provision of technical assistance as needed.
• Annual non-medical case management chart audits to ensure accordance with Wisconsin non-medical case management practice standards.
• Non-medical case management training and certification to ensure that case managers meet minimal training and knowledge requirements.

The AIDS/HIV Program’s AIDS Drug Assistance Program (ADAP) and Health Insurance Premium Subsidy Program also perform extensive quality checks, including, but not limited to:
• Monthly monitoring of utilization reports to assess trends in cost, usage and client demographics.
• Annual client recertification (re-application) for ADAP and the AIDS/HIV Health Insurance Premium Subsidy Programs, including screening for Medicaid (MA), Veterans Affairs, and Health Insurance Risk Sharing Plan (HIRSP) eligibility to ensure payer of last resort.
• Annual credential verification of ADAP prescribing physicians.
• Annual claims payment audits.
• Weekly verification, prior to payment, for MA eligibility on clients for whom pharmacy claims have been submitted.

The AIDS/HIV Program co-sponsors monthly MATEC HIV Treaters teleconferencing meetings to ensure quality care by supporting collaboration among HIV health care providers statewide, including low volume and high volume treaters. The AIDS/HIV Program also works closely with MATEC staff to ensure quality of services by providing technical assistance to medical providers whose client base has a lower than average level of viral load suppression.

Consumer input is also an important component of quality management. All contracted agencies are required to solicit consumer feedback that can be utilized to improve service delivery. Examples of activities used to gain consumer input include:
- **Client surveys**: Two types of surveys are most often used. The first involves issuing a survey each time a service is provided. This is most often utilized in a clinical setting. The second survey is a broader survey encompassing multiple service areas and is usually conducted on an annual basis.
- **Consumer Advisory Boards**: A group of consumers, that ideally represent a cross section of the population served. Similar to a board of directors, the consumer advisory board offers strategic ideas on agency direction.
- **Consumer representation on board of directors**: The governing board of an agency. Inclusion of consumers brings additional viewpoints to the decision making process.
- **Focus groups**: This tool is often used by agencies to gather consumer feedback to answer a specific question or set of questions. For example “What new services would enhance your quality of life?” or “How could case management services better serve you?”
- **Grievance policies**: All agencies are required to have procedures in place to address client complaints, and to inform clients of these policies. Regular review of grievances provide learning opportunities for agencies to see where improvements can be made.

**Evaluation**

Full-time staff positions in the AIDS/HIV Program’s Prevention and Care Units are dedicated to evaluation and quality management. Epidemiologists are responsible for coordinating analysis, interpretation, reporting, and use of data. The epidemiologists also help to ensure data quality, conduct routine surveillance, and assist with data collection.

Four principles guide monitoring and evaluation activities:
1. Data are collected and maintained in a secure and confidential manner.
2. Data are to be of the highest possible quality.
3. Available data resources are used efficiently.
4. Monitoring and evaluation priorities respond to changing data needs that are required for monitoring the HIV epidemic; and guiding the planning, implementation, and evaluation of HIV prevention and care services.

The AIDS/HIV Program routinely analyzes and uses data from the following sources:
- HIV surveillance (eHARS).
- AIDS Drug Assistance Program (ADAP) database.
- Counseling and testing data (EvaluationWeb).
- HIV prevention program data (EvaluationWeb).
- Partner Services data (PSWeb).
- HIV care and treatment data submitted by grantees.
- STD surveillance (WEDSS).
- Hepatitis C surveillance (WEDSS).
- Population surveys (Youth Risk Behavior Survey and Behavioral Risk Factor Survey) regarding health conditions of youth and adults identifying as lesbian, gay or bisexual and/or engaging in same sex behaviors.

The AIDS/HIV Program ensures the confidentiality and security of all AIDS/HIV client data. All Program staff complete training on data security and Wisconsin’s HIV confidentiality laws. Grantees are required to establish agency-specific security and confidentiality policies as well as staff training ensuring client confidentiality, data security, and compliance with Wisconsin statutory confidentiality requirements.

Activities directed at ensuring the quality of AIDS/HIV Program and grantee data include:
- Reviewing data on a regular basis to find and correct missing or incongruent data.
- Providing training and technical assistance to sites as needed to ensure correct and complete data collection.
- Using available data resources to check consistency of demographic, risk, and testing data.

Surveillance
The AIDS/HIV Program Surveillance Unit measures and monitors the impact of HIV and AIDS on disease incidence and mortality through the analysis of HIV and AIDS surveillance data. Confidential, name-associated reporting of confirmed HIV infection and AIDS to the State Epidemiologist is required by Wisconsin statute (s. 252.15).

Case reports are submitted to the Surveillance Unit from private physicians, hospitals, clinics, ambulatory care facilities, sexually transmitted disease clinics, the Wisconsin correctional system, family planning clinics, perinatal clinics, Indian health clinics, blood and plasma centers, military entrance processing stations, and laboratories performing HIV testing. Other sources of AIDS/HIV surveillance data include state client assistance programs (AIDS/HIV Drug Assistance Program and AIDS/HIV Health Insurance Premium Subsidy Program), tumor registry reports, ICD-9 discharge code reviews conducted by the Bureau of Health Information and Policy, vital records death certificate registry, and the tuberculosis (TB) registry.

The Surveillance Unit analyzes and reports surveillance data in ways that maximize the usefulness to groups engaged in planning and evaluating HIV prevention, care, and treatment activities. Surveillance staff collaborate with the Statewide Action Planning Group and the coordinators of the Ryan White Program, the AIDS Drug Assistance Program (ADAP), the AIDS/HIV Health Insurance Premium Subsidy Program, the Laboratory Reimbursement
Program, Partner Services Program, and the quality assurance and evaluation staff of the HIV Prevention and Care Units to conduct epidemiologic investigations and provide special epidemiologic analyses and reports.

Confidentiality
The AIDS/HIV Program ensures the confidentiality and security of all AIDS/HIV client data. All surveillance data is maintained in compliance with CDC Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Program: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action; Wisconsin Statutes and Administrative Code; Wisconsin Department of Health Services (DHS) work rules, and Wisconsin Division of Public Health Guidelines for AIDS/HIV Surveillance, Confidentiality, Security and Release of Patient/Client Data. Within one week of employment by the DHS, new employees and contract employees working in the Wisconsin AIDS/HIV Program receive training regarding data security and confidentiality. In addition, new employees and contractors are required to participate in DHS online privacy and confidentiality training within seven days of employment. Annually, all AIDS/HIV Program staff and contract employees review security and confidentiality guidelines and provide certification of compliance which is documented by the AIDS/HIV Surveillance Coordinator. DHS employees and contractors are also required to participate annually in the DHS online privacy and confidentiality refresher training. Grantees are required to establish agency-specific security and confidentiality policies as well as staff training to ensure client confidentiality, data security, and compliance with state and federal confidentiality requirements.

Epidemiologic and surveillance data are utilized widely for program planning. Examples of data utilization include:
- Analysis of surveillance, testing and population data to establish targets for the number of persons by risk group and race/ethnicity to be tested overall and by agency type.
- Performance review of testing, prevention, and surveillance data to direct resources to better match trends in the epidemic.
- Identification of emerging risk populations or clusters of newly diagnosed disease to direct funded interventions.
- Analysis of epidemiologic data sources collected outside of the AIDS/HIV Program to assist in program planning and evaluation.

Data analyses are disseminated widely, through a variety of venues including:
- The AIDS/HIV Program statistics and reports web site (http://dhs.wisconsin.gov/aids-hiv/Stats/index.htm);
- Hepatitis C Program statistics and reports (http://www.dhs.wisconsin.gov/communicable/ViralHepatitis/HepC/HepCProgram.htm);
- At meetings of the Statewide Action Planning Group, HIV services providers, the LGBT Youth Consortium, and Division of Public Health initiatives such as development of the Healthy Wisconsin 2020 state health plan and the biannual Youth Sexual Behavior Report.

In response to the March 2012 release of the Institute of Medicine (IOM) report Monitoring HIV Care in the United States: Indicators and Data Systems, the AIDS/HIV Program will be examining the IOM’s recommended set of core indicators for clinical HIV care and mental health, substance abuse, and supportive services. The core and additional indicators were identified as important measures to be used by the federal Department of Health and Human Services (DHHS) to assess the impact of the NHAS and the ACA on improving HIV/AIDS care and access to supportive services for individuals with HIV. The AIDS/HIV Program will align
data collection, monitoring, and evaluation efforts to conform to DHHS funding requirements that may develop as a result of implementing the IOM recommendations.
VII. Prevent-Test-Link-Treat: A Framework for Statewide HIV Community Planning

In 2004, the Wisconsin AIDS/HIV Program developed the framework Prevent-Test-Link-Treat to organize and plan for HIV services. Prevent-Test-Link-Treat is a comprehensive approach to organizing and summarizing HIV-related services through statewide community planning focused on the integration of effective and efficient HIV-related services. In planning and delivering services, consideration is given to an array of factors which influence the health of individuals and communities. Some of the determinants of health include:

- the biology of HIV
- individual knowledge, attitudes, and behaviors
- access to health care
- education
- literacy
- economic opportunities
- employment
- working conditions
- housing and food
- family and social supports

HIV prevention and care services focus on factors and behaviors that directly impact HIV transmission as well as other forces such as discrimination, marginalization, and stigma that limit opportunities, diminish aspirations, and reinforce disparities. The Prevent-Test-Link-Treat framework for HIV community planning focuses on these and other factors which support, promote, and protect the health and well-being of individuals and communities that are at risk (including those unaware of or denying risk) and those living with HIV.

### Wisconsin’s HIV Prevent-Test-Link-Treat Framework

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<th>PREVENT</th>
<th>GROUP LEVEL</th>
<th>COMMUNITY LEVEL</th>
<th>STRUCTURAL LEVEL</th>
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<tbody>
<tr>
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<tr>
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<td>Routine Testing</td>
<td>Targeted Testing</td>
<td>Social Networks Testing</td>
<td>Partner Services</td>
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<tr>
<td><strong>LINK</strong></td>
<td>Outreach</td>
<td>Partner Services</td>
<td>Case Management (Non-Medical)</td>
<td>Other Support Services</td>
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<tr>
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<td>Primary Medical Care</td>
<td>Case Management (Medical)</td>
<td>Medications</td>
<td>Oral Health</td>
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The Prevent-Test-Link-Treat framework identifies HIV prevention and care interventions and service categories, while the framework known as the “continuum of care” focuses on the flow...
and spectrum of services and the critical elements associated with successful engagement in care. This framework can help identify service gaps and improve the continuum of care.

**Spectrum of the Continuum of Care**

The HIV care continuum, which is sometimes referred to as the HIV treatment cascade, is a model used by federal, state and local agencies to identify ways to improve the delivery of services to people living with HIV. The care continuum focuses on measuring client outcomes at critical points across the HIV care spectrum, with the key goal of viral load suppression in order to improve individual health outcomes and reduce HIV transmission.

The AIDS/HIV Program utilizes the care continuum framework to identify health care service gaps, plan services, and assess the impact of interventions and programs. The Wisconsin HIV Care Continuum graph is illustrated below and was examined in greater detail in the February 2014 issue of Wisconsin AIDS/HIV Program Notes.

**Wisconsin HIV Care Continuum, 2011 New Diagnoses and Prevalent Cases**


**Legend for Wisconsin HIV Care Continuum graph shown above**

*At High Risk:* These are people most likely to become infected with HIV. The size of this population is unknown but is larger than the number of people infected with HIV in Wisconsin.

*Living with HIV:* The CDC estimates that 16% of those infected with HIV are unaware of their infection, although the percent unaware may vary by population. Therefore, those living with HIV in Wisconsin are comprised of both those aware and unaware of their HIV infection.

*Diagnosed and Living with HIV:* An estimated 6,244 of the 2011 prevalent cases were alive and living in Wisconsin at the end of 2012.

*Linkage within Three Months of Diagnosis:* Among the 245 new diagnoses statewide during 2011, 81% showed evidence of linkage to care within three months of diagnosis. An additional 15% of people newly diagnosed were linked to care more than three months after diagnosis, and 4% had no evidence of linkage at the time of analysis. Of the nine persons never linked to care, all were male, eight were non-White, all were MSM or had unknown risk, and six were under age 30 at the time of HIV diagnosis.

*In Care:* Of those diagnosed and living with HIV, 63% had at least one care visit during 2012.

*Retained in Care:* Of those diagnosed and living with HIV, 51% had at least two visits, 90 days apart, during 2012.

*On ART:* ART usage is not reported in Wisconsin and therefore the proportion of people on treatment in Wisconsin is unknown.

*Suppressed Viral Load:* Of those diagnosed and living with HIV, 46% had suppressed viral load as of their last viral load test in 2012.

*Viral Suppression among Those in Care:* Most (82%) of those who had at least one viral load test (indicating some care) were virally suppressed as of their last viral load test during 2012.

The Wisconsin AIDS/HIV Program is increasingly focusing service coordination and collaboration through linkage to care initiatives. A current initiative supported by a federal Special Project of National Significance (SPNS) grant\(^1\) is directed at improving the quality of life for persons living with HIV and decreasing the incidence of HIV infections by improving systematic linkages to and retention in care. Collaborative efforts among service providers are expected to ensure access, engagement, and retention in a continuum of quality prevention, care, and support services.

**Funding**

Financing and financial support of HIV prevention and care programs are fundamental and critically important in developing and sustaining core prevention and care services. Wisconsin benefits from a combination of federal and state funding dedicated to HIV prevention and care services and activities.

**Federal Support: Centers for Disease Control and Prevention**

Federal funding from the CDC supports the majority of prevention and surveillance activities coordinated by the Wisconsin AIDS/HIV Program. Funding occurs through a CDC Cooperative Agreement which is awarded based on approval of the State’s annual funding application. Separate funding applications and awards are submitted for HIV prevention funds and HIV

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surveillance. The federal fiscal year for CDC funding awarded to Wisconsin is the calendar year (January – December).

**Federal Support: Health Resources and Services Administration**

Other than Medicaid, the federal Health Resources and Services Administration (HRSA) is the major source of federal funding which supports HIV care services in Wisconsin. The HIV/AIDS Bureau administers the Ryan White HIV/AIDS Program under the following Parts:

- **Part A** provides grants to Eligible Metropolitan Areas and Transitional Grants Areas that have 1,000–2,000 new AIDS cases in the past five years and have populations of at least 50,000. (Wisconsin is not eligible for Part A funding.)

- **Part B** provides grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Although the Wisconsin AIDS/HIV program is the Part B grantee, direct services are provided with Part B funding via subcontracts with service providers.

- **Part C** provides grants directly to service providers for service provision and planning and capacity building grants.

- **Part D** provides family-centered comprehensive care to children, youth, women, and their families.

- **Part F** funds special demonstration projects, AIDS Education and Training Centers which support education and training of health care providers, dental programs, and Minority AIDS Initiative grants which provide funding to evaluate and address the disproportionate impact of HIV/AIDS on women and minorities.

**Federal Support: Substance Abuse Treatment Block Grant**

The Division of Mental Health and Substance Abuse Services (DMHSAS) in the Wisconsin Department of Health Services administers the State’s share of federal funding under the Federal Substance Abuse Prevention and Treatment Block Grant. DMHSAS contracts with the Division of Public Health to support local agencies in providing HIV-related prevention services to persons receiving substance abuse treatment services.

In addition to base federal funding, the Wisconsin AIDS/HIV Program occasionally receives additional federal funding from competitive grant awards and supplemental or one-time funding opportunities.

**State Support**

State funds, known as general purpose revenue (GPR), address critical unmet needs in HIV prevention and care services in Wisconsin. GPR supports various prevention and care services, including Mike Johnson Life Care and Early Intervention Services, the Wisconsin AIDS/HIV Drug Assistance Program, and the AIDS/HIV Health Insurance Premium Subsidy Program. GPR funding is awarded to local agencies on the State’s fiscal year, July through June.

Community-based agencies, academic institutions and health care agencies also receive direct funding from a variety of sources, including but not limited to federal, state and municipal government, private foundations, and other private sector and public support.

*Addendum III* includes summary tables highlighting federal and state funding supporting HIV-related activities coordinated through the Wisconsin AIDS/HIV Program.
Wisconsin HIV Service Directions

The following section provides an overview of major initiatives that will guide the course of HIV-related services coordinated by the Wisconsin AIDS/HIV Program in the immediate future. Priority focus areas, objectives, and activities are aligned with the Prevent-Test-Link-Treat framework for community planning and support the following three primary goals of the National HIV/AIDS Strategy:

1. Reducing HIV incidence.
2. Increasing access to care and optimizing health outcomes.

A. PREVENT

Prevention is a central concept in public health and one that is critical to all HIV-related activities. HIV prevention services are those that demonstrate effectiveness in eliminating or lowering the risk of HIV transmission and promoting the health of HIV positive persons. Priority populations for prevention services include:

- Gay, bisexual and other men who have sex with men (MSM), especially young MSM and MSM of color.
- People who inject drugs (PWID).
- High risk heterosexuals (individuals who have sex partners of the other sex who are HIV positive, MSM, or PWID).
- Sexually active HIV positive persons.

Prevention interventions occur at four levels:

- Individual
- Group
- Community
- Structural

Individual Level Interventions (ILI) are one-on-one approaches to prevention. ILI include risk reduction counseling with a skills building component provided to one person at a time, in single or multiple sessions. Group Level Interventions (GLI) are provided to groups of individuals with similar risk behaviors and include risk reduction education or counseling sessions with a targeted skills-building component. Community Level Interventions (CLI) are directed at influencing a large peer group or community to adopt healthier behaviors and to support each other in maintaining those behaviors once they have become community norms. Structural Interventions (SI) focus on changing or influencing social, political, or economic environments and do so indirectly rather than intervening directly with individuals, groups, or communities.

Prevention for Positives

With advances in HIV medical care, many persons with HIV are living longer. Most individuals who become aware that they are HIV-positive change behaviors to reduce or eliminate the risk of transmitting HIV to sexual and/or needle-sharing partners, however, some find it difficult to maintain behavior changes over time and some individuals drop out of care. Staff providing

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1 In addressing sexually active persons at risk, it is important to note that the risk for HIV transmission is greater for individuals with multiple concurrent sex partners compared to persons with limited numbers of sex partners and who are in serial monogamous (one-partner-at-a-time) relationships.
prevention for positives services assist persons in linking to needed services and maintaining active participation and retention in medical care.

During early stages of HIV infection, large concentrations of HIV (viral load) can increase the chance that an HIV-positive person passes HIV to their partners. Prevention interventions that assist HIV-positive persons to adopt or maintain healthy behaviors can greatly reduce HIV transmission.

**Treatment as Prevention**
Treatment as prevention refers to the personal and public health benefits of using antiretroviral therapy to continuously suppress HIV viral load in the blood and genital fluids, which decreases the risk of transmitting the virus to others. The concept of *community viral load* is a way of examining groups of HIV-positive persons living near each other or within the same social network, and looking at the collective impact of antiretroviral treatments on the overall risk for HIV infection within the community. Increased collaboration between HIV prevention and linkage to care projects focuses on assisting persons living with HIV to remain engaged in HIV care.

**Condom Promotion and Distribution**
Condom promotion and condom distribution address barriers to condom use and the availability of condoms among high-risk populations. Condom distribution programs involve not only the distribution of condoms, but also targeted education and marketing programs that correct misinformation about condom use, address stigma associated with using and carrying condoms, and increase efficacy in using condoms consistently and correctly.

Condom promotion and distribution efforts delivered through individual and group interventions are effective in increasing condom use and reducing unprotected sex. Community condom distribution interventions work to build support for condom use as a community norm. As a structural intervention, condom promotion and distribution is designed to address external factors that impact the availability, accessibility, and acceptability of condoms. Structural interventions have demonstrated effectiveness in increasing condom use, condom acquisition and condom carrying; promoting delayed sexual initiation or abstinence among youth; and reducing STIs. CDC guidance indicates that condom distribution programs are most effective when they combine elements of structural, individual, group and/or community level activities.

**LGBT Health**
The lesbian, gay, bisexual, and transgender (LGBT) community is made up of people from diverse backgrounds, and its members vary by race, ethnicity, age, income, and education. Despite differences among LGBT people, one experience many share is encountering stigma or discrimination. This social inequality is often associated with poorer health status. Evidence indicates that Wisconsin's LGBT youth and adults experience greater adverse health outcomes with regard to alcohol, drug, and tobacco use, safety and violence, mental health, and HIV/AIDS when compared to their non-LGBT peers. In order to create a health promoting environment and to reduce health inequities, LGBT persons must have access to culturally competent prevention and health care services and must be included in public health outreach programs (see DHS [LGBT Health website](#)).

**Social Marketing**
Social marketing utilizes contemporary marketing efforts to achieve a social good. In Wisconsin, social marketing efforts focus on reducing rates of HIV in YBMSM in Milwaukee. These efforts
are supported by a variety of community partners and are initially directed at reducing anti-gay stigma which may lead to unfavorable social conditions that contribute to HIV transmission, especially among YBMSM. Development of the social marketing campaign included a community readiness assessment conducted by the Center for AIDS Intervention Research at the Medical College of Wisconsin. The social marketing campaign, known as Acceptance Journeys, is utilizing print, radio, and the web to direct messages to the Black and LGBT communities as well as clergy and congregants. The focus of the first phase of Acceptance Journeys, which is led by Diverse and Resilient, Inc., is to increase positive attitudes towards LGBT people of color. Through a variety of media, Acceptance Journeys unfolds real life stories depicting LGBT persons and a non-LGBT person, mostly people of color, with the non-LGBT person describing their journey to coming to accept their LGBT loved one. The first phase of this social marketing campaign is designed to change attitudes towards LGBT people in communities of color and to reduce internalized homophobia in LGBT people themselves.

Nonoccupational Postexposure and Pre-exposure Prophylaxis
Nonoccupational postexposure prophylaxis (nPEP) and pre-exposure prophylaxis (PrEP) are two important biomedical prevention interventions. nPEP utilizes prophylactic medications as soon as possible after a known sexual or needle-sharing exposure to HIV. The CDC released recommendations for nPEP in January 2005.

On May 14, 2014, the US Public Health Service released the first comprehensive clinical practice guidelines for PrEP. The guidelines were developed by a federal inter-agency working group led by CDC, and reflect input from providers, HIV patients, partners, and affected communities. With PrEP, uninfected persons at higher risk for HIV infection take a combination of tenofovir and emtricitabine (brand name Truvada) daily. Combined with regular HIV testing, medical assessment and consistent condom use, PrEP has been clinically shown to reduce the risk of becoming infected with HIV among very high-risk individuals.

Implementation of these guidelines require careful clinical, behavioral, and financial considerations. The Wisconsin AIDS/HIV Program will collaborate with clinicians and at-risk populations in promoting the implementation of nPEP and PrEP consistent with current clinical recommendations, interim guidance, and future standards of practice.

Information and Referral
The Wisconsin HIV/STD/Hepatitis C Information and Referral Center (IRC), funded by the Wisconsin Department of Health Services, provides statewide information and referral through a toll-free hotline and comprehensive website and database located at http://www.arcw.org/aidsline/. The IRC provides information and referral for the spectrum of prevention, testing, linkage, and treatment services.

Prevention Objectives & Priority Activities: 2012-2015

Focus: Social Media/Technology Based Outreach to MSM

Objective: Reduce HIV risk behaviors among MSM who use the Internet to find sexual partners and network with peers. [Supporting NHAS Goals 1 & 3]

Priority activities include:
- Implementing one-on-one online risk reduction counseling with MSM using Internet chat services.
• Delivering condom use and HIV testing messages at social networking sites serving as online meeting places for MSM.
• Monitoring community attitudes, knowledge and beliefs about HIV as expressed in Internet venues, and sharing these with HIV prevention providers to improve program development.
• Providing an online resource for questions about HIV prevention and care, and providing referrals to HIV testing, care and STI services.
• Developing smart phone outreach initiatives.

**Focus: Prevention for Positives**

**Objective:** Ensure that newly-diagnosed individuals identified through Prevention for Positives service providers are referred and successfully linked to HIV care and other services.

[Supporting NHAS Goal 2]

**Priority activities include:**

• Distributing policies and procedures to Counseling & Testing and HIV Partner Services providers to continue ensuring 1.) referral to HIV care and other services as the standard of care for persons who are newly diagnosed or previously diagnosed and not receiving HIV specialty medical care, and 2.) periodic updating of referral lists and agreements with agencies providing services for HIV-positive persons.
• Providing training to support staff effectiveness at assessing client needs and making appropriate client referrals.
• Establishing mechanisms through the EvaluationWeb data system to ensure documentation of initial and updated referrals to appropriate services for all HIV-positive clients.

**Objective:** Ensure that individuals who are referred to services follow through in completing their initial appointment.

[Supporting NHAS Goal 2]

**Priority activities include:**

• Maintaining methods to confirm client access of services, including securing client consent to share information with appropriate providers.
• Maintaining and promoting policies & procedures to encourage more effective communication between HIV prevention and care agencies regarding client completion of service referrals.
• Establishing mechanisms through the EvaluationWeb data system to ensure documentation of HIV-positive clients accessing referred services.
• Coordinating communications with medical case managers to ensure that clients are engaged in care.
• Coordinating with Partner Services to ensure that referred clients are linked to care.

**Objective:** Deliver an effective behavioral intervention to HIV-positive clinic patients, using existing resources to serve the maximum number of people.

[Supporting NHAS Goals 1, 2 & 3]
Priority activities include:
- Piloting prevention for positives interventions in 2013 at three clinics and expand during 2013-2015 to include other clinics in the state. Intervention components include:
  - Clinics adopting prevention as an essential component of patient care and providers delivering the intervention to HIV-positive patients in HIV outpatient clinics.
  - Prevention messaging integrated into clinic visits so that every patient is counseled at every visit and providers routinely initiate a brief discussion with the patient or client about safer sex that focuses on self-protection, partner protection, and disclosure.
  - Supportive relationships built and maintained between the patient and the provider.
  - Referrals for needs that require more extensive counseling and services.
  - Waiting room posters and brochures used to reinforce prevention messages delivered by the provider.

Focus: Condom Promotion & Distribution

Objective: Increase accessibility of condoms to high-risk populations.
[Supporting NHAS Goals 1 & 3]

Priority activities include:
- Identifying appropriate venues for distributing condoms to risk populations and scheduling regular distribution times.
- Assisting local providers in identifying cost-effective ways to purchase condoms in bulk and minimize cost of delivery and distribution.
- Exploring web-based methods for distributing condoms to at-risk populations and partner agencies.
- Increasing and improving coordination efforts of condom distribution through HIV Partner Services, HIV CTR and clinic sites serving HIV positive persons.
- Promoting the accessibility, availability, and acceptability of condoms.

Objective: To increase knowledge of correct condom use among target populations.
[Supporting NHAS Goals 1 & 3]

Priority activities include:
- Updating condom education to be more appealing and appropriate for populations, with attention to health literacy and cultural competence (e.g. "teach back" education models that focus on skill-building).
- Using focus groups, key informant interviews and published research to identify knowledge gaps & misinformation about condom use and efficacy among target populations.
- Utilizing web-based social networks and new communication technologies to inform target populations about condom use, efficacy and availability.
- Educating providers who are well-placed to distribute and promote condoms to high-risk populations.
Objective: To decrease stigma and negative perceptions around condom use. [Supporting NHAS Goals 1 & 3]

Priority activities include:
- Utilizing special events (PrideFest, other LGBT community celebrations, National Condom Week, etc.) to build community support for condom use.
- Developing projects that use population peers as educators and promoters of condom use, and as 'secondary distributors' to at-risk individuals.
- Using focus groups, key informant interviews and existing research to identify specific attitude barriers to consistent condom use and develop targeted messages to address them.
- Exploring strategies such as specific condom branding and large-scale coordinated social marketing campaigns.

Focus: Project Chica Group Level Intervention

Objective: Reduce HIV risk behaviors among high-risk Latina transgender population. [Supporting NHAS Goals 1 & 3]

Priority activities include:
- Implementing initial and periodic risk assessment of group clients.
- Implementing Project Chica curriculum, adapted for Latina transgender clients from the CDC SISTA EBI.
- Distributing condoms and referring to needed services such as mental health, substance abuse and HIV CTR.

Focus: SHEBA Group-level Intervention

Objective: Reduce HIV risk behaviors among high-risk Black transgender population. [Supporting NHAS Goals 1 & 3]

Priority activities include:
- Implementing initial and periodic risk assessment of group clients.
- Implementing TWISTA curriculum, adapted for Black transgender clients from the CDC SISTA EBI.
- Implementing adapted motivational interviewing EBI protocol.
- Distributing condoms and referring to needed services such as mental health, substance abuse, and HIV CTR.

Focus: PWID Harm Reduction Outreach (SSP - Syringe Support Program)

Objective: Reduce HIV risk behaviors among PWID. [Supporting NHAS Goals 1 & 3]

Priority activities include:
- Providing individual outreach education to PWID on issues such as proper needle cleaning, needle disposal, vein care, and hepatitis C risks.
- Referring PWID to needed services such as health care, recovery programs, and mental health services.
- Promoting correct disposal of injection drug equipment.
• Collaborating with privately funded syringe exchange programs.

**Focus: Viral Hepatitis**

**Objective:** Improve viral hepatitis disease surveillance.

[Supporting *NHAS* Goals 1, 2, 3]

**Priority activities include:**

• Developing a protocol for enhanced surveillance of HCV infections in persons under 25 years of age.

• Revising hepatitis C guidelines for local health department to include protocols for reflexive HCV testing, HCV rapid testing and enhanced follow-up up of HCV infection in persons less than 25 years of age.

• Assisting the Wisconsin Immunization Program with data clean up and analysis of hepatitis B data.

**Objective:** Reduce viral hepatitis caused by drug-use behaviors.

[Supporting *NHAS* Goals 1 & 3]

**Priority activities include:**

• Increasing outreach and harm reduction efforts to PWID through improved collaboration and integration with HIV and STD prevention and outreach projects serving PWID.

• Increasing HCV testing provided by HIV harm reduction and outreach programs that reach PWID.

**Objective:** Improve viral hepatitis health education and risk reduction.

[Supporting *NHAS* Goals 1 & 3]

**Priority activities include:**

• Developing and distributing age-specific, culturally appropriate HCV prevention materials targeted at high risk youth (i.e. PWID under age 25 years).

• Revising and distributing public education material on HCV infection risks and testing recommendations that can be used by health care providers, community clinics, local public health departments, federally qualified health centers, public STD clinics, and other settings that the general public and high risk populations access.

**Objective:** Eliminate transmission of vaccine preventable viral hepatitis.

[Supporting *NHAS* Goals 1 & 3]

**Priority activities include:**

• Continuing to offer monovalent hepatitis B (HBV) and combination Twinrix vaccine to adults at high risk for HBV infection.

• Continuing to support HBV vaccine efforts within the Wisconsin Department of Corrections.

**Objective:** Prevent healthcare-associated viral hepatitis.

[Supporting *NHAS* Goals 1 & 3]

**Priority activities include:**

• Providing technical assistance related to viral hepatitis to the Health Care Acquired Infection Project in the Bureau of Communicable Disease and Emergency Response.
Focus: Lesbian, Gay, Bisexual and Transgender (LGBT) Health

Objective: Improve the extent and quality of data collected and analyzed, and use of data regarding sexual minority populations. These include both young people and adults who identify as LGBT and individuals who have sexual contact with partners of the same sex, irrespective of sexual orientation.
[Supporting NHAS Goals 1 & 3]

Priority activities include:
- Analyzing and disseminating data from the YRBS and BRFS demonstrating health disparities experienced by LGBT populations.
- Preparing a summary of demographic data regarding LGBT populations in Wisconsin.
- Broadly disseminating analyses of LGBT health outcomes and demographic data through:
  - Reports tracking health disparities and progress for Healthiest Wisconsin 2020.
  - Presentations at statewide conferences and other venues.
  - Articles or links to the data reports in newsletters and journals of medical, education, and other professionals.

Objective: Improve the reach and quality of services to LGBT populations through support of LGBT services and cultural competence training to improve service providers’ ability to effectively serve LGBT young people and adults.
[Supporting NHAS Goals 2 & 3]

Priority activities include:
- Developing web-based LGBT trainings for providers.
- Meeting with DHS program staff to share program-specific LGBT data fact sheets and assessing current efforts to include LGBT populations in their work.

Objective: Reduce health disparities experienced by LGBT people through more favorable policies and community engagement.
[Supporting NHAS Goals 2 & 3]

Priority activities include:
- Add Nutrition and Physical Activity and Resiliency Factors as health topics to the DHS LGBT website.
- Advocate for the addition of a housing question to the YRBS.
- Provide support to Acceptance Journeys.
- Develop LGBT section in Minority Health Report/Healthiest Wisconsin 2020 baseline report.

Focus: Medical prophylaxis including Pre-exposure Prophylaxis (PrEP) and Non-occupational Post-Exposure Prophylaxis (nPEP)

Objective: Improve medical and HIV service provider knowledge about PrEP and nPEP.

Priority activities include:
- Promoting the use of PrEP in clinical settings in accord with current practice standards.
• Providing language and messaging for prevention and care providers to talk with clients about PrEP, including messaging about the risks and benefits of PrEP.
• Streamlining and publicizing the process and increasing access for appropriate use of nPEP.

Objective: Increase community awareness and education about PrEP and nPEP.

Priority activities include:
• Gathering input from gay and bisexual men and other appropriate populations on how to deliver messages about PrEP and nPEP.
• Delivering messages to these populations which will raise awareness and educate about the risks and benefits of PrEP and nPEP.

Objective: Explore funding for PrEP.

Priority activities include:
• Determining to what extent insurance or other payment methods will cover PrEP.
• Assessing the level of stigma in accessing various payment methods.

B. TEST

HIV testing is one of the most important interventions in controlling the spread of HIV infection. It is the first step to linking persons infected with HIV to medical care. Testing services promote early detection of HIV infection. For persons testing positive for HIV, awareness of their HIV status can help them take steps to protect their own health and that of their partners. Research indicates that most persons reduce high risk behaviors after knowing they are infected with HIV. For those testing negative, the testing process is an opportunity to be informed and take action to avoid risks and stay uninfected.

The focus of publicly funded counseling, testing, and referral (CTR) services is two-fold: 1) to identify undiagnosed HIV infection and provide linkages to HIV specialty care services and 2) to promote primary and secondary prevention through providing or linking persons with individualized, client-centered risk reduction planning and counseling. HIV education and counseling, which is provided in all publicly funded CTR venues, focuses on reducing individual risk behaviors, providing information regarding the HIV antibody test, and assisting the individual in making a decision regarding HIV testing. HIV positive persons are referred for medical follow-up, case management, and partner services (PS).

Publicly funded CTR services provide both confidential and anonymous testing to individuals who at risk for HIV infection. Approximately 90% of clients are tested confidentially. However, anonymous testing offers an opportunity for individuals who have significant concerns about privacy to undergo HIV testing without having their name (identity) connected with their HIV test results. For confidential testing, a client’s name is known and is connected with their HIV test result. Positive HIV test results of confidential tests are reported to the AIDS/HIV Program for purposes of HIV surveillance and public health follow-up.

The Wisconsin State Laboratory of Hygiene provides HIV laboratory services to the CTR Program. The standard blood testing algorithm that is used is capable of identifying very early, acute infection - prior to antibody response. This algorithm is consistent with CDC’s 2014 recommendations for HIV testing. Additional testing for acute HIV infection is directed to
individuals who have had exposure in the past month to someone who is known to be HIV-infected. Once someone is identified in acute HIV infection, CTR staff immediately assists them in gaining prompt access to HIV medical care and partner services. Intervention during acute infection can reduce damage to the infected person’s immune system and prevent the transmission of HIV to others during this early and highly infectious stage of HIV infection.

Consumers have the option of self-administered HIV home testing by purchasing an HIV testing kit online or at local pharmacies. There are two options for home testing by either 1. collecting a sample at home and forwarding it to a medical laboratory where the test is analyzed (Home Access® HIV-1 Test System) or 2. collecting a sample, running the test, and obtaining the test result at home (OraQuick® In-Home HIV Test). This second option uses a rapid HIV test which was approved by the FDA in July 2012 and has been available commercially since October 2012. Positive test results of the more recent home test kit are considered preliminary results that need to be confirmed by additional laboratory testing.

Testing services promote early detection of HIV infection through:
- Routine testing for segments of the general population.
- Targeted testing for high risk persons.
- Resting of sexual and needle sharing partners of HIV positive persons (through Partner Services).

**Routine Testing**

Routine HIV testing occurs as part of regular medical care. The federal Centers for Disease Control and Prevention released recommendations that all persons age 13-64 years undergo HIV testing as a routine part of health care, similar to the way screening occurs for other health conditions. The CDC also recommends that all pregnant women receive HIV testing during prenatal care.

In August 2012, the CDC released the document Recommendations for the Identification of Chronic Hepatitis C Virus Infection Among Persons Born During 1945-1965. The purpose of these recommendations is to better identify persons living with HCV infection. An estimated 2.7-3.9 million persons in the U.S. are living with HCV infection and the majority are currently unaware of their infection. New HCV therapies that can halt disease progression and provide a virologic cure (i.e., sustained viral clearance following completion of treatment) in most persons. Targeted testing and linkage to care for infected persons in the 1945-1965 birth cohort is expected to reduce HCV-related morbidity and mortality.

**Targeted Testing**

Targeted HIV testing is directed to individuals at higher risk for HIV infection, including:
- Sexually active gay, bisexual and other men who have sex with men (MSM).
- Persons who have had unprotected sex with someone known to be infected with HIV.
- Women who have had unprotected sex with bisexual males or who have exchanged sex for money or drugs.
- Persons who have shared injection drug equipment (such as needles, syringes, cotton, water) with others.
- Persons diagnosed with a sexually transmitted disease (STD) like syphilis or gonorrhea.
- Persons diagnosed with hepatitis B or C or tuberculosis (TB).

The Wisconsin Department of Health Services supports targeted HIV testing through a variety of agencies, venues, and strategies, including:
- Community-based organizations.
• AIDS service organizations.
• Local health departments.
• MSM outreach.
• PWID outreach.
• Substance abuse treatment facilities.
• STD clinics.
• Jails and correctional settings.
• Medical settings/community health centers.
• Social networks.
• Sex worker outreach.

Social networks testing
Social networks testing is a peer-driven, recruitment strategy to reach and provide HIV testing to high risk persons who may be infected but unaware of their status. This prevention intervention enlists persons newly and previously diagnosed HIV-positive and high-risk HIV negative persons as recruiters who encourage members of their social networks to undergo HIV testing. The strategy is based on findings that individuals are linked with large social networks and that infectious diseases often spread through these networks. Wisconsin was one of the early adopters of social networks HIV testing.

Partner Services Testing
Partner Services (PS) staff notify sexual and needle sharing partners of HIV positive persons that they may be at risk for HIV infection. In addition to notifying partners of their risk and providing client-centered HIV education and counseling, PS staff offer partners immediate access or referral to HIV testing services. PS has the highest rate of identifying new HIV cases (positivity rate) of any testing initiative in Wisconsin, with approximately 14% of persons testing positive for HIV infection.

Testing Objectives & Priority Activities for 2012-2015

Focus: Identification of HIV in high risk populations

Objective: Establish and implement annual goals for testing high risk populations.
[Supporting NHAS Goals 1 & 3]

Priority activities include:
• Establishing testing targets for high risk groups based Wisconsin surveillance data, as well as national estimates of the percentage of HIV positive individuals who are unaware of their infection.
• Allocating testing targets to funded agencies using the following criteria:
  o Regional epidemiologic and population demographic data.
  o Cultural competency for working effectively with target populations.
  o Historical and current demographics of client-base.
  o Past and current performance reviews.
  o Targeted populations for agency social networks testing plans.
• Monitoring and evaluating attainment of testing goals quarterly, providing technical assistance to sites as needed to meet goals.
• Supporting planning meetings among sites with similar testing target populations to coordinate services and facilitate collaboration.
Objective: Use testing strategies demonstrated to yield the highest number of first-time testers and the highest prevalence of positive results. [Supporting NHAS Goals 1 & 3]

Priority activities include:
- Utilizing a Social Networks Strategy to provide testing to high risk and disproportionately affected populations through select CTR sites.
- Providing opportunities for testing of social network members through case management and medical services sites.
- Identifying and responding to HIV case clusters and other localized increases in HIV cases using public and private community partnerships.
- Providing technical assistance to grant funded testing sites to promote a cultural norm of biannual testing among MSM.
- Providing routine HIV screening at local public health STD testing sites.
- Utilizing surveillance data and zip code data to develop testing site locations and types in southeastern Wisconsin.

Objective: Employ a variety of testing technologies and CDC-recommended algorithms to identify undiagnosed infection at its earliest stage. [Supporting NHAS Goal 1]

Priority activities include:
- Working with the Wisconsin State Laboratory of Hygiene to validate new HIV tests and testing algorithms based on CDC recommendations.
- Promoting testing to identify acute infection in high risk populations, particularly MSM.
- Developing protocols to link clients with rapid reactive results to HIV specialty services prior to clients receiving their confirmatory results.
- Supporting high quality testing by encouraging agencies to employ or train staff in phlebotomy for tests requiring venipuncture blood samples.
- Encouraging providers serving pregnant women to make perinatal HIV testing a standard of care, and monitoring HIV testing and seropositivity in expectant women through PeriData.net.
- Consulting with clinical providers on effective implementation of routine HIV screening, providing policy and procedure support on routine HIV screening practice, including implementation of opt-out testing in accordance with current Wisconsin statutes.

Objective: Promote appropriate use of the OraQuick home (over-the-counter) rapid HIV test through communication of key information regarding the test (e.g. performance, need for follow-up testing, and linkage to medical care) to consumers and community stakeholders such as physicians, pharmacists and CTR providers.

Priority activities include:
- Developing and implementing a communication plan that includes specific messages for various stakeholder groups and identifies the means through which these messages are communicated.
- Updating the AIDS/HIV Program website to include information regarding the test for both the community and clinicians.
- Assessing the impact of the test on the use of CTR services, including the use of CTR sites to perform follow-up testing after a home rapid test.
• Working with manufacturers of the home rapid HIV testing or large national pharmacies to determine the number of tests bought in Wisconsin, and ideally, the number of positives identified.
• Working with retail outlets to ensure individuals testing positive have information and access to counseling and medical resources.

**Objective:** Coordinate testing activities among public and private providers that do not receive AIDS/HIV Program funding.
[Supporting NHAS Goal 1]

**Priority activities include:**
• Ensuring communication and collaboration between CDC-directly funded agencies and state-funded and private testing providers.
• Participating in planning activities for HIV testing at Milwaukee PrideFest and other LGBT community celebrations and events to ensure a collaborative and comprehensive approach to testing persons at higher risk for HIV.
• Promoting testing standards related to revised algorithms and linkage/retention in care activities through meetings, webinars, and electronic communication.
• Monitoring and promoting the implementation of the provisions of the Affordable Care Act regarding insurance coverage of HIV testing services.

**Focus: Reduce transmission and risk activities in high risk populations**

**Objective:** Provide client centered risk reduction counseling.
[Supporting NHAS Goals 1 & 3]

**Priority activities include:**
• Training public test sites on client-centered risk reduction counseling.
• Developing and supporting task groups to identify and support enhanced risk reduction counseling for high-risk repeat testers and persons testing positive who continue to engage in risk activities.

**Objective:** Facilitate linkage to HIV medical evaluation and HIV Partner Services.
[Supporting NHAS Goal 2]

**Priority activities include:**
• Providing training to all public test sites on linking clients testing positive to HIV specialty services.
• Requiring confidential testing as a program standard, allowing anonymous testing only in situations where the client would not otherwise be tested.
• Conducting quarterly quality assurance analysis of testing data to monitor linkages to services.
• Analyzing linkage to HIV specialty services based on client demographics, test site types, and individual agencies.
• Providing technical assistance to sites that do not meet CDC performance indicators for linking persons to HIV specialty services.
• Coordinating with Ryan White and Life Care Services to ensure linkage to and retention in care through “Linkage to Care Specialists” for clients not receiving their test results or at risk of missing an initial appointment or dropping out of care.
**Focus: Collaboration between HIV and viral hepatitis testing services**

**Objective:** Improve viral hepatitis testing to prevent new infections and liver disease. [Supporting NHAS Goal 1]

**Priority activities include:**
- Continuing to collaborate with local health departments, the Wisconsin Department of Corrections (DOC) and the Wisconsin State Laboratory of Hygiene on viral hepatitis screening initiatives that target adults at high risk.
- Improving HCV screening, counseling and testing and referral in public sites by revising and disseminating risk assessment and harm reduction screening, reference and referral materials.
- Collaborating on the pilot of hepatitis C rapid testing with PWID served by HIV prevention programs.
- Piloting and implementing an HCV rapid testing technology in 5-7 sites that currently use HIV rapid testing and serve young PWID.
- Expanding HCV rapid testing to state licensed methadone treatment facilities.
- Promoting implementation of federal guidelines for HCV testing for individuals born between 1945 and 1965.
- Encourage routine screening for viral hepatitis for HIV positive individuals.

**C. LINK**

Linkage services assist persons at high risk for or diagnosed with HIV infection in gaining access to needed services. These services focus on:
- Improving initial linkages to care immediately following HIV diagnosis.
- Establishing positive and enduring relationships between HIV positive clients and clinicians.
- Identifying individuals at risk of falling out of care and intervening to maintain them in care.
- Identifying individuals who have lapsed from care and re-engaging them in care.

For HIV positive persons, linkage services focus on ensuring access and adherence to comprehensive medical services, HIV medications, and other critical health and support services. Persons who are uninfected but at high risk for HIV transmission may need assistance in linking to and accessing health and support services as well as ongoing prevention services. Linkage services include:
- Outreach.
- Non-medical case management.
- Medical case management.
- Services directed to partners of HIV positive persons (Partner Services).
- Other support services (including information and referral).

**Outreach & Early Identification of Individuals with HIV/AIDS**

Outreach is an intervention that is usually conducted face-to-face in places where clients congregate, including needle exchange and outreach for the primary purpose of promoting counseling, testing, and referral (CTR). Outreach is typically delivered at a location of convenience to the target population and the level of intensity is not as high as that of an ILI. Outreach focuses on information dissemination, prevention messages and referral rather than
skills building and behavior change typical of ILI. This intervention is intended to introduce individuals to HIV prevention messages and recruit individuals into more intensive interventions that are directed at changes in attitudes, beliefs and high-risk behavior. The Care and Treatment Program funds outreach services that are focused on early identification of individuals with HIV/AIDS and bringing HIV positive individuals not currently in care into care and treatment services.

**Partner Services**
Partner services (PS) provide HIV positive individuals and their sexual and needle-sharing partners a range of services, including assessment of HIV-related health and human service needs and assistance in accessing services. PS staff provide follow-up to confirm that linkage has occurred. Linkage services take place when PS providers assist clients and their partners in assessing their needs and in locating service providers who can address those needs. PS providers conduct follow-up contact with clients to ensure that clients were successfully engaged with identified service providers. In Wisconsin, HIV PS is coordinated by the Wisconsin AIDS/HIV Program and provided to clients by staff in select local health departments.

**Medical and Non-medical Case Management**
Case management is directed at ensuring that HIV positive persons with complex needs receive timely, coordinated services and that resource links are made and utilized to maintain an individual’s ability to function independently in a community of their choice as long as practical. Case management involves the active participation of the client or the client’s designated representative in all aspects of the case management process. Case management encourages collaboration, cost efficiency, and service integration to avoid service duplication. HIV case management services are provided through AIDS service organizations, community-based organizations, and select HIV health care clinics.

**Linkage to Care Specialists**
In 2011, the Wisconsin AIDS/HIV Program was awarded a 4-year Linkage to Care grant by the federal Health Resources and Services Administration. The largest component of this grant is intensive, time-limited, case management services provided by Linkage to Care Specialists (LTCS). LTCS are located at agencies that serve a large number of high-risk individuals and at sites that have successfully implemented the Social Network Strategy (SNS) for testing in target populations. Throughout the duration of the project, high priority HIV positive individuals will be assigned to a LTCS who will monitor and assist clients in accessing services for a minimum of 3 medical evaluation visits over a period of up to 9 months. Prior to the conclusion of services, the LTCS will provide a close-out assessment to determine whether the client should be referred to long term case management services.

**Other Support Services**
Support services are important in assisting individuals in accessing services and staying engaged in HIV-related prevention and care services. These services can be effectively and efficiently delivered when co-located with care and treatment services. Support services subsidized with federal Ryan White and state Life Care Services funds include:
- Food bank/home-delivered meals - provision of actual food or meals and household (e.g. hygiene or cleaning) supplies.
- Legal services - provision of legal services allowable under the Ryan White Program.
- Linguistic services - provision of interpretation and translation services.
- Medical transportation - direct provision of transportation or a voucher for transportation to a client specifically to access health care services.
In Wisconsin, many of these services are either provided directly or coordinated by AIDS service organizations and other community-based organizations. Additional HIV-related support services are provided by other agencies and through a variety of funding sources such as support for housing funded under the federally funded Housing Opportunities for Persons with AIDS (HOPWA) Program administered by the Wisconsin Department of Commerce.

**Link Objectives & Priority Activities for 2012-2015**

**Focus: Linkage to Care**

*Objective:* Implement Institute of Medicine (IOM) recommendations for monitoring HIV Care in the United States.  
[Supporting NHAS Goal 2]

**Priority activities include:**
- Evaluating existing data collection mechanisms and performing a capacity assessment of funded providers to track recommended indicators.
- Implementing tracking of IOM recommended indicators.

*Objective:* Ensure access to linkage to care services for all high risk populations across Wisconsin.  
[Supporting NHAS Goals 2 & 3]

**Priority activities include:**
- Establishing partnerships with non-traditional providers such as non-Ryan White funded Federally Qualified Health Centers (FQHC) and community health centers to ensure awareness of interventions and availability of services.
- Providing technical assistance and capacity building support to non-traditional providers in assessing rates of retention and improving retention in care.

*Objective:* Ensure linkage to both medical and supportive services.  
[Supporting NHAS Goal 2]

**Priority activities include:**
- Evaluating client to determine health and supportive care needs.
- Linking client to health care including HIV specialty care, primary health care, dental care, and other health care as needed.
- Linking client to relevant supportive services (i.e.: housing assistance, food banks, transportation assistance, etc.) that promote adherence to health care.

*Objective:* Deploy an algorithm for identification of acute HIV infection.  
[Supporting NHAS Goals 1 & 2]

**Priority activities include:**
- Refining and distributing an acute HIV testing algorithm to identified testing sites.
- Piloting acute HIV screening at multiple CTR sites throughout the southern and southeastern regions.
- Referring clients with newly identified HIV infection at HIV counseling, testing, and referral (CTR) sites to Linkage to Care Specialists (LTCS).
**Objective:** Identify and train LTCS to facilitate initial linkages and retention in care for high risk HIV positive individuals.
[Supporting NHAS Goals 2 & 3]

*Priority activities include:*
- Contracting with local community organizations for 10 LTCS to pilot the health navigator intervention.
- Developing and delivering training to identified LTCS.
- Defining linkage to care service and activities.
- Generating an algorithm for assignment of priority cases to LTCS.

**Objective:** Develop profile of patients “at risk” for falling out of care.
[Supporting NHAS Goals 2 & 3]

*Priority activities include:*
- Compiling data from clinical and community HIV providers on socio-behavioral factors that are indicative of individuals likely to fall out of care.
- Utilizing data to develop a “profile” that will assist HIV treatment centers in targeting resources effectively.
- Establishing systematic mechanisms for sharing care-related health information between AIDS/HIV Program and community providers.

**Objective:** Collaborate with the Department of Corrections (DOC) to establish stronger systematic linkages and re-engagement support for individuals being released from incarceration.
[Supporting NHAS Goals 2 & 3]

*Priority activities include:*
- Offering all HIV positive individuals, with scheduled release dates and plans to locate to the southern or southeastern regions from the Department of Corrections, the opportunity to work with a LTCS.
- Coordinating discharge planning efforts with clinic based LTCS or case managers.

**Focus: Partner Services (PS)**

**Objective:** Increase the number of sexual and needle-sharing partners, of HIV positive individuals, notified through Internet Partner Services (IPS).
[Supporting NHAS Goals 1 & 3]

*Priority activities include:*
- Intensifying training of local PS providers regarding the implementation of IPS.
- Informing HIV care providers (case managers, clinicians, other providers) about the availability of IPS and the importance of partner-specific Internet and social media contact information in PS.

**Objective:** Reduce the number of single-jurisdictional PS agencies from 11 agencies to 6.
[Supporting NHAS Goals 1, 2 & 3]

*Priority activities include:*
- Reinitiating discussions with state and local health department staff in the Western Region regarding regionalization of PS.
• Negotiating and establishing contracts with local health departments for the implementation of multi-jurisdictional PS.
• Providing consultation and technical assistance to new multi-jurisdictional agencies.

Objective: Increase the usability and implementation Partner ServicesWeb database by local PS providers. [Supporting NHAS Goals 1, 2 & 3]

Priority activities include:
• Developing and disseminating user-friendly Partner ServicesWeb policies and procedures.
• Collaborating with the Partner ServicesWeb vendor in refining Partner ServicesWeb.
• Intensifying consultation and technical assistance regarding local PS provider implementation of Partner ServicesWeb.

Objective: Increase HIV care and service providers knowledge and understanding of PS. [Supporting NHAS Goals 2 & 3]

Priority activities include:
• Developing and disseminating PS print and electronic promotional materials among HIV service providers.
• Participating in presentations at case managers and HIV treaters meetings and trainings.

Objective: Collaborate with state and local STD public health staff in identifying individuals at risk for HIV and provide timely HIV counseling, testing, and linkage to care services. [Supporting NHAS Goals 1, 2 & 3]

Priority activities include:
• Identifying public health agencies and staff providing STD services in LHDs responsible for providing HIV PS.
• Collaborating with local PS providers in facilitating discussions and joint efforts in LHDs to identify, screen, and routinely test persons who are at risk for HIV and other STDs, to facilitate linkage to care, and to elicit and refer at-risk partners to PS and other needed services.

Objective: Monitor HIV PS data to identify acute HIV cluster infections. [Supporting NHAS Goals 1 & 3]

Priority activities include:
• Ongoing monitoring and analysis of HIV PS data to identify trends and potential targeted epidemiologic investigations.
• Collaborating with state HIV surveillance, epidemiology and LHD staff in planning, implementing, and evaluating select contact and cluster investigations.

D. TREAT

Treatment services promote the health of HIV positive persons through the direct provision of primary medical care and other core medical services, the provision of and referral to support services directed at improving access and adherence to care, and the integration of prevention services with HIV-related and other primary care medical services for persons living with HIV.
The federal agency HRSA, under Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, identifies core medical services to include:

- Primary medical care.
- Medical case management (including treatment adherence).
- Early intervention services.
- Medical nutrition therapy.
- Medications.
- Oral health.
- Mental health.
- Substance abuse.
- Health insurance assistance.

Publicly funded care services typically have eligibility requirements that clients must meet in order to participate in a program.

**Primary Medical Care**
Primary medical care is HIV-related routine health care that is provided in an outpatient clinical (non-hospital) setting and includes professional diagnostic and therapeutic services that are usually provided by a physician, physician’s assistant, clinical nurse specialist, or nurse practitioner. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, diagnosis and treatment of common physical and mental health conditions, prescribing medications and medication management, education and counseling on health issues, continuing care and management of chronic conditions, monitoring of CD4 counts and viral loads, and referral to and provision of specialty care. Private medical providers are the primary source of HIV-related health care for persons with HIV infection in Wisconsin. Clinical care settings include private medical clinics, academic medical centers, Federally Qualified Health Centers, and other community-based medical facilities. Many HIV-related primary care services in Wisconsin are supported with federal funding under the Ryan White HIV/AIDS Treatment Extension Act.

**Medical Case Management**
Medical case management includes a range of client-centered services that link clients with health care, non-medical and other services. These services focus heavily on coordination and follow-up of medical treatments and provision of treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS treatment with the goal of clients achieving an undetectable viral load. These services are necessary to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care. Medical Case Managers also conduct prevention for positives activities to promote healthy relationships and prevent disease transmission.

**Early Intervention Services**
Early intervention services include counseling individuals with respect to HIV/AIDS, testing, providing referrals, conducting periodic medical evaluations for individuals with HIV/AIDS, and providing therapeutic measures.

**Medications**
Current medications in managing HIV disease include antiretroviral drugs and other medications which prevent or treat health conditions associated with HIV infection. Since the advent of HAART in the 1990’s, there has been a dramatic increase in the health and longevity of individuals who start HAART early in the course of HIV infection. In Wisconsin, the AIDS/HIV Drug Assistance Program (ADAP) provides drug coverage to financially needy persons for the
treatment of HIV infection and AIDS. The ADAP is designed to maintain the health and
independence of persons living with HIV infection in Wisconsin by providing access to HIV-
related antiretroviral drugs, HIV-related prophylactic drugs, and hepatitis C medications as well
as vaccines for hepatitis A and B.

Oral Health Care
Oral health care is an important part of the overall health care of persons with HIV infection.
Poor oral health can adversely affect quality of life by complicating medical conditions and by
interfering with medication adherence, especially when pain or discomfort interferes with a
person’s ability to manage daily routines. Oral health care includes diagnostic, preventive, and
therapeutic services typically provided by general dental practitioners, dental specialists, dental
hygienists and auxiliaries, and other trained primary care providers.

Mental Health
Persons living with HIV may experience a range of mental health issues at different points in
their life. These issues vary greatly, ranging from emotional distress associated with living with a
chronic illness, to depression and anxiety occurring as a result of learning one’s HIV status, to
severe mental illness. Mental health services which support persons living with HIV take many
forms, including psychosocial support groups, individual and group counseling, intensive
psychotherapy, medication management, and hospitalization. To identify mental health service
needs, persons living with HIV need access to primary care providers who are skilled in
screening for mental health issues and mental health professionals.

Substance Abuse
Persons living with HIV have disproportionately high rates of substance use and abuse
compared to the general population. Substance abuse adversely affects risk reduction
behaviors, increases morbidity, and decreases the quality of life and access and adherence to
HIV medications. Persons living with HIV and substance abuse need access to: a.) primary care
providers skilled in screening for substance abuse problems, referring to treatment, and tailoring
HIV medical treatment to diverse lifestyles and substance abuse treatment interactions. They
also need access to mental health professionals competent in providing culturally sensitive
substance abuse services.

Health Insurance Premium & Cost Sharing Assistance
These services consist of financial assistance for eligible individuals living with HIV to maintain
continuing health insurance coverage or to receive medical benefits under a health insurance
program. The AIDS/HIV Health Insurance Premium Subsidy Program purchases group health
continuation coverage (COBRA), Medicare supplement policies, Medicare Part D Prescription
Drug Plans, and individual health insurance policies for persons living with HIV and AIDS. For
eligible uninsured individuals, the Insurance Program purchases silver-level coverage through
the federal Marketplace. The AIDS/HIV Health Insurance Premium Subsidy Program purchases
the silver-level policies with prescription drug coverage for participants, which expands access
to care for participants and saves ADAP funds. This is because the cost to pay for the silver-
level premiums, pharmaceutical deductibles, and co-insurance is less than the full cost of ADAP
covered medications for these individuals.

Medical Home
While the category of “medical home” is not a fundable service under Ryan White, to better
coordinate all aspects of care, the AIDS/HIV Program is encouraging the development of
medical homes. In the medical home model each patient is assigned a care team, composed of
medical care and support service staff, who work as a unit to identify client needs and develop a
care plan to address each need. The AIDS/HIV Program has collaborated closely with the Wisconsin Medicaid Program and the two state-designated AIDS service organizations (AIDS Resource Center of Wisconsin and AIDS Network) to develop the HIV Medical Home model and negotiate the terms of the State Plan Amendment approved by the Centers for Medicaid and Medicare Services in January 2013. All agencies receiving Ryan White and/or Life Care Services funding are expected to coordinate all aspects of client care by providing services in house or establishing partnerships to make and accept care referrals. In late 2011 the Program issued a Request for Proposal (RFP) to determine Ryan White Part B contractors. The RFP required applicants to “demonstrate the ability to work jointly with other providers to ensure that needed services are coordinated and that clients experience a seamless continuum of care.” A client will be more likely to adhere to care and obtain better health outcomes when medical and support needs are coordinated by a central contact.

**Treat Objectives & Priority Activities for 2012-2015**

**Focus: Ryan White Initiatives**

*Objective:* Expand HIV care delivery and capacity.  
[Supporting NHAS Goal 2]

**Priority activities include:**
- Contracting Ryan White Part B funds to AIDS service organizations and community based organizations that have the ability and capacity to provide core medical care and coordinate support services in a clinical setting.
- Developing strategies to improve access to care for underserved populations.
- Coordinating efforts with Ryan White Part C and D grantees to ensure efficient and effective use of resources and to prevent service duplication.
- Encouraging improved mental health and substance abuse screenings, organizing trainings for providers, and increasing funding for mental health and substance abuse care.
- Ensuring the viability of the ADAP and client access to antiretrovirals by reducing costs through increased efficiencies, aggressively pursuing pharmaceutical company rebates, and maximizing federal grant opportunities and state general purpose revenue funds.

*Objective:* Enhance program assessment, planning, and evaluation activities to promote improved health outcomes.  
[Supporting NHAS Goal 2]

**Priority activities include:**
- Identifying barriers to services through a statewide needs assessment of both providers and consumers.
- Collaborating with the SAPG, Wisconsin’s joint prevention and care planning body.
- Continuing development of prevention and care joint initiatives such as the Linkage to Care program.

*Objective:* Assess the impact of the Affordable Care Act (ACA) on the Ryan White and Life Care Services Programs.
Priority activities include:

- Monitoring the implementation of 2014 provisions related to Medicaid eligibility.
- Monitoring Wisconsin Medicaid’s implementation of the ACA provision related to Medicaid eligibility.
- Monitoring impact of the ACA on the reauthorization of the Ryan White Program.
- Educating providers and clients on the Ryan White and Life Care Services benefits in light of ACA enactment.
- Monitoring the 2014 Health Insurance Marketplace provision that will provide access to health insurance.

Objective: Increase cultural competency of services and providers.

Priority activities include:

- Supporting the work of MATEC, providers, and other key stakeholders in improving the diversity of the health and supportive workforce.
- Developing agency cultural competence indicators and performance measures to ensure individuals receive appropriate care.

Objective: Ensure access to care for foreign born or undocumented individuals.

Priority activities include:

- Supporting outreach efforts that inform minority communities about available services for undocumented individuals.
- Educating providers that Ryan White services are available to individuals not eligible for other state or federal programs because of citizenship requirements.
- Promoting partnerships with immigrant and alien service organizations to promote access to Ryan White services.

Objective: Enhance access to care.

Priority activities include:

- Continuing utilization of Minority AIDS Initiative funding to increase the number of minority individuals enrolled in the ADAP and AIDS/HIV Insurance Premium Subsidy Programs.
- Utilizing Emerging Communities funding to increase access to care for minority individuals in the Milwaukee Metropolitan Statistical Area.
- Ensuring uninsured individuals have access to comprehensive health care through the AIDS/HIV Insurance Premium Subsidy Program.
- Educating and encouraging eligible individuals to access health care coverage through Medicaid or the federal Marketplace.
- Promoting partnerships with Federally Qualified Health Centers to provide low income individuals with more quality care options.

Objective: Ensure the delivery of quality services.

[Supporting NHAS Goal 2]

Priority activities include:
- Continuing support of MATEC monthly treaters meetings where medical providers share case studies and best practices.
- Continuing the development of uniform performance measures that ensure all clients receive quality care.
- Collaborating with the SAPG and providers to ensure that people living with HIV are aware of available services and know how to access services.
- Promoting care coordination activities to ensure that clients receive comprehensive and complimentary care.

Objective: Enhance care coordination.

[Supporting NHAS Goal 2]

Priority activities include:
- Developing a networked system to monitor the services provided and where the services are provided.
- Developing a medical home model that utilizes a team approach to ensure that patient care and supportive needs are addressed.
- Facilitating communication opportunities between providers on the care continuum to increase care services while reducing service overlaps.
- Expanding efforts and opportunities for the Early Identification of Individuals with HIV/AIDS and linking them to care.

Objective: Promote the continuing development of Ryan White program effectiveness.

[Supporting NHAS Goal 2]

Priority activities include:
- Collaborating with federal partners on program reauthorization.
- Coordinating activities with the Affordable Care Act to maximize care resources.

Focus: HIV Case Management

Objective: Develop standards for medical case management.

[Supporting NHAS Goal 2]

Priority activity:
- Assembling a provider workgroup to define medical case management services, developing standards of practice, and refining performance measures.

Objective: Revise & update standards for non-medical case management to stay current with state and federal initiatives.

[Supporting NHAS Goal 2]

Priority activities include:
- Incorporate linkage to care activities into non-medical case management programs for lower priority populations.
- Revising service definition, requirements and quality assurance activities.
**Objective**: Provide continuing education for case managers funded by the Ryan White and LCS programs.

[Supporting NHAS Goal 2]

**Priority activities include:**
- Developing ongoing education targeted towards skills building for case managers working in both medical and non-medical settings.

**Objective**: Ensure the availability of medical case management services in HIV specialty clinics.

[Supporting NHAS Goal 2]

**Priority activities include:**
- Building the capacity of existing Ryan White funded clinical settings to provide medical case management services.
- Forging new partnerships among non-Ryan White funded, high-volume clinical settings to ensure knowledge of case management and linkage to care services.

**Objective**: Expand availability of case management training.

[Supporting NHAS Goal 2]

**Priority activities include:**
- Developing and providing more online and distance learning opportunities for training and professional development.

**Objective**: Reduce case load burden for case managers by promoting client self-management.

[Supporting NHAS Goal 2]

**Priority activities include:**
- Support short-term, intensive case management activities of LTCS that will develop client skills and knowledge resulting in less need for on-going case management services.
- Shifting existing case management resources toward high risk populations through specific, high impact interventions such as medical case management and linkage to care.
- Promote brief case management services for low acuity clients to ensure case load room for all high acuity clients.
- Support efforts to provide self-management trainings (i.e.: budgeting and finance counseling, treatment adherence counseling, etc.)

**Objective**: Improve quality monitoring of Ryan White and Life Care Services funded providers.

[Supporting NHAS Goal 2]

**Priority activities include:**
- Revamping existing annual audit processes.
- Improving data collection and analysis from existing service providers.
Focus: Viral Hepatitis

Objective: Improve viral hepatitis care and treatment to prevent liver disease.
[Supporting NHAS Goals 2 & 3]

Priority activities include:
- Supporting efforts to maintain and improve access to HCV treatment medications through Medicaid and patient assistance programs.
- Assessing and analyzing the impact and scope of healthcare costs associated with HCV.
- Promoting integrated care by developing a network of physicians trained to provide prevention and care services for persons at risk for or infected with viral hepatitis.
- Encouraging routine screening for viral hepatitis for HIV positive individuals.

Focus: Wisconsin AIDS Drug Assistance Program (ADAP) & AIDS/HIV Health Insurance Premium Subsidy Program

Objective: Continue prescription drug assistance and insurance premium assistance to eligible HIV-positive individuals who are not insured or are underinsured.
[Supporting NHAS Goals 2 & 3]

Priority activities
- Monitoring program budget and expenditures to ensure sufficient funds are available.
- Reviewing program utilization monthly.
- Updating ADAP and the AIDS/HIV Health Insurance Premium Subsidy Program budget forecasts quarterly.
- Prioritizing all Food and Drug Administration (FDA) approved antiretroviral medications for ADAP coverage.
- Identifying and purchasing the most cost effective health insurance coverage available that includes prescription drug coverage.
- Developing contingency plans for cost containment strategies if available funding is projected to be insufficient to meet program needs.

Objective: Assess the impact of the Affordable Care Act (ACA) on ADAP and the AIDS/HIV Health Insurance Premium Subsidy Program.
[Supporting NHAS Goals 2 & 3]

Priority activities
- Monitoring the implementation of 2014 provisions related to Medicaid eligibility.
- Monitoring Wisconsin Medicaid’s implementation of the ACA provisions related to Medicaid eligibility.
- Monitoring the 2014 Health Insurance Marketplace provision that will provide access to health insurance.
- Verifying that ADAP expenditures are counted toward the true out-of-pocket (TrOOP) cost for program participants with Medicare Part D prescription drug coverage to reduce costs for participants and maximize the cost efficiency for ADAP.

Objective: Enhance quality assurance activities for ADAP and the AIDS/HIV Health Insurance Premium Subsidy Program.
[Supporting NHAS Goals 2 & 3]

Priority activities
• Implementing HRSA/ADAP performance measures related to application determination, eligibility recertification, and formulary requirements.
• Analyzing data to identify suboptimal treatment regimens and follow-up with providers.
• Revising recertification process to optimize efficiency and adhere to HRSA’s guidelines.
• Analyzing program usage and completing financial audits to ensure accuracy.

**Objective:** Reduce disparities in access to care through the ADAP and AIDS/HIV Health Insurance Premium Subsidy Program.
[Supporting NHAS Goals 2 & 3]

**Priority activities**
• Promoting awareness of AIDS/HIV drug assistance programs to increase the number of HIV-positive individuals receiving treatment.
• Working closely with health care providers and service agencies to conduct outreach to minority individuals with HIV infection to enroll them in ADAP and other health care and support services.

**Objective:** Streamline processes to reimburse pharmacies for covered medications and to make health insurance premium payments.
[Supporting NHAS Goals 2 & 3]

**Priority activities**
• Ongoing electronic claims processing utilizing Medicaid’s InterChange system.
ADDENDUM I

WEB LINKS TO EPIDEMIOLOGIC PROFILES & WEB-BASED RESOURCES

**Wisconsin AIDS/HIV Surveillance Annual Report:**
Cases Reported through December 31, 2014
http://www.dhs.wisconsin.gov/publications/P0/P00484.pdf

**Other Wisconsin HIV Surveillance and Statistical Reports**
http://www.dhs.wisconsin.gov/aids-hiv/Stats/index.htm

**Practice Standards and Administrative Guidelines for HIV related Non-medical Case Management**
https://www.dhs.wisconsin.gov/publications/p0/p00829.pdf

**Quality Management Plan for Ryan White Part B and Life Care Services Funded Programs**
https://www.dhs.wisconsin.gov/publications/p0/p00830.pdf

**Resources for Wisconsin Clinicians**
http://www.dhs.wisconsin.gov/aids-hiv/ClinicianResources/index.htm

**Wisconsin AIDS/HIV Program**
http://www.dhs.wisconsin.gov/aids-hiv/

**Wisconsin AIDS/HIV Program Notes**
https://www.dhs.wisconsin.gov/aids-hiv/notes.htm

**Wisconsin Hepatitis C Program**
https://www.dhs.wisconsin.gov/viral-hepatitis/hcv-program.htm

**Wisconsin State Health Plan: Healthiest Wisconsin 2020**
http://www.dhs.wisconsin.gov/hw2020/

**Healthiest Wisconsin 2020 Baseline and Health Disparities Report**
ADDENDUM II

REVIEW OF 2009 WISCONSIN HIV COMPREHENSIVE PLAN:
MAJOR RYAN WHITE RELATED ACCOMPLISHMENTS

This Addendum addresses a HRSA requirement for review of a prior comprehensive plan. In 2009, the Wisconsin AIDS/HIV Program created the Wisconsin HIV Comprehensive Plan. This document consolidated planning activities for Wisconsin HIV prevention and care services into a single living document that was updated no less than annually. The Comprehensive Plan was organized based on the conceptual framework of Prevent-Test-Link-Treat, which supports integrated planning and service implementation to ensure optimal use of resources and outcomes for people living with HIV and populations at risk for HIV infection.

The 2009 Wisconsin HIV Comprehensive Plan had four overarching goals:
• Goal 1: Eliminate health disparities so that all people living with HIV in Wisconsin receive needed HIV medical care, treatment, and social support.
• Goal 2: Improve access to quality medical care and needed social support services.
• Goal 3: Develop strategies that identify the needs of people living with HIV who are not in care or who are lost to care, especially the needs of historically underserved populations.
• Goal 4: Strengthen the continuum of care between HIV prevention and care services.

While these goals, by their very nature and focus, have ongoing activities supporting them, significant achievements have been made. The following are major accomplishments of Ryan White related activities that evolved from the 2009 Comprehensive Plan.

• The AIDS/HIV Programs is one of seven demonstration states selected to develop an innovative and replicable model to successfully link and retain individuals in care. The Wisconsin model encompasses all four goals of the Comprehensive Plan. The model involves strong collaboration throughout the care continuum, from identification of HIV positive individuals to the successful enrollment of individuals in care and support services. The initial focus group is on young MSM of color, a group that has been disproportionately impacted by the HIV epidemic. Through the use of Linkage to Care Specialists, the model is focusing on linking HIV positive individuals to the best care and support services to meet identified needs. The model also has a component focused on re-engaging individuals who have fallen from care.

• In November 2011, the AIDS/HIV Program conducted a Request for Proposal competitive process to identify providers for Ryan White Part B services. The successful applicants demonstrated ability to 1) provide efficient and effective care 2) provide culturally competent care 3) serve a largely uninsured or underinsured population 4) provide care statewide with a focus on Milwaukee and rural areas and 5) have the ability to make referrals by demonstrating established relationships with prevention and other service providers.

• The AIDS/HIV Program continues to operate the ADAP and AIDS/HIV Health Insurance Premium Subsidy Programs without having to implement a wait list or other cost containment initiatives. This ensures that the most vulnerable individuals continue to have access to life saving medications.

• Relationships with non-traditional providers have been developed through the ongoing support of the monthly Treaters meetings, quarterly meetings with Department of
Corrections staff, publication of the monthly *Program Notes*, and participation in the learning sessions for the Linkage to Care grant.

Even with these achievements, work remains to be done. The newly developed *WHAS* continues to align activities overseen by the Wisconsin AIDS/HIV Program within the Prevent-Test-Link-Treat framework utilized in the 2009 Wisconsin HIV Comprehensive Plan. All activities are designed to meet identified needs, gaps, and continuing challenges. Activities can be found in the following sections of the *WHAS*:

- Prevent: pages 29-37.
- Test: pages 37-42.
- Link: pages 42-46.
- Treat: pages 46-54.
CDC HIV Prevention Cooperative Agreement funding in Wisconsin
Wisconsin is eligible for and receives Category A: HIV Prevention Programs for Health Departments funding from CDC, currently under Funding Opportunity Announcement PS12-1201. Wisconsin also receives Category C: Demonstration Projects to Implement and Evaluate Innovative, High Impact HIV Prevention Interventions and Strategies which is awarded on a competitive basis. Wisconsin is not eligible for funding under Category B: Expanded HIV Testing for Disproportionately Affected Populations.

Category A
The Wisconsin Department of Health Services is the grantee for HIV Prevention Category A funds. These funds are awarded as base funding by the CDC, and are determined for each state by the CDC using a formula partially based on local HIV seroprevalence and incidence. A new five-year grant cycle for CDC HIV Prevention Cooperative Agreement funding began on January 1, 2012.

The CDC identified the following four Core Component Interventions for the PS12-120 funding cycle:

- Targeted HIV testing.
- Prevention for HIV-positive persons, including HIV partner services.
- Condom distribution.
- Policy initiatives.

Additionally, the CDC listed the following three Required Activities for the grant period:

- Jurisdictional HIV planning.
- Capacity building (CB) and technical assistance (TA).
- Program planning, monitoring and evaluation, and quality assurance (QA).

Finally, the CDC outlined the following three optional Recommended Components:

- Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk.
- Social Marketing, Media and Mobilization.
- Pre-exposure Prophylaxis and Non Occupational Post-exposure Prophylaxis Services.

The Prevention grants fund thirteen organizations that have demonstrated the ability to provide culturally competent HIV prevention services effectively targeted to persons at highest risk for HIV infection. HIV prevention services are collocated with clinical services whenever possible.

Contracted agencies for 2013 include:

- AIDS Network
- AIDS Resource Center of Wisconsin
- Beloit Area Community Health Center
- BESTD Clinic
- Black Health Coalition
- Diverse and Resilient, Inc.
- OutReach, Inc.
- Pathfinders, Inc.
- Sixteenth Street Community Health Center
- STD Specialties
• United Migrant Opportunity Services (UMOS)
• Youth Services of Southern Wisconsin (Youth SOS)

Additionally, several local health departments received funding to conduct HIV Partner Services and/or Disease Investigative Specialist services. These health departments include:
• Brown County
• Eau Claire City/County
• Kenosha County
• La Crosse County
• Public Health of Madison and Dane County
• Marathon County
• City of Milwaukee Health Department
• Racine County
• Rock County
• Waukesha County
• Winnebago County

Finally, grants were given to tribal HIV coordinators at eleven different tribal nations within Wisconsin:
• Bad River
• Ho Chunk
• Lac Courte Oreilles
• Lac du Flambeau
• Menominee
• Oneida
• Potawatomi
• Red Cliff
• Sokaogon
• St. Croix
• Stockbridge-Munsee

**Category C**
The following Wisconsin providers were awarded Category C funding in 2013 to continue and expand the efforts around the EndHIV project in Milwaukee, Wisconsin:

- **Diverse and Resilient, Inc.** receives funds to support the next phase of the Acceptance Journeys social marketing campaign, which was developed in response to the results of the 2010 EpiAid investigation in Milwaukee.
- **Black Health Coalition** receives funds to conduct a community mobilization intervention with young Black MSM in Milwaukee.
- **Milwaukee City Health Department** receives funding to support a CDS (Community Disease Specialist) to focus on HIV and syphilis partner services efforts with young MSM of Color.
- **Pathfinders** is funded for a structural level intervention targeting runaway and homeless GBT males.

**Beyond the CDC HIV Prevention Cooperative Agreement**
Wisconsin has been fortunate to have executive and legislative support of the AIDS/HIV
Program. In 2012, the AIDS/HIV Prevention Program was given $260,000 in Wisconsin General Purpose Revenue (GPR) to target HIV prevention outreach to out-of-treatment injection drug users. An additional $566,200 in GPR was budgeted for HIV prevention programming at Wisconsin's two AIDS Service Organizations (ASOs). A special faith-based HIV Prevention project conducted in Milwaukee by Black Health Coalition was supported by $50,000 in GPR for 2012, and $113,800 of GPR was used to support fee-for-service HIV testing, mostly conducted through local health departments. The Program also has an additional $75,000 each year for HIV Prevention as part of the AODA block grant.

**HIV prevention programs in Wisconsin receiving funds directly from Federal sources**

In 2012, several major federal awards are directly supporting HIV prevention efforts. Both awards target MSM of color in the greater Milwaukee area:

- The CDC awarded Diverse and Resilient, Inc. funding under Funding Opportunity Announcements PS10-1003 and PS11-1013. This funding supports various behavioral interventions with persons at increased risk for HIV, particularly young MSM and MSM of Color. Funded projects include
  - **BE ABLE**: Group-level intervention for HIV- Black gay and bisexual men, ages 21-35, to discuss issues in the community with the purpose of reducing HIV transmission.
  - **mPOWERMENT**: Community-level intervention for young gay and bisexual men of various races, ages 14-21, to shape a healthy community for themselves, build positive social connections, and support their friends to have safer sex.
  - **Counseling and Testing**: MSM of color, ages 13-29.
  - **Personalized Cognitive Counseling**: An individual-level single session counseling intervention for young MSM of color who are repeat HIV testers.
  - **Community Promise**: Role model stories created based on interviews with young gay and bisexual men of color, ages 13-29 that have made positive behavior change. Peer advocates are recruited from the target population and trained to distribute stories to social networks.
  - **Comprehensive Risk Counseling and Services (CRCS) and Choosing Life: Empowerment! Action! Results! (CLEAR)**: Client-centered, individual-level intervention with HIV positive MSM of colors, ages 13-29, using cognitive behavioral techniques to change behavior.

  This funding runs from 2010-2016, and approximately $650,000 a year.

- SAMHSA awarded the AIDS Resource Center of Wisconsin (ARCW) funding for 2012 – 2016 to support two behavioral interventions directed at young MSM of color and high risk heterosexual women in order to reduce and eliminate the occurrence of substance abuse and HIV infection within these populations. SAMHSA is providing approximately $300,000 a year for this effort.

- The National Institute of Mental Health has awarded the Center for AIDS Intervention Research (CAIR) within the Medical College of Wisconsin to research social networks. This three site study (Milwaukee, Miami, and Cleveland) will examine the effectiveness of using social networks to increase safer sex norms and to decrease risky sexual behaviors for 18-29 year Black MSM who are members of social networks and engaged in risky sexual behavior. Funding runs 2010-2015 and is $800,000 a year divided between the three study sites. CAIR has also received supplemental funding from
NIMH to examine linkage and retention in care from multiple perspectives through interviews with testers at counseling, testing, and referral (CTR) sites, individuals at clinics or organizations that have identified new HIV diagnoses but are not CTR sites, Partner Services staff, and African American MSM living with HIV.

HRSA Ryan White funding in Wisconsin
Wisconsin is eligible for and receives funding under four Ryan White Parts: B, C, D, and F.

Part B
The Wisconsin Department of Health Services is the grantee for Ryan White Part B funds. These funds encompass:
- Formula funds supporting contracts for direct services at eight agencies and supporting the AIDS/HIV Health Insurance Premium Subsidy Program.
- ADAP funds supporting the provision of medications and health insurance through the ADAP and Insurance programs.
- ADAP supplemental funds supporting the provision of medications in the ADAP.
- Emerging Communities supporting the provision of direct services in the Milwaukee MSA.
- Minority AIDS Initiative funds supporting efforts to minority patients with the ADAP.

In November 2011, the Wisconsin Department of Health Services conducted a Request for Proposal (RFP) to award Part B funds through 2016. Based on review of identified service needs and gaps, it was determined that nine services were most needed and would be eligible for Part B funding. The nine services are:

**Core Services**
- Outpatient/ambulatory medical care.
- Oral health care.
- Mental health services.
- Outpatient substance abuse services.
- Medical case management

**Support Services**
- Non-medical case management.
- Housing services.
- Legal services
- Medical transportation

As a result of the RFP process, seven agencies were awarded contracts to provide Part B core and support services. The contracted agencies include:
- AIDS Network
- AIDS Resource Center of Wisconsin
- Legal Aid Society of Milwaukee
- Medical College of Wisconsin – Department of Pediatrics
- Medical College of Wisconsin – Infectious Disease Clinic
- Milwaukee Health Services, Inc.
- Sixteenth Street Community Health Center
- University of Wisconsin Hospital and Clinics

In determining how to distribute funds, some key factors were considered including:
• Epidemiologic profile: The majority of Wisconsin's cases are located in the southeastern region of the state. To address this trend just over 60% of funds are directed to this region.
• Cultural competency: Consistent with national trends, member of minority populations are much more likely to be impacted by HIV than their white counterparts. Selected agencies had to demonstrate the ability to reach and serve target populations.
• Uninsured status: As Ryan White funds are a payer of last resort, it was important that agencies provide services to clients who lack other resources and care options.
• Established networks: If agencies were unable to provide a service on site, they had to demonstrate the ability to make referrals and follow up on the referrals to ensure client needs were addressed.

Additionally, Sixteenth Street Community Health Center and Milwaukee Health Services are the contracted providers for the Minority AIDS Initiative funds. Each clinic serves a patient base that has more than a 90% minority composition. Sixteenth Street Community Health Center focuses on the Hispanic community while Milwaukee Health Services focuses on the Black community.

Part C
Four Wisconsin providers are Ryan White Part C grantees.
• **AIDS Resource Center of Wisconsin** receives funds to provide outpatient/ambulatory care and oral health care;
• **Milwaukee Health Services** receives funding for medications, outpatient/ambulatory medical care, oral health care, early intervention services, mental health services, outpatient substance abuse services, non-medical case management, health education and risk reduction, medical transportation, and outreach services;
• **Sixteenth Street Community Health Center** receives funds to provide medications, outpatient/ambulatory medical care, medical case management, oral health care, early intervention services, mental health services, health education and risk reduction, and outreach services; and
• **University of Wisconsin Hospital and Clinics** receive funding for medications, outpatient/ambulatory medical care, medical case management, oral health care, mental health services, and benefits and disability counseling.

Part D
The Medical College of Wisconsin – Department of Pediatrics is Wisconsin’s sole recipient of Ryan White Part D funds. The funds support the Primary Care Network which provides services to HIV positive pregnant women, children, and their families. Funded services include medications, medical case management, mental health services, outpatient substance abuse services, emergency financial assistance, food bank/home delivered meals, health education and risk reduction, linguistic services, medical transportation, outreach services, psychosocial support services, and community treatment adherence counseling.

Part F
Ryan White Part F funds the AIDS Education and Training Centers (AETC) and demonstration projects through the Special Projects of National Significance (SPNS) initiatives.

Wisconsin is part of the Midwest AIDS Training and Education Center (MATEC) based at the University of Illinois at Chicago and receives Part F funding as an AETC. The Wisconsin site of MATEC is part of the University of Wisconsin at Madison. Part F funds provide technical assistance, training, and education opportunities to HIV medical providers.
The Wisconsin Department of Health Services receives two Part F grants. One grant supports the rebuild of the ADAP database to ensure it meets HRSA specifications to collect and generate the data necessary to complete the annual ADAP Data Report. The second grant provides funding as part of a four year SPNS initiative to develop an innovative and replicable Linkage to Care model.

Beyond Ryan White
Wisconsin has been fortunate to have executive and legislative support of the AIDS/HIV Program. Wisconsin Statute 252.12(2)(a)8. created the Michael Johnson Life Care Services and Early Intervention Program and provides over $3.5 million in state revenue to support the work of Wisconsin’s two AIDS service organizations. Additionally, state revenues provide over $6.2 million in support for the ADAP.

The Wisconsin Medicaid Program is also a primary provider of medical care services for Wisconsin’s HIV positive individuals. Annually, the Medicaid Program pays more than $30 million to providers to render care and treatment services for HIV positive individuals.

Funds are also available to agencies and providers through non-governmental grants. Many corporations and philanthropic organizations provide grants that can be used to provide services that may be restricted under governmental programs.

How do all of these come together?
The Wisconsin AIDS/HIV Program works to support the efforts of all HIV service providers regardless of contractual relationship.

- Bi-monthly meetings of HIV Prevention providers are conducted in the Milwaukee area, so agency staff can work together on common challenges and share strategies for reaching target populations.
- HIV Prevention staff hold quarterly meetings in the Madison Metro area and in the Fox Valley metro area where funded HIV prevention providers, local health departments and community-based organizations serving at-risk communities develop strategies around coordinated observance of HIV-related awareness days (World AIDS Day, HIV Testing Day, etc.) and discuss long-term objectives for HIV prevention in their community.
- Through a contract with MATEC, monthly meetings are held that bring together providers from across the state to present case histories and discuss best practices, treatments, and care options.
- The periodic newsletter Wisconsin AIDS/HIV Program Notes is sent to all tribal clinics, all local public health departments, over 40 individual clinicians, HIV prevention and care service providers, infection preventionists, and other partners to keep them informed on new policies, programs, studies, and treatment guidelines.
- As of February 2011, all lab results for CD4 counts and viral loads are required to be submitted to the AIDS/HIV Program’s Surveillance Unit, allowing the Program to better monitor the community viral load.
- A key component of the SPNS Linkage to Care initiative is to foster stronger communication and relationships with non-traditional providers. A quarterly newsletter and annual learning sessions keeps all partners and stakeholders informed on the project’s progress and successful strategies that can be implemented at the local level. This initiative is also providing a format to demonstrate the mutual benefits of information exchanges and encouraging non-traditional providers to work cooperatively with the Program and Ryan White funded colleagues.
• The HIV Counseling, Testing and Referral Coordinator collaborates with agencies directly funded by the CDC in assessing and establishing HIV testing targets for HIV counseling, testing and referral for agencies funded by the AIDS/HIV Program.

Impact of State and Local Budget Cuts
In the previous biennium, State agencies and programs, including the AIDS/HIV Program, received a 10% cut in state revenue. To compensate for the loss in state revenue, the AIDS/HIV Program has adopted the following strategies:
• Prioritizing ADAP: To ensure that the ADAP remained viable and able to provide life-saving medications, the ADAP was exempted from the 10% budget reduction and cuts were absorbed in other program areas.
• Streamlining service delivery: The 2011 Request for Proposal allowed the AIDS/HIV Program to prioritize services and contract with providers best able to deliver services in an efficient and effective manner.
• Consolidating services: Prior to the 2011 Request for Proposal process, the AIDS/HIV Program discontinued contracts with underperforming providers and directed funds to providers better able to address service needs.
• Increasing program efficiencies: The goal of the Linkage to Care grant is to develop a model for successful long term care participation that can be implemented program-wide and reduce the need for ongoing long term case management services. The Program is exploring better data sharing capabilities that will allow the Program and providers to track and monitor the delivery of services.
### CARE Grant Funding by HRSA Core Services and Support Services Categories, Wisconsin

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAP (Federal)*</td>
<td></td>
<td>$4,391,195</td>
<td></td>
<td></td>
<td></td>
<td>$4,391,195</td>
</tr>
<tr>
<td>ADAP (GPR)</td>
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<td>$1,306,220</td>
<td></td>
<td></td>
<td></td>
<td>$1,306,220</td>
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<tr>
<td>Medications (local)</td>
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<td></td>
<td>$59,400</td>
<td>$700</td>
<td></td>
<td>$60,100</td>
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<tr>
<td>Outpatient/Ambulatory Medical Care</td>
<td></td>
<td>$1,028,457</td>
<td>$574,871</td>
<td>$896,087</td>
<td></td>
<td>$2,501,415</td>
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<tr>
<td>Medical Case Management/Adherence</td>
<td></td>
<td>$1,386,467</td>
<td>$995,967</td>
<td>$337,843</td>
<td>$720,556</td>
<td>$3,440,833</td>
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<tr>
<td>Oral Health</td>
<td></td>
<td>$509,579</td>
<td>$338,113</td>
<td>$72,057</td>
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<td>$919,749</td>
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<tr>
<td>Early Intervention Services</td>
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<td>$191,000</td>
<td>$176,708</td>
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<td>$367,708</td>
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<td>Mental Health</td>
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<td>$530,106</td>
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<td>$114,190</td>
<td>$33,909</td>
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<td>Substance Abuse</td>
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<td>$59,191</td>
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<td></td>
<td>$70,191</td>
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<td><strong>Total Core Services Allocation</strong></td>
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<td>$3,454,609</td>
<td>$8,141,606</td>
<td>$1,669,285</td>
<td>$792,612</td>
<td>$14,058,112</td>
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<tr>
<td>Non-Medical Case Management</td>
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<td></td>
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<td>$103,035</td>
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<tr>
<td>Emergency Financial Assistance</td>
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<td></td>
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<td>$2,000</td>
</tr>
<tr>
<td>Food bank/home-delivered meals</td>
<td></td>
<td>$101,159</td>
<td></td>
<td></td>
<td></td>
<td>$104,159</td>
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<tr>
<td>Health Education/Risk Reduction</td>
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<td>$7,009</td>
<td>$15,000</td>
<td>$205,793</td>
<td>$227,802</td>
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<td>Housing</td>
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<td>$51,556</td>
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<td></td>
<td></td>
<td>$51,556</td>
</tr>
<tr>
<td>Legal</td>
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<td>$121,232</td>
<td>$69,254</td>
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<td>$190,486</td>
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<tr>
<td>Linguistics</td>
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<td></td>
<td></td>
<td>$1,000</td>
<td></td>
<td>$1,000</td>
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<tr>
<td>Medical Transportation</td>
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<td>$34,999</td>
<td>$875</td>
<td>$8,000</td>
<td></td>
<td>$43,874</td>
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<tr>
<td>Outreach</td>
<td></td>
<td>$53,737</td>
<td>$75,546</td>
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<td>$132,283</td>
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<tr>
<td>Psychosocial Support Services</td>
<td></td>
<td></td>
<td></td>
<td>$11,101</td>
<td></td>
<td>$11,101</td>
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<tr>
<td>Substance Abuse Residential</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$12,000</td>
</tr>
<tr>
<td>Treatment Adherence Counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$12,000</td>
<td>$12,000</td>
</tr>
<tr>
<td><strong>Total Support Services Allocation</strong></td>
<td></td>
<td>$222,391</td>
<td>$209,546</td>
<td>$186,465</td>
<td>$55,101</td>
<td>$879,296</td>
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<tr>
<td><strong>Total Core and Support Services Allocation</strong></td>
<td></td>
<td>$3,677,000</td>
<td>$8,351,152</td>
<td>$1,855,750</td>
<td>$847,713</td>
<td>$14,937,408</td>
</tr>
</tbody>
</table>

* The fiscal year for GPR and Early Intervention funding spans July 1 through June 30. The fiscal year for Ryan White Part B funding generally spans April 1 through March 31 except for special projects which may vary. The fiscal year time frames for Ryan White Parts C, D, and F vary.

* Includes funds for medications and insurance premiums.
## 2015 HIV Prevention Funding

### PS12-1201 Category A funding by CDC evaluation category

**2015 - Reporting for areas with >30% of the HIV Epidemic**

<table>
<thead>
<tr>
<th>City</th>
<th>&quot;% of HIV&quot;</th>
<th>% funding from PS12-1201 Cat A</th>
<th>Activities funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milwaukee</td>
<td>48%</td>
<td>54.50%</td>
<td>- HIV Partner Services&lt;br&gt;- HIV Testing in healthcare settings&lt;br&gt;- HIV Testing in non-healthcare settings&lt;br&gt;- EBI (harm reduction) w/ IDUs&lt;br&gt;- Group EBIs with transgender clients&lt;br&gt;- condom distribution&lt;br&gt;- social marketing and community mobilization</td>
</tr>
</tbody>
</table>

* defined as reported newly-diagnosed HIV cases in 2014

### Category A component spending

<table>
<thead>
<tr>
<th></th>
<th>Required Components</th>
<th>Recommended Components</th>
<th>other (administrative, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 824,663</td>
<td>$ 183,765</td>
<td>$ 569,780</td>
</tr>
<tr>
<td></td>
<td>52.3%</td>
<td>11.6%</td>
<td></td>
</tr>
</tbody>
</table>

### Allocation by Risk Category

<table>
<thead>
<tr>
<th>HIV Testing*</th>
<th>Allocation by Risk Category</th>
<th>Allocation by Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MSM</td>
<td>IDU</td>
</tr>
<tr>
<td>$ 318,018.00</td>
<td>$ 190,811</td>
<td>$ 111,306</td>
</tr>
</tbody>
</table>

**"Other*" = HIV testing not targeted by race**

### Comprehensive Prevention with Positives (CPP)

| Partner Services* | $ 327,000.00 |

### Condom Distribution

| All Risk Populations | $ 137,645 |
## HIV Prevention Budget Breakdown, all funding sources 2015

### 2015 FINAL

<table>
<thead>
<tr>
<th>2015 TOTALS (final award)</th>
<th>Allocations by Funding Source⁴</th>
<th>GPR</th>
<th>HRSA</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CDC PS12-1201</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>$1,597,208 $100,000</td>
<td>$914,660</td>
<td>$441,000</td>
<td>$75,000</td>
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</table>

#### REQUIRED PROGRAM COMPONENTS

<table>
<thead>
<tr>
<th></th>
<th>Category A</th>
<th>Category C</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV testing</td>
<td>$706,048</td>
<td>$318,018</td>
<td>$328,030</td>
<td>$60,000</td>
<td></td>
</tr>
<tr>
<td>Comprehensive prevention with positives²</td>
<td>$607,880</td>
<td>$327,000</td>
<td>$28,000</td>
<td>$63,880</td>
<td>$189,000</td>
</tr>
<tr>
<td>Condom distribution³</td>
<td>$327,035</td>
<td>$137,645</td>
<td>$189,390</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Initiatives</td>
<td>$42,000</td>
<td>$42,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total for All Required Components</strong></td>
<td>$1,682,963</td>
<td>$824,663</td>
<td>$28,000</td>
<td>$581,300</td>
<td>$249,000</td>
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#### RECOMMENDED PROGRAM COMPONENTS

<table>
<thead>
<tr>
<th></th>
<th>Category A</th>
<th>Category C</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Marketing, Media</td>
<td>$136,765</td>
<td>$45,765</td>
<td>$51,000</td>
<td>$40,000</td>
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<tr>
<td>EBIs with MSM, TG, IDU</td>
<td>$61,000</td>
<td>$61,000</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Structural and Community Level Interventions</td>
<td>$148,000</td>
<td>$77,000</td>
<td>$21,000</td>
<td>$50,000</td>
<td></td>
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<tr>
<td>Harm Reduction to IDUs</td>
<td>$318,360</td>
<td>$243,360</td>
<td>$75,000</td>
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<tr>
<td><strong>Total All Recommended Components</strong></td>
<td>$664,125</td>
<td>$183,765</td>
<td>$72,000</td>
<td>$333,360</td>
<td>$0</td>
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</table>

#### REQUIRED ACTIVITIES/OTHER SUPPORT SERVICES

<table>
<thead>
<tr>
<th></th>
<th>Category A</th>
<th>Category C</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring and Evaluation</td>
<td>$213,800</td>
<td>$147,800</td>
<td></td>
<td>$66,000</td>
<td></td>
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<tr>
<td>Jurisdictional HIV Prevention Planning</td>
<td>$116,000</td>
<td>$50,000</td>
<td></td>
<td>$66,000</td>
<td></td>
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<tr>
<td>Capacity Building/ Technical Assistance</td>
<td>$259,000</td>
<td>$199,000</td>
<td></td>
<td>$60,000</td>
<td></td>
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<tr>
<td>Agency's General Operations/Admin Activities</td>
<td>$172,980</td>
<td>$172,980</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>TOTAL Other</strong></td>
<td>$761,780</td>
<td>$569,780</td>
<td>$0</td>
<td>$0</td>
<td>$192,000</td>
</tr>
</tbody>
</table>

| TOTAL FUNDS (PS12-1201 & non-PS12-1201) | $3,108,868 | $1,578,208 | $100,000 | $914,660 | $441,000 | $75,000 |
2015 HIV Prevention and Care Contracted Agencies and Services

Note: The following table identifies HIV prevention and care services and the respective agencies funded in 2013 by the Wisconsin Department of Health Services (DHS), Division of Public Health. Funding was awarded from several funding sources and on a variety of 12-month cycles. The table does not include an agency’s HIV-related services or other agencies providing HIV services that are supported through sources other than DHS.

<table>
<thead>
<tr>
<th>Agency Funding</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARCW – Statewide</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td>$118,923</td>
</tr>
<tr>
<td><strong>Care</strong></td>
<td>$51,556</td>
</tr>
</tbody>
</table>

| **ARCW – South** |
| **Prevention** | $113,484 | Targeted HIV CTR with high risk populations (MSM, IDU, sex partners at risk). |
| | | IDU harm reduction outreach. |
| | | HIV prevention education outreach to MSM venues. |
| **Care** | $768,555 | Outpatient/ambulatory medical care. |
| | | Oral health services. |
| | | Medical case management. |
| | | Medical transportation. |
| | | Legal services. |
| | | Food bank/home-delivered meals. |
## ARCW – Southeast

| Prevention | $305,760 | • Targeted HIV CTR with high risk populations (MSM, IDU, sex partners at risk).  
| • Internet-based health education and information services targeting MSM.  
| • IDU harm reduction outreach.  
| • HIV prevention education outreach to MSM venues. |
| --- | --- | --- |
| Care | $3,392,202 | • Outpatient/ambulatory medical care.  
| • Oral health services.  
| • Mental health services.  
| • Outpatient substance abuse services.  
| • Medical case management.  
| • Medical transportation.  
| • Legal services.  
| • Food bank/home-delivered meals. |

## ARCW – Northeast

| Prevention | $117,110 | • Targeted HIV CTR with high risk populations (MSM, IDU, sex partners at risk).  
| • Social networks CTR with HIV positive case management clients.  
| • Internet-based health education and information services targeting MSM.  
| • IDU harm reduction outreach.  
| • HIV prevention education outreach to MSM venues. |
| --- | --- | --- |
| Care | $507,700 | • Outpatient/ambulatory medical care.  
| • Oral health services.  
| • Mental health services.  
| • Medical case management.  
| • Medical transportation.  
<p>| • Food bank/home-delivered meals. |</p>
<table>
<thead>
<tr>
<th>Organization</th>
<th>Prevention</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARCW – North</strong></td>
<td>$80,360</td>
<td>$126,949</td>
</tr>
</tbody>
</table>
| Prevention | • Targeted HIV CTR with high risk populations (MSM, IDU, sex partners at risk).  
  • Internet-based health education and information services targeting MSM.  
  • IDU harm reduction outreach.  
  • HIV prevention education outreach to MSM venues. | • Medical case management.  
  • Medical transportation. | |
| **ARCW – West** | $106,820 | $266,438 |
| Prevention | • Targeted HIV CTR with high risk populations (MSM, IDU, sex partners at risk).  
  • Social networks HIV CTR with HIV positive case management clients.  
  • Internet-based health education and information services targeting MSM.  
  • IDU harm reduction outreach.  
  • HIV prevention education outreach to MSM venues. | • Mental health services.  
  • Medical case management.  
  • Medical transportation.  
  • Food bank/home-delivered meals. | |
| **BESTD Clinic (aka Brady Street Clinic)** | $31,590 | |
| Prevention | • HIV testing in high risk communities. | |
| **Black Health Coalition** | $95,765 | |
| Prevention | • Faith-based HIV CTR in high prevalence Black neighborhoods.  
  • HIV prevention capacity building with faith-based communities. | |
# Wisconsin HIV/AIDS Strategy 2012-2015

## Brown County HD
- **Care**
  - $12,000
  - HIV Partner Services / Linkage to care. *(Coordinated by Prevention Unit)*

## Diverse and Resilient
- **Prevention**
  - $98,100
  - Capacity building for providers serving MSM youth statewide.
  - Ongoing group for transgender Black SHEBA.

## Eau Claire City/ County HD
- **Care**
  - $75,000
  - HIV partner services / linkage to care. *(Coordinated by Prevention Unit)*

## Kenosha County Health Department
- **Care**
  - $13,000
  - HIV partner services / linkage to care. *(Coordinated by Prevention Unit)*

## La Crosse County Health Department
- **Care**
  - $16,000
  - Partner services/linkage-to-care.

## Legal Aid Society of Milwaukee, Inc
- **Care**
  - $35,000
  - Legal services.

## Local Health Departments (multiple agencies)
- **Prevention**
  - $140,000
  - HIV testing through fee-exempt testing and provision of HIV test kits.
  - Fee-for-service HIV partner services within local jurisdictions.

## Luther Consulting, Inc.
- **Prevention**
  - $10,800
  - Coordination of web-based data reporting consistent with CDC requirements.
- **Care**
  - $10,000
  - Coordination of web-based data reporting consistent with requirements of HRSA’s Ryan White Services Report (client-level data report).

## Public Health of Madison and Dane County
- **Prevention**
  - $21,000
  - HIV partner services (“PCRS”) for multi-county jurisdiction.
- **Care**
  - $20,000
  - Partner services/linkage-to-care. *(Coordinated by Prevention Unit)*

## Marathon County HD
- **Care**
  - $10,000
  - HIV partner services / linkage to care. *(Coordinated by Prevention Unit)*

## Midwest AIDS Training and Education Center (MATEC)
- **Care**
  - $25,148
  - Support for HIV Treaters’ Meeting.

## Medical College of Wisconsin – Center for AIDS Intervention Research
- **Care**
  - $59,000
  - Linkage to care qualitative evaluation.
## Wisconsin HIV/AIDS Strategy 2012-2015

### Medical College of Wisconsin – Infectious Disease Clinic

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>$203,737</td>
</tr>
<tr>
<td>- Medical case management.</td>
<td></td>
</tr>
<tr>
<td>- Mental health services.</td>
<td></td>
</tr>
<tr>
<td>- Outreach</td>
<td></td>
</tr>
</tbody>
</table>

### Medical College of Wisconsin – Pediatrics Department

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>$200,000</td>
</tr>
<tr>
<td>- Medical case management (statewide for HIV + pregnant women, their newborns, and family members).</td>
<td></td>
</tr>
</tbody>
</table>

### City of Milwaukee Health Department

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>$172,000</td>
</tr>
<tr>
<td>- HIV partner services in southeast Wisconsin.</td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td>$53,000</td>
</tr>
<tr>
<td>- Partner services/linkage-to-care.(Coordinated by Prevention Unit)</td>
<td></td>
</tr>
</tbody>
</table>

### Milwaukee Health Services, Inc

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>$37,000</td>
</tr>
<tr>
<td>- Medical Case Management.</td>
<td></td>
</tr>
</tbody>
</table>

### OutReach, Inc

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>$25,000</td>
</tr>
<tr>
<td>- Condom distribution as a structural &amp; community intervention (TG &amp; MSM).</td>
<td></td>
</tr>
</tbody>
</table>

### Outreach Community Health Center

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>$37,000</td>
</tr>
<tr>
<td>- Medical Case Management.</td>
<td></td>
</tr>
</tbody>
</table>

### Pathfinders, Inc.

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>$36,175</td>
</tr>
<tr>
<td>- Condom distribution as a structural &amp; community intervention (YMSM).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Q-BLOK intervention for homeless YMSM.</td>
<td></td>
</tr>
</tbody>
</table>

### Price County HD

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>$9,000</td>
</tr>
<tr>
<td>- HIV partner services/linkage to care. (Coordinated by Prevention Unit)</td>
<td></td>
</tr>
</tbody>
</table>

### Racine HD

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>$13,000</td>
</tr>
<tr>
<td>- HIV partner services /linkage to care. (Coordinated by Prevention Unit)</td>
<td></td>
</tr>
</tbody>
</table>

### Rock County HD

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>$13,000</td>
</tr>
<tr>
<td>- HIV partner services /linkage to care. (Coordinated by Prevention Unit)</td>
<td></td>
</tr>
</tbody>
</table>

### Sixteenth Street Community Health Center

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>$91,517</td>
</tr>
<tr>
<td>- Prevention with HIV+.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- HIV CTR with Latino high risk populations (MSM, IDU, sex partners at risk).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Group prevention with Latina TG populations CHICAS.</td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td>$229,000</td>
</tr>
<tr>
<td>- Outpatient/ambulatory medical care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Oral health care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mental health services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medical case management (bilingual services).</td>
<td></td>
</tr>
</tbody>
</table>
### STD Specialties Clinic DBA Holton Street Clinic

<table>
<thead>
<tr>
<th>Prevention</th>
<th>$88,445</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach and clinic CTR targeting MSM and partners at risk.</td>
<td></td>
</tr>
</tbody>
</table>

### Tribal Health Clinics
(Bad River, Ho Chunk, Lac Courte Oreilles, Lac du Flambeau, Menominee, Oneida, Potawatomi, Red Cliff, Sokaogon, St. Croix, Stockbridge-Munsee)

<table>
<thead>
<tr>
<th>Prevention</th>
<th>$77,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV capacity building grants of $7,000 each for 11 Tribal nations to support HIV social networks testing, high risk testing strategies and culturally-specific prevention education.</td>
<td></td>
</tr>
</tbody>
</table>

### UMOS

<table>
<thead>
<tr>
<th>Prevention</th>
<th>$127,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted CTR with high risk Latino/a high risk populations (MSM, IDU, sex partners at risk).</td>
<td></td>
</tr>
<tr>
<td>Social Networks Strategy HIV testing w/ YMSM.</td>
<td></td>
</tr>
<tr>
<td>Condom Distribution as Structural &amp; Community Intervention (Latino MSM).</td>
<td></td>
</tr>
<tr>
<td>Safety Counts (EBI) HIV prevention group for PWID and partners.</td>
<td></td>
</tr>
</tbody>
</table>

### UW Hospital & Clinics

<table>
<thead>
<tr>
<th>Care</th>
<th>$567,244</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient/ambulatory medical care.</td>
<td></td>
</tr>
<tr>
<td>Mental health services.</td>
<td></td>
</tr>
<tr>
<td>Outpatient substance abuse services.</td>
<td></td>
</tr>
<tr>
<td>Medical case management.</td>
<td></td>
</tr>
<tr>
<td>Linkage to care quantitative evaluation.</td>
<td></td>
</tr>
</tbody>
</table>

### UW Professional Development & Applied Studies

<table>
<thead>
<tr>
<th>Prevention</th>
<th>$80,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity building/training for HIV prevention providers.</td>
<td></td>
</tr>
<tr>
<td>Community planning coordination.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care</th>
<th>$120,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and non-medical case management training.</td>
<td></td>
</tr>
<tr>
<td>Community planning coordination.</td>
<td></td>
</tr>
</tbody>
</table>

### UW – State Laboratory of Hygiene

<table>
<thead>
<tr>
<th>Prevention</th>
<th>$250,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing and support of statewide HIV CTR Program.</td>
<td></td>
</tr>
</tbody>
</table>

### Waukesha County HD

<table>
<thead>
<tr>
<th>Care</th>
<th>$13,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV partner services /linkage to care. (Coordinated by Prevention Unit)</td>
<td></td>
</tr>
</tbody>
</table>

### Winnebago County HD

<table>
<thead>
<tr>
<th>Care</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV partner services/linkage to care. (Coordinated by Prevention Unit)</td>
<td></td>
</tr>
</tbody>
</table>
## ADDENDUM IV

MET/UNMET NEED ANALYSIS – WISCONSIN:
CASES DIAGNOSED ON OR BEFORE 12/31/2013 & SERVICE DATES BETWEEN 1/1/2013
AND 12/31/2013

<table>
<thead>
<tr>
<th>Living Cases*</th>
<th>Met Need**</th>
<th>Unmet Need***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>Percent</td>
<td>Cases</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6758</td>
<td>4528</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>2577</td>
<td>1640</td>
</tr>
<tr>
<td>American Indian</td>
<td>35</td>
<td>21</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>72</td>
<td>52</td>
</tr>
<tr>
<td>Hispanic</td>
<td>821</td>
<td>528</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>78</td>
<td>66</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>White</td>
<td>3174</td>
<td>2221</td>
</tr>
<tr>
<td><strong>Current Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1339</td>
<td>985</td>
</tr>
<tr>
<td>Male</td>
<td>5379</td>
<td>3511</td>
</tr>
<tr>
<td>Transgender</td>
<td>39</td>
<td>31</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Risk Exposure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>3505</td>
<td>2459</td>
</tr>
<tr>
<td>MSM &amp; IDU</td>
<td>401</td>
<td>247</td>
</tr>
<tr>
<td>IDU</td>
<td>641</td>
<td>355</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>965</td>
<td>707</td>
</tr>
<tr>
<td>Mother at risk</td>
<td>65</td>
<td>55</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
<td>28</td>
</tr>
<tr>
<td>Unknown</td>
<td>1138</td>
<td>677</td>
</tr>
<tr>
<td><strong>Disease Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV (non-AIDS)</td>
<td>3237</td>
<td>2001</td>
</tr>
<tr>
<td>AIDS</td>
<td>3521</td>
<td>2527</td>
</tr>
<tr>
<td><strong>Current Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=14</td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>15-29</td>
<td>667</td>
<td>519</td>
</tr>
<tr>
<td>30-49</td>
<td>3224</td>
<td>3076</td>
</tr>
<tr>
<td>50+</td>
<td>2834</td>
<td>3625</td>
</tr>
<tr>
<td><strong>Diagnosis year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1981-1999</td>
<td>3038</td>
<td>1779</td>
</tr>
<tr>
<td>2000-2013</td>
<td>3720</td>
<td>2749</td>
</tr>
<tr>
<td><strong>Prevalent County</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milwaukee</td>
<td>3320</td>
<td>2254</td>
</tr>
<tr>
<td>Dane</td>
<td>828</td>
<td>546</td>
</tr>
<tr>
<td>Kenosha</td>
<td>241</td>
<td>146</td>
</tr>
<tr>
<td>Racine</td>
<td>229</td>
<td>154</td>
</tr>
<tr>
<td>Brown</td>
<td>234</td>
<td>164</td>
</tr>
<tr>
<td>Waukesha</td>
<td>173</td>
<td>125</td>
</tr>
</tbody>
</table>

*Persons reported with HIV infection (AIDS or non-AIDS) for whom no notification of death has been received, and whose last known address is in Wisconsin.

**Within the specified time interval persons are considered to have met need if there is evidence that the have had 1) an HIV viral load or CD4 count reported to the AIDS/HIV Surveillance Unit of the Wisconsin Division of Public Health or 2) a pharmacy claim submitted to the Wisconsin AIDS Drug Assistance Program (ADAP).
Early Identification of Individuals with HIV/AIDS Estimate

As of the end of 2014, 6,899 individuals reported with HIV or AIDS were presumed to be alive and living in Wisconsin. Three-quarters (75%) of these were first diagnosed in Wisconsin; the others were initially diagnosed elsewhere. The Centers for Disease Control and Prevention (CDC) estimates that 14% of people living with HIV (PLHIV) are unaware of their HIV status. Thus, an estimated 1,125 in the state are unaware of their HIV infection, so the total number of PLHIV in Wisconsin is estimated to be 8,024.
ADDENDUM V

STATEWIDE ACTION PLANNING GROUP

Wisconsin HIV Community Planning Network Coordinator
Barbara Nehls-Lowe

Health Department Co-Chair
James Vergeront, Director
AIDS/HIV Program, Bureau of Communicable Diseases and Emergency Response
Division of Public Health, Wisconsin Department of Health Services

Community Co-Chair 2015
Anne Brosowsky-Roth, Milwaukee

Community Co-Chair Elect 2015
Daniel Ross

Past Community Co-Chair 2013-2014
Anthony Harris

Past Community Co-Chair 2012-2013
Jeff Smith, Milwaukee

Past Community Co-Chair 2011-2012
Jose Salazar, Milwaukee

Past Community Co-Chair 2010-2011
Johnny King, Milwaukee

Past Community Co-Chair 2009 - 2010
Greg Milward, Madison

Past Community Co-Chair 2008 – 2009
Sarah Sloan, Lake Tomahawk

Past Community Co-Chair 2007 – 2008
Christina Garcia, Milwaukee

2015 Members
Lisa Baker, Madison
Norah Boynton, Madison
Michelle Broaddus, Milwaukee
Isaiah Brokenleg, Minocqua
Anne Brosowsky-Roth, Grafton
Ruthie Burich, Milwaukee
Rabiah Buser, Oshkosh
Joel Duffrin, Madison
Deborah Eastman, Edgerton
Sheryl Henderson, Madison
Chloe Jackson, Milwaukee
Hugo Jimenez, Milwaukee
Michael Lewis, Milwaukee
Ken Multhauf, Milwaukee
Winsome Panton, Milwaukee
Kristine Radtke, Eau Claire
Daniel Ross, Madison
Jose Salazar, Milwaukee
Annette Sallay, Madison
Charles Smart, Milwaukee
John Steines, Madison
Cheryl Thiede, Eau Claire
Jessica Tyler, Tomah
James Vergeront, Madison
David Wenten, Milwaukee
Thomas Wik, Jr, Altoona
Dennis Wojciechowski, Milwaukee
Ricardo Wynn, Milwaukee
External Partner Participation in Development of the WHAS

Throughout the year the Wisconsin AIDS/HIV Program works with providers, persons living with AIDS/HIV (PLWAH), and the community at large to address needs and gaps in services and develop potential solutions. For the purposes of the SCSN, the AIDS/HIV Program also held three independent meetings that devoted time to these topics and solicited input from:
- All Wisconsin Ryan White grantees and contractors.
- People living with AIDS/HIV.
- Providers of both care and prevention services.

Two Statewide Action Planning Group meetings were held to work on the WHAS. One meeting was held on February 16, 2012 in DeForest, Wisconsin and the second meeting was held April 19, 2012 in Brookfield, Wisconsin. Additionally, a two-day learning session was held April 26 and 27, 2012 in Waukesha. The learning session was dedicated to the development of a Linkage to Care model and included a detailed discussion of statewide needs from both the provider and client perspectives. The following agencies attended these meetings. While only agency names are listed, the attendees included persons living with HIV and those affected by HIV.

February 16, 2012 SAPG Attendees
- AIDS Network (Ryan White Part B contractor and Ryan White Part F contractor)
- Center for AIDS Intervention Research (Ryan White Part F contractor)
- Diverse and Resilient
- Madison-Dane County Public Health
- Mental Health Center of Dane County
- Midwest AIDS Training and Education Center (Ryan White Part F grantee)
- Milwaukee Health Services (Ryan White Part C grantee and Ryan White Part F contractor)
- Rodney Scheel House
- Sixteenth Street Community Health Center (Ryan White Part B contractor, Ryan White Part C grantee, and Ryan White Part F contractor)
- STD Specialties Clinic, Inc
- United Migrant Opportunity Services (Ryan White Part F contractor)
- University of Wisconsin Hospital and Clinics (Ryan White Part B contractor, Ryan White Part C grantee, and Ryan White Part D contractor)

April 19, 2012 SAPG Attendees
- Center for AIDS Intervention Research (Ryan White Part F contractor)
- Diverse and Resilient
- Madison-Dane County Public Health Department
- Medical College of Wisconsin Department of Pediatrics (Ryan White Part B contractor and Ryan White Part D grantee)
- Mental Health Center of Dane County
- Midwest AIDS Training and Education Center (Ryan White Part F grantee)
- Milwaukee Health Department
- Milwaukee Health Services (Ryan White Part C grantee and Ryan White Part F contractor)
- Planned Parenthood of Wisconsin
- Rodney Scheel House

- Sixteenth Street Community Health Center (Ryan White Part B contractor, Ryan White Part C grantee, and Ryan White Part F contractor)
- STD Specialties Clinic, Inc
- University of Wisconsin HIV Clinic (Ryan White Part B contractor, Ryan White Part C grantee, and Ryan White Part D contractor)
- Winnebago County Health Department

April 26-27, 2012 Linkage to Care Learning Session Attendees

- AIDS Network (Ryan White Part B contractor and Ryan White Part F contractor)
- Beloit Area Community Health Center
- Brady East STD Clinic
- Center for AIDS Intervention Research (Ryan White Part F contractor)
- Children’s Hospital of Wisconsin (Ryan White Part B subcontractor and Ryan White Part D contractor)
- Diverse and Resilient
- Health Care for the Homeless (Ryan White Part F contractor)
- Madison-Dane County Public Health
- Medical College of Wisconsin Infectious Disease Clinic (Ryan White Part B contractor)
- Medical College of Wisconsin Department of Pediatrics (Ryan White Part B contractor and Ryan White Part D grantee)
- Midwest AIDS Training and Education Center (Ryan White Part F grantee)
- Milwaukee Health Department
- Milwaukee Health Services (Ryan White Part C grantee and Ryan White Part F contractor)
- Milwaukee LGBT Community Center
- Pathfinders
- Planned Parenthood of Wisconsin
- Sixteenth Street Community Health Center (Ryan White Part B contractor, Ryan White Part C grantee, and Ryan White Part F contractor)
- United Migrant Opportunity Services (Ryan White Part F contractor)
- University of Wisconsin Hospital and Clinics (Ryan White Part B contractor, Ryan White Part C grantee, and Ryan White Part D contractor)
- Waukesha County Health Department
- Wisconsin Department of Corrections
ADDENDUM VI

RELEVANT TIMELINES

Preventing HIV Infections (Prevent)
The Wisconsin AIDS/HIV Program partners with many providers and organizations to provide education and services designed to prevent HIV transmission. Activities that address needs and gaps include:

• In 2012, approximately $1.9 million in combined federal and state funding will be used to support HIV Prevention activities (including prevention education, HIV testing and HIV partner services) coordinated by the DHS AIDS/HIV Program.
• CDC funded prevention activities renew annually and run on a calendar year January 1 through December 31. Most state funded prevention activities also renew annually and run on a calendar year.
• State funded prevention activities with tribal HIV Prevention coordinators renew annually and run on a federal fiscal year October 1 through September 30.
• The Statewide Action Planning Group holds quarterly meetings to exchange information with providers, consumers, and community members.
• AIDS/HIV Program staff attend CDC sponsored trainings and meetings including the bi-annual HIV Prevention Leadership Summit (HPLS), periodic (usually annual) CDC HIV Prevention Grantee meetings, and multiple meetings coordinated by NASTAD (the National Alliance of State and Territorial AIDS Directors) each year.
• In 2012, the DHS HIV Prevention program will fund 16 agencies to provide HIV prevention education and risk reduction activities, including HIV prevention with HIV-positive persons.
• HIV Prevention activities are targeted based on local HIV epidemiology, with providers given annual client service targets based on race, risk behavior, age, geography and other factors.
• HIV Prevention staff meet with service providers at bi-monthly CBO meetings, quarterly regional meetings of providers in the Madison area and in the Fox Valley area, and semi-annual meetings of CTR providers and HIV PS providers.

Identifying HIV Positive Individuals (Test)
The AIDS/HIV Program supports HIV testing initiatives throughout the state. Testing sites are expected to provide pre and posttest counseling, notify individuals of test results, and connect positive individuals with Partner Services and medical care. Activities that address needs and gaps include:

• CDC funded testing contracts renew annually and run on a calendar year.
• In 2014, the DHS HIV Program is supporting 14 HIV testing providers through direct grant contracts or fee-for-service HIV testing agreements. Additionally, approximately 18 additional programs are supported by the provision of no-cost HIV rapid tests and free laboratory services through fee-exempt public health agreements.
• HIV CTR grant funded and fee-for-service activities are targeted based on local HIV epidemiology, with providers given annual client service targets based on race, risk behavior, age, geography and other factors.
• Several of the CDC-funded CTR (counseling, testing and referral) providers have been trained in and conduct Social Networks Testing.
• HRSA funded Ryan White Part F Linkage to Care for the expansion of Social Networks Testing contract runs on a Ryan White project year September 1 through August 31.
• The Statewide Action Planning Group holds quarterly meetings to exchange information with providers, consumers, and community members.
• The Prevention unit provides funding and coordination support for several testing events each year, coordinated with national observance days (National Black AIDS/HIV Awareness Day, National HIV Testing Day, etc.)
**Improving Linkage and Retention in Care (Link and Treat)**

A primary goal of the AIDS/HIV Program is to improve the number of HIV positive individuals linked to care immediately after a positive result and then successfully retaining them in care. Participation in medical care is vital to improving and maintaining individual health, community health, and in preventing disease transmission. Activities that address needs and gaps include:

- HRSA funded Ryan White Part B Care contracts are determined every 5 years based on a competitive Request for Proposal process.
- HRSA funded Ryan White Part B Care contracts are renewed annually, contingent on agency performance and available funding, and run on a Ryan White project year April 1 through March 31.
- HRSA funded Ryan White Part B Supplemental contracts are renewed annually, contingent on agency performance and available funding, and run on a Ryan White project year of September 30 through September 29.
- HRSA funded Ryan White Part F Linkage to Care contracts are renewed annually and run on a Ryan White project year of September 1 through August 31.
- AIDS/HIV Program staff monitor contract compliance on a monthly basis.
- AIDS/HIV Program staff conduct annual site visits.
- Biannually, contracted partners complete reports detailing provided services and identifying needs.
- Annually, contracted partners and AIDS/HIV Program staff complete federal Ryan White Services Reports.
- Annually, AIDS/HIV Program staff complete federal ADAP data reports.
- The Statewide Action Planning Group holds quarterly meetings to exchange information with providers, consumers, and community members.
- AIDS/HIV Program staff attend HRSA and NASTAD sponsored trainings and meetings including the All Grantee Meeting and the Annual ADAP Conference.
- MATEC hosts monthly Treaters Meetings where clinicians review cases and share best practices and treatment protocols.
- AIDS/HIV Program staff work in collaboration with the University of Wisconsin-Madison, Division of Continuing Studies, HIV Training System to develop, produce and evaluate training for Ryan White funded case managers and other front-line staff to ensure quality professional development opportunities and to raise the quality of social and clinical service delivery in Wisconsin.
- Ryan White funded case managers are required to complete the initial training courses 1) HIV Basic Facts; 2) HIV Counseling Skills; and 3) New Case Manager Training and Orientation. They must also successfully pass a basic HIV knowledge assessment. Following certification by the AIDS/HIV Program, case managers are required to document 12 hours of on-going training per calendar year.
- A statewide HIV case manager meeting is held each January to provide programmatic updates and share best practices with all Ryan White funded case managers.
ADDENDUM VII

STAFF RESOURCES SUPPORTING THE WISCONSIN HIV/AIDS STRATEGY

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Wisconsin AIDS/HIV Training System
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Vacant
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ADDENDUM VIII

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Tasha Jenkins, Director

Regional Offices

Minority Health Program
Evelyn Cruz, Minority Health Officer

Program & Policy
Maria Flores

University of Wisconsin Population Health Fellow
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Donna Moore, Director
Madhu Thandassery, AIDS/HIV Budget & Policy Analyst

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Megan Eberbrock

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Wisconsin HIV/AIDS Strategy

ADDENDUM IX
STATEWIDE ACTION PLANNING GROUP CONCURRENCE LETTER
(page 1 of 2)

Continuing Studies
UNIVERSITY OF WISCONSIN–MADISON

CDC
Grants Management Office
Grants Management Branch, Procurement and Grants Office
Funding Opportunity Announcement PS12-1201
Centers for Disease Control and Prevention, MS E-15
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146

Wisconsin HIV Community Planning
Statewide Action Planning Group
Letter of Concurrence

The Statewide Action Planning Group (SAPG) of the Wisconsin HIV Community Planning Network concurs with the 2012-2015 Wisconsin HIV/AIDS Strategy which includes, by incorporation, Wisconsin’s jurisdictional HIV prevention plan. The Strategy demonstrates a collaborative, coordinated, and results-oriented approach to HIV prevention, care, and treatment to ensure that prevention services and resources are directed to areas with greatest HIV disease burden and are focused on reductions in HIV incidence. The SAPG, Wisconsin AIDS/HIV Program and all of our community partners are firmly committed to improving the outcomes for persons living with HIV along the HIV care continuum.

Over the past twelve months, the SAPG reviewed and discussed the following HIV prevention and care topics through formal presentations, statewide meetings, small workgroup discussions, and committee work:

- Overview of the Wisconsin HIV/AIDS Strategy
- Community Engagement
- Needs Assessment
- A Closer Look at Youth and HIV
- Harm Reduction, Injection Drug Use & HIV/Viral Hepatitis
- Epidemiology of HIV in Wisconsin
- Healthy Wisconsin 2020 Disparities Report
- An Update on PrEP and nPEP
- A Look at a Local Success Story (partnership and community engagement after a cluster)
- Condom Distribution Efforts – Three Communities
- Updates on the Affordable Care Act
- Preventing HIV Infection in Children
STATEWIDE ACTION PLANNING GROUP CONCURRENCE LETTER  
(page 2 of 2)

- Growing up with HIV
- Case Management Guidelines
- The Wisconsin HIV Care Continuum: Programs and Challenges
- Minority Men who Have Sex with Men – A Look at the Milwaukee Numbers

In addition, SAGP members reviewed and discussed the following focus papers that are appended to the Wisconsin Strategy 2012-2015:

- Community Engagement: A Process and Outcome for HIV Services
- Needs Assessment and the Wisconsin HIV/AIDS Strategy

Date signed: September 18, 2014
Brookfield, WI
ADDENDUM X

2013 Focus Papers

Adverse Childhood Experiences

Affordable Care Act:
Implications for Persons Living with HIV Infection

Special Project of National Significance: Linkage to Care

Wisconsin HIV Care Continuum
Adverse Childhood Experiences

Experiencing a trauma can change or affect the way individuals perceive themselves and the world. This is especially true for negative childhood experiences which can lead to poorer mental and physical health, poorer school and work success, and lower socioeconomic status in adulthood. Trauma reactions are complex reactions to repeated stressors and adverse experiences. This often shapes a person’s identity and results in symptoms and behaviors that are attempts to cope with accumulated emotional pain, anxiety, fear, and hopelessness. The effect of these adverse experiences often results in chronic health problems, mental illness, risks for HIV infection (including injection drug use), addiction issues, and self-destructive behaviors.7

Adverse childhood experiences (ACEs) and approaches to working with those experiencing ACEs are increasingly the focus of health and human services providers, both nationally and statewide. Advocates and consumers of mental health services in Wisconsin have led efforts to create service delivery systems where staff have a greater understanding of the role of trauma in individual lives.8

In 1995, the Centers for Disease Control and Prevention (CDC) partnered with Kaiser Permanente’s Department of Preventive Medicine in San Diego to examine the long-term impact of early childhood trauma (childhood abuse and serious forms of household dysfunction) on health. The Kaiser-CDC study tracked 17,000 people from 1995-1997 who offered detailed information on personal traumatic experiences. The study demonstrated a clear association between various traumatic childhood experiences and poor physical and mental health, work continuity, and relationships experienced later in life.

Adverse childhood experiences (ACEs) fall into three categories -- neglect (emotional and physical), abuse (sexual, physical, and emotional), and household dysfunction (household substance abuse, parental divorce, household mental illness, mother treated violently, and incarcerated household member).9 While ACEs can have a devastating impact on individuals, service providers and agency staff interacting with those with a history of ACEs can build resilience and promote healing, regardless of the type of services they provide.

ACEs in Wisconsin

For social service providers, it is likely that most clients will have at least one ACE.3 In the Wisconsin ACEs study, 56% of the adult population reported experiencing at least one ACE, which is similar to the rate in the adult population in national studies. The Wisconsin ACE study drew data from the Behavioral Risk Factor Survey (BRFS) which incorporated questions about ACEs in 2010 and 2011. More than 4,000 randomly selected people in Wisconsin were asked these questions.

One simple measure of assessing an individual’s ACE is a count of the number of experiences identified by an individual. The threshold of four ACEs allows a large enough sample for

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9 Centers for Disease Control and Prevention. Adverse Childhood Experiences Study. Available at http://www.cdc.gov/ace/data.htm
statistical comparisons and therefore is used as a “high” ACE score.\textsuperscript{10} The following results show ACEs by race/ethnicity, sexual orientation, income, education, urbanization, and disability status.\textsuperscript{11} The national Kaiser and CDC study did not ask about sexual minority status, so it is not currently possible to compare Wisconsin to national data on that status.

**Note regarding the graphs**

The graphs below show colored bars for the percent of respondents in each group that had four or more ACEs. The error bars (the ‘I’ at the top of each graph) shows the confidence intervals for the percentage estimates provided.

The confidence interval of a survey estimate is like the margin of error in a media poll. Both show the extent to which a result, or estimate, may differ from the true population-level value of the item being measured, i.e., potential error. In a media poll, the phrase “within the margin of error” is used, meaning that the difference between two items is not large enough to be considered definitive or statistically significant. The same applies to other kinds of survey estimates and their confidence intervals. If confidence intervals overlap, the difference between the two estimates is not likely to be statistically significant. In general, the smaller the survey sample, the larger the confidence intervals of the estimates produced with the data and the greater potential error.

In the text below, where it states that one group is more likely than another group to have four or more ACEs, it means that the difference is statistically significant. Where the sample size for a particular group is too small, the estimate is considered unreliable and the estimate is not shown.

![Figure 1: Age-adjusted rate of four or more Adverse Childhood Experiences (ACEs) among Wisconsin adults by race/ethnicity, 2010-2011](image)

Source: Wisconsin Department of Health Services, Behavioral Risk Factor Survey (BRFS), 2008-2011 landline-only dataset

Note: Populations estimates that are considered unreliable are excluded.


Figure 1 shows the percent of respondents with four or more ACEs by race/ethnicity. A larger percentage of Blacks than Whites had four or more ACEs. Differences between Hispanics and Blacks as well as Hispanics and Whites were not significant.

Figure 2 shows that difference in the percent reporting four or more ACEs between heterosexual (sexual majority) and gay/lesbian/bisexual (sexual minority) populations was not significant. It is important to note that the confidence interval for gay/lesbian/bisexual is large because the sample size is small.

A study that used a larger sample (n=22,071) of 2010 BRFS respondents from three U.S. states (Wisconsin, Maine and Washington) found that gay/lesbian and bisexual individuals had a greater likelihood of having six or more ACEs compared to their heterosexual peers. 12

The Chicago Department of Public Health examined ACEs in a sample of 570 men who have sex with men (MSM). Nearly one-third (32%) of Chicago MSM surveyed reported four or more ACEs. The percentages were higher for Black (42%) and Hispanic (42%) MSM compared to White MSM (25%) and for MSM under age 25 (42%) compared to MSM ages 25 and older (29%). HIV-positive MSM reported 1.5 times more ACEs than HIV-negative MSM and 50% of HIV-positive MSM had ACE scores indicative of high levels of childhood abuse or household dysfunction. Chicago MSM who had high levels of ACEs were twice as likely to have unprotected sex with a casual partner and were twice as likely to report being afraid to find out their current HIV status. 13

Figures 3 and 4 respectively show that populations with lower income and education (socio-economic status, or SES) levels were more likely to have four or more ACEs compared to those with middle SES levels. Middle SES level populations were more likely to have four or more ACEs compared to higher SES populations.

Residents of Wisconsin’s 34 non-metro (rural) counties were less likely to report four or more ACEs than residents of the state’s 37 small metro counties or Milwaukee County.
Differences between Milwaukee County and small metro counties were not significant (Figure 5).

**Figure 5: Age-adjusted rate of four or more Adverse Childhood Experiences (ACEs) among Wisconsin adults by level of urbanization, 2010-2011**

![Chart showing differences in ACE rates between Milwaukee County and small metro counties.]

Source: Wisconsin Department of Health Services, Behavioral Risk Factor Survey (BRFS), 2008-2011 landline-only dataset.

People with disabilities were much more likely than people without disabilities to report four or more ACEs (Figure 6).

**Figure 6: Rate of four or more Adverse Childhood Experiences (ACEs) by disability status, Wisconsin adults, ages 18-64, 2010-2011**

![Chart showing higher ACE rates among adults with disabilities.]

Source: Wisconsin Department of Health Services, Behavioral Risk Factor Survey (BRFS), 2008-2011 landline-only dataset.
The relationship between ACEs, TIC, and HIV
National and local studies have documented links between ACEs and negative adult health outcomes. Some of these outcomes are linked to HIV risk behaviors. The Wisconsin ACE report notes that a variety of studies (the Kaiser ACE study and those from other states) demonstrate a powerful relationship between ACE scores and a variety of risk behaviors, including smoking, drinking, and risk behaviors not measured in the BRFS such as drug use, sexual activity, and suicidality.14

Chicago MSM in the study described previously who had four or more ACEs were twice as likely to have unprotected sex with a casual partner and were twice as likely to report being afraid to find out their current HIV status.15 (See Figure 7)

As ACE scores increase from zero to four, prevalence of injection drug use dramatically increases. For those surveyed in the original Kaiser study, prevalence of injection drug use rose from 0.3% for those with 0 ACEs to 3.4% for those with four ACEs.8

Trauma-Informed Care
Trauma-informed care (TIC) is a philosophy of service delivery that recognizes the impact of trauma on individuals and the importance of delivering services and creating service delivery settings and systems that facilitate healing and avoid inadvertent traumatization. TIC shifts the

role of the caretaker to one of collaborator and empowers clients to be actively engaged in making their own choices. TIC includes a cultural shift that supports an organizational climate for clients and service providers that is built on trust and is personal, creative, open, and healing. Trauma-informed care assumes that people seeking services most likely have trauma histories, and staff acknowledge that ACEs are a frequent co-existing condition that contributes to the experience of stress and development of health risk behaviors.

**Wisconsin activities**
The Wisconsin ACE report outlines policy recommendations to improve the health, functioning, and productivity of Wisconsin residents. These recommendations are spread across four broad strategies:\footnote{16 O’Connor C, Finkbiner C, Watson L. Adverse childhood experiences in Wisconsin: findings from the 2010 Behavioral Risk Factor Survey. 2012 Madison WI: Children’s Trust Fund and Child Abuse Prevention Fund of Children’s Hospital and Health System. Available at http://wichildrenstrustfund.org/files/WisconsinACEs.pdf.}

- Increase awareness of ACEs and their impact on health and well-being.
- Increase assessment of and response to ACEs in health care settings.
- Enhance the capacity of communities to prevent and respond to ACEs.
- Continue to collect Wisconsin-specific data on the relationship between ACEs and health outcomes.

**Recent activities**
Efforts by the Wisconsin AIDS/HIV Program have largely fit into the first and third strategies: *Increase awareness of ACEs and their impact on health and well-being and Enhance the capacity of communities to prevent and respond to ACEs.*

In November, 2012, the HIV Statewide Action Planning Group devoted attention to Adverse Childhood Experiences (ACEs). Department of Health Services staff presented data from The Children’s Trust Fund report on ACEs data for Wisconsin, which provides a series of policy recommendations.

In December 2012, AIDS/HIV Program staff presented to the Diverse & Resilient Community Advisory Board regarding Adverse Childhood Experiences (ACEs) and strategies for preventing exploitive relationships among youth. Four observations and implications from that discussion emerged:

1. A provider noted that most of her agency’s clients (homeless and runaway youth) have high ACE scores (4 or more). Counselors often know the impact of ACEs on clients’ lives but have not all been trained in how to work with clients with these experiences.

   Implication: Staff working with clients with ACEs at agencies across the state would benefit from additional training in trauma-informed care.

2. Providers noted that in addition to what is referred to as the ‘traditional’ ACEs, many LGBT young people experience trauma related to bullying, anti-gay discrimination, family rejection, and homelessness.

   Implication: Programs that aim to reduce bullying of LGBT youth and anti-gay discrimination are needed.
3. A provider who facilitates support groups of adult men observed that it has been very helpful for participants to learn about the relationship between ACEs and adult behaviors and health conditions.

Implication: Education for community members about the impact of ACEs can serve as one intervention within a more comprehensive array of services.

4. Providers serving both young heterosexual females and young gay males noted that adolescents sometimes date men in their twenties and thirties, rather than same-age peers, in part because they believe that the older partners will provide stability and financial support. The potential risks and consequences of age-disparate partnerships are often not acknowledged.

Implication: Changing community norms to discourage age-disparate partnerships needs to go beyond youth; it should also address the attitudes of parents and the broader community and acknowledge the underlying reasons youth are engaged in these relationships.

Future activities
- Offer training on trauma-informed care through the UW-Madison HIV Training System. Audiences will include HIV case managers and HIV prevention service providers.
  - Two webinars (planned for late summer/early fall 2013)
  - One full day on TIC for providers with a focus on those with ongoing relationships with individuals (planned for late 2013)
- Support agencies in implementing strategies to provide trauma-informed care.
- Encourage HIV prevention grantees to implement the recommendations from the December meeting regarding ACEs.
- Analyze data on ACEs from the Behavioral Risk Factor Survey by multiple populations experiencing health disparities (The slides appear in this paper.)
- Analyze data regarding age-disparate sexual partnerships along with demographic and health outcome data from the Youth Risk Behavior Survey.

Resources
Several state and local resources are available in addition to those cited in this paper. For example, the logic model on the DHS site outlines a Wisconsin plan for trauma-informed care.

DHS on Trauma Informed Care
http://www.dhs.wisconsin.gov/tic/

DHS brochure on TIC
http://www.dhs.wisconsin.gov/publications/P0/p00202.pdf

SAMHSA National Center for Trauma-Informed Care
http://www.samhsa.gov/nctic/
This paper provides an overview of the Affordable Care Act (ACA) and highlights implications of the ACA for persons living with HIV infection. The paper includes background information on ACA and review of select ACA provisions, including a summary of reforms for the private health insurance market. The paper also highlights the ACA’s implications on the Ryan White HIV/AIDS Program and activities undertaken by the Wisconsin AIDS/HIV Program to support the implementation of provisions of the ACA that impact persons living with HIV in Wisconsin. Topics covered in this paper include the following:

- **Background**
- **Expanding Access, Availability and Affordability of Health Insurance**
  - Health Insurance Marketplace
  - Medicaid Expansion
- **Private Health Insurance Market Reforms**
  - Guaranteed Issue and Renewability
  - Coverage of Preexisting Health Conditions
  - Rating Restrictions
  - Essential Health Benefits
  - Coverage of Preventive Health Services
  - Prohibitions on Lifetime and Annual Limits
- **The Ryan White HIV/AIDS Program**
- **Consumer Assistance**
  - Navigators
  - Certified Application Counselors
  - Regional Enrollment Networks
  - HIV Case Managers and Linkage to Care Specialists
- **ACA Timeline and Action Plan**
- **Appendix A: How Will the Affordable Care Act Affect Me?**
- **Appendix B: Regional Enrollment Networks DHS Staff Contacts**

**Background**

Current insurance practices make it difficult for individuals living with HIV/AIDS to access health insurance in the individual market. Approximately 17% of individuals living with HIV have private health insurance and nearly 30% are uninsured.\(^{17}\) The Affordable Care Act (ACA), signed into law on March 23, 2010, expands access to health insurance for millions of Americans, including those living with HIV/AIDS by:

- Implementing several private health insurance market reforms.
- Expanding access and availability of coverage through the creation of the Health Insurance Marketplace and expansion of Medicaid.

Full implementation of the ACA will significantly improve progress towards the goals of the National HIV/AIDS Strategy:

- Reduce new HIV infections.
- Increase access to care

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• Improve health outcomes for individuals living with HIV, reduce HIV-related health disparities.\(^{18}\)

**Expanding Access, Availability and Affordability of Health Insurance**

The ACA establishes an individual mandate which requires most U.S. citizens and legal residents to have qualifying health coverage effective January 1, 2014. Those without coverage may have to pay a tax penalty known as an Individual Shared Responsibility Payment.\(^{19}\)

With the requirement for all Americans to have health insurance, the ACA seeks to expand coverage options and simplify the way in which consumers compare and purchase insurance through the creation of the Health Insurance Marketplace and expansion of state Medicaid programs.

**Health Insurance Marketplace**

The cornerstone of the ACA is the creation of the Health Insurance Marketplace. The Marketplace will provide consumers with a new way to shop for health insurance. Individuals who are lawfully present in the United States, not incarcerated and who do not have access to other types of minimal essential health coverage will be able to use the Marketplace to compare available insurance plans, determine their eligibility for Medicaid, Advanced Premium Tax Credits and Cost-Sharing Subsidies, and purchase coverage. Wisconsin’s Marketplace will be established and operated by the federal government and accessible via [www.healthcare.gov](http://www.healthcare.gov) when open enrollment begins on October 1, 2013.

Insurance plans offered through the Marketplace must meet all requirements dictated by ACA’s private health insurance market reforms, including coverage of Essential Health Benefits (EHB) which are discussed later in this paper. Plans will be categorized based on the concept of “actuarial value” which represents the amount or share of health care expenses a plan covers. The categories or “tiers” – bronze, silver, gold, and platinum – will generally cover greater shares of health care costs when moving from a lower tier (e.g. bronze) to a higher one (e.g. platinum), although the specific details could vary across plans.

Some individuals and families who purchase insurance through the Marketplace will be eligible for lower cost premiums and reduced cost-sharing. This will be especially significant for individuals living with HIV/AIDS who are disproportionately affected by poverty. Individuals and families with incomes between 100% and 400% of the Federal Poverty Level (FPL)\(^{20}\) who do not have access to other types of coverage will be eligible for Advanced Premium Tax Credits. The amount of the tax credit will be determined by the individual’s household income and will be paid directly to the insurance company on behalf of the policyholder, reducing the amount of the premium that the individual must pay out-of-pocket. Individuals and families with incomes between 100% and 250% FPL will also be eligible for cost-sharing subsidies which will reduce the cost of their deductible, coinsurance and copayments. Individuals must be enrolled in a silver level plan to receive cost-sharing subsidies.

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Wisconsin HIV/AIDS Strategy

2013 Focus Paper -- Affordable Care Act: Implications for Persons Living with HIV Infection

Medicaid Expansion
The ACA originally required states to expand Medicaid eligibility. In June 2012, the Supreme Court ruled that states could not be required to implement Medicaid expansion. Following this decision, Wisconsin chose not to implement Medicaid expansion under the ACA; however, several changes will be made to the state’s existing Medicaid programs known as BadgerCare starting in 2014. The following is a summary of key changes to BadgerCare outlined in the 2013-2015 state biennial budget:

- Income eligibility for parents, caretaker relatives of children and childless adults will be reduced from 200% FPL to 100% FPL.
- The cap on enrollment for childless adults under 100% FPL will be lifted.
- All BadgerCare members will be covered under the Standard Plan which provides comprehensive coverage, including coverage for brand name drugs and routine dental services.
- Childless adults will no longer have to pay an annual enrollment fee.
- Parents, relative caretakers of children, and childless adults will no longer have to pay monthly premiums.
- Household composition and income will be determined using Modified Adjusted Gross Income (MAGI) which is based on the applicant’s tax filing information.21

Several changes to BadgerCare are illustrated in the figures below. Figure 1 shows eligibility and coverage under the current BadgerCare Program. Figure 2 illustrates eligibility and coverage under BadgerCare starting in 2014 and beyond.

Figure 1

The Legislative Fiscal Bureau estimates that these changes will result in an estimated 87,000 people losing their current BadgerCare coverage, while at the same time expanding coverage to 82,000 newly eligible childless adults. These changes will significantly impact individuals living with HIV who have household incomes under 100% FPL. Individuals will no longer have to wait until there health deteriorates resulting in disability to qualify for Medicaid coverage.

Private Health Insurance Market Reforms
The private health insurance market reforms included in the ACA establish a benchmark that private insurance plans must meet regarding a number of factors:
- Access to coverage.
- Benefits.
- Cost-sharing.
- Consumer protections.

The majority of these market reforms apply only to individual and small group plans (those with less than 50 members). However, individual and small group plans offered both inside and outside of the Health Insurance Marketplace are subject to these requirements. Several market reforms have already been implemented, while others do not take effect until full implementation of the ACA in 2014. These reforms will have a significant impact on access to coverage for individuals living with HIV/AIDS, who prior to ACA implementation were often denied coverage or offered unaffordable coverage in the individual market based solely on their HIV status. The following is a summary of private health insurance market reforms required under the ACA that are likely to have the most salient impact on individuals living with HIV/AIDS.

Guaranteed Issue and Renewability
Beginning in 2014, health insurance must be offered on a guaranteed issue basis. Private insurance plans must accept every applicant for coverage as long as the applicant agrees to the terms and conditions of the plan (i.e., payment of monthly premium). Insurance companies will no longer be able to base eligibility or coverage on health related factors such as medical condition, past medical claims history, genetic information or disability. Plans must also renew
coverage if requested by the policyholder or plan sponsor. Individuals living with HIV/AIDS will no longer be denied coverage based on their HIV diagnosis.

Coverage of Preexisting Health Conditions
A “preexisting health condition” is defined as a medical condition that was present before the date of enrollment in health insurance. A condition may be deemed preexisting whether or not the individual received medical advice, diagnosis, treatment or care prior to enrollment in health insurance. Beginning in 2014, insurance companies are not only prohibited from denying coverage to individuals based on preexisting conditions such as HIV, they are also barred from excluding coverage of specific services based on the health conditions of the policyholder. This provision has already gone into effect for children under the age of 19 and will be expanded to all individuals regardless of age starting in 2014.

Before the implementation of this requirement, many states developed high-risk sharing plans and/or preexisting condition insurance plans to provide coverage for individuals with preexisting conditions who could not access insurance through the individual market. In Wisconsin, individuals with HIV and other medical conditions had the option to enroll in the Health Insurance Risk Sharing Plan (HIRSP). Since all individuals will have access to insurance regardless of their health status in 2014, HIRSP will no longer offer coverage and coverage for all current members will be terminated on December 31, 2013. Individuals who lose their HIRSP coverage will need to access coverage through BadgerCare or the Health Insurance Marketplace.

Rating Restrictions
Beginning in 2014, insurance plans will not be allowed to charge increased premiums to individuals based on health factors. Variations in the cost of premiums will only be allowed based on individual or family enrollment, geographic area, age, and tobacco use.

Essential Health Benefits
Individual and small group plans offered both inside and outside of the Health Insurance Marketplace must cover a core set of services known as essential health benefits (EHB). EHB must include services within ten categories established by the federal government. These ten categories include:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder treatments (including behavioral health treatment).
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services (including oral and vision care).

In Wisconsin, the specific services covered under each of these categories will be defined by services currently covered in the largest existing small group plan available in the state, which is

---

the United HealthCare Choice Plus Plan.\textsuperscript{23} This will provide individuals living with HIV in Wisconsin access to a number of antiretroviral medications from each drug class.

**Coverage of Preventive Health Services**

The ACA requires individual plans, small group plans, and Medicare to cover preventive health services without imposing cost-sharing on policyholders. Preventive services include immunizations as recommended by the Centers for Disease Control and Prevention (CDC), preventive care and screenings identified by the Health Resources and Services Administration (HRSA), and services with an effect rating of “A” or “B” from the United States Preventive Services Task Force (USPSTF). This will give individuals living with HIV/AIDS access to important clinical services including screenings for hepatitis C, syphilis, cervical cancer, alcohol misuse and depression without the burden of deductible, coinsurance or co-payments. HIV testing for all adults ages 15-65 is also included in this provision.\textsuperscript{24}

**Prohibitions on Lifetime and Annual Limits**

Under the ACA, plans will no longer be allowed to impose lifetime or annual limits on coverage of EHB. This will be particularly beneficial to individuals with chronic diseases including those living with HIV/AIDS, who are more likely to exceed annual and lifetime limits due to high costs of medications and other necessary treatments.

**The Ryan White HIV/AIDS Program**

The Ryan White HIV/AIDS Program (RWHAP) provides medical care and support services to uninsured and underinsured individuals living with HIV/AIDS. After Medicare and Medicaid, it is currently the third largest source of federal funding for HIV care in the United States. The ACA will provide many individuals living with HIV access to health insurance for the first time, which has led many to question whether the RWHAP will still be needed in the future.

Advocates argue that the ACA does not provide individuals living with HIV with all of the care and support services necessary to achieve optimal clinical outcomes, including viral suppression. To support this argument, they cite data which shows that 70% of clients currently served by the RWHAP already have public or private insurance coverage.\textsuperscript{25} RWHAP covers services that are historically not covered by public or private insurance, but are critical in ensuring that individuals living with HIV remain engaged and retained in medical care. Figure 3, from the Kaiser Family Foundation, provides examples of services provided by RWHAP which support clients along the HIV Treatment Cascade. Several of these services, including non-medical case management, medical case management and treatment adherence are not typically covered by other payer sources.


The Obama Administration has confirmed support for sustaining the RWHAP after full implementation of the ACA. President Obama’s Budget Proposal for Fiscal Year 2014 includes both appropriations for the RWHAP and language justifying the important role the program will continue to play in wrapping around coverage provided under the ACA. While the RWHAP may undergo restructuring in the future, it appears that the program will remain intact throughout the transition to and initial implementation of the ACA in 2014.

**Consumer Assistance**

Due to the complexity of the ACA, consumers will likely need assistance determining their eligibility for and enrolling in coverage. The ACA creates new requirements and resources for consumer assistance. In addition to these federal programs, Wisconsin Department of Health Services (DHS) is also developing infrastructure to assist consumers.

**Navigators**

The ACA requires all Marketplaces to establish a Navigator program. The role of Navigators is to help consumers understand their coverage options and guide them through the enrollment process. Navigators are funded by the federal government through Navigator Grants. In August, CMS announced the following Wisconsin agencies as recipients of Navigator funding:

- Partners for Community Development, Inc.
- Northwest Wisconsin Concentrated Employment Program, Inc.
- Legal Action of Wisconsin, Senior LAW
- National Council of Urban Indian Health
- National Healthy Start Association
Navigators at these agencies will have to complete federal and state training requirements and register with the Office of the Commissioner of Insurance (OCI) before they are able to assist consumers.

**Certified Application Counselors**
The role of certified application counselors (CAC) is similar to that of Navigators, however there is no federal funding supporting CAC efforts. Organizations must apply via marketplace.cms.gov to become a CAC organization. Once their application has been approved by CMS they can identify which staff within their organization will become certified as CACs. Much like Navigators, CACs must complete federal and state training and register with OCI before assisting consumers.26

**Regional Enrollment Networks**
DHS is currently in the process of establishing Regional Enrollment Networks (REN) throughout the state. These networks will consist of various agencies that will work together in different capacities to support consumer enrollment in BadgerCare and the Marketplace. Agencies will identify whether they are able to directly enroll consumers, or if they will operate as an information and referral source only. Agencies throughout the state, including AIDS Service Organizations and health care delivery organizations, are encouraged to join the appropriate REN in their area. Appendix B provides contact information for Department of Health staff that are responsible for the coordination of RENs throughout the state.

**HIV Case Managers and Linkage to Care Specialists**
Existing clients of AIDS/HIV Program funded agencies will likely turn to their case managers and/or linkage to care specialists (LTCS) for assistance with enrollment. The AIDS/HIV Program recognizes the important role case managers and LTCSs will play once open enrollment begins and encourages agencies to designate staff as CACs and/or join REN to best support their clients during this transition. More information on how agencies can prepare for ACA implementation is provided in the “ACA Timeline and Action Plan” section of this paper.

**ACA Timeline and Action Plan**
The Wisconsin AIDS/HIV Program is undertaking a number of activities to facilitate the transition of individuals living with HIV/AIDS into appropriate health coverage once open enrollment beings on October 1, 2013. It is recommended that agencies funded by the AIDS/HIV Program also take an active role in this process as case managers, linkage to care specialists (LTCSs), and other relevant staff will undoubtedly play a key role in assisting with client enrollment.

The following table summarizes AIDS/HIV Program activities as well as suggested activities for agencies serving HIV positive clients and a proposed timeline for when these activities should occur. Activities include both general education and targeted outreach. The table also outlines key dates and deadline that agencies should be aware of when planning and coordinating ACA-related activities.

---

### Timeline and Key Dates

| Already Completed |

**Designated HIV Care Services Coordinator as point person within AIDS/HIV Program for collection and dissemination of ACA-related information.**

- Hosted ACA informational sessions at Linkage to Care Learning Session, Annual Case Manager Meeting and New Case Manager Orientation and Training.

- Hosted ACA educational session for clients at UW HIV Clinic.

**AUGUST**

**Mid-August:** CAC State and Federal Training available online.

8/15: Deadline to become partner agency in REN.


- Designate AIDS/HIV Program as Certified Application Counselor (CAC) Organization and identify appropriate staff to complete CAC training requirements.

- Provide ACA information for consumers and providers on AIDS/HIV Program Website.

- Use ADAP client data to identify clients who will experience changes in coverage or coverage options effective 2014.

**SEPTEMBER**

9/15: REN action plans in place.

9/20: DHS begins to notify current BadgerCare Plus members of potential changes in coverage and begins targeted telephone outreach.

9/29: DHS begins notifying individuals on Core Plan Wait List and Basic Plan of potential coverage opportunities.

- Host one-day ACA workshop entitled “The Affordable Care Act: Preparing for Open Enrollment” (September 10, 2013).

- Participate in MATEC Health Reform Workshop (September 26, 2013).

- Host educational sessions covering health insurance and ACA basis for consumers statewide.

- Mail letters to ADAP clients detailing eligibility for BadgerCare or the Marketplace, including Premium Tax Credits and Cost-Sharing Subsidies, based on current insurance status and household income listed on most recent ADAP application.

---

### AIDS/HIV Program Activities

- Designated staff or develop committee tasked with leading agency’s ACA transition and implementation efforts.

- Apply to become a CAC Organization through the Marketplace.

- Once identified as a CAC Organization, identify which staff will complete CAC training and role of staff that do not complete training.

- Identify agency as a partner in appropriate Regional Enrollment Network (REN).

---

### Suggested Local Agency Activities

- Ensure that case managers, LTCSs and other relevant staff attend trainings hosted by AIDS/HIV Program, CMS or other appropriate organizations.

- Ensure that appropriate staff have completed federal and state CAC training and exams and registered with OCI.

- Provide educational information to client’s in-person and/or via agency website.
## Timeline and Key Dates

<table>
<thead>
<tr>
<th>Month</th>
<th>Key Dates</th>
<th>AIDS/HIV Program Activities</th>
<th>Suggested Local Agency Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OCTOBER</strong></td>
<td></td>
<td>✓ Provide lists of ADAP clients who will experience changes based on above information to case management agencies, if an agency has been identified on the client’s ADAP application.</td>
<td>✓ Use information provided by AIDS/HIV Program to assist ADAP clients with enrollment in appropriate coverage.</td>
</tr>
<tr>
<td><strong>10/1</strong></td>
<td>Open enrollment via the Marketplace begins.</td>
<td>✓ Use handout provided in Appendix A to divide current caseload (clients not included in ADAP information from the state) into groups based on insurance status and household income to determine potential impact of the ACA.</td>
<td>Use handout provided in Appendix A to divide current caseload (clients not included in ADAP information from the state) into groups based on insurance status and household income to determine potential impact of the ACA.</td>
</tr>
<tr>
<td><strong>10/1</strong></td>
<td>ADAP 6 Month Recertifications due.</td>
<td>✓ Process ADAP Re-certifications and provide assistance or referral to clients who do not have case managers and need assistance enrolling in coverage.</td>
<td>✓ Develop strategy to ensure that all new clients are screened and enrolled in coverage as soon as possible.</td>
</tr>
<tr>
<td><strong>NOVEMBER</strong></td>
<td></td>
<td>✓ Host post-ACA implementation conference calls for case managers, LTCSs, and other relevant staff to discuss ongoing questions related to enrollment.</td>
<td>✓ Continue client enrollment.</td>
</tr>
<tr>
<td><strong>11/18</strong></td>
<td>DHS begins processing BadgerCare applications using new eligibility rules and modified adjusted gross (MAGI) to determine income and household size.</td>
<td>✓ Host post-ACA implementation conference calls for case managers, LTCSs, and other relevant staff to discuss ongoing questions related to enrollment.</td>
<td>Continue to monitor implementation of the ACA and provide ongoing technical assistance and education for providers and consumers.</td>
</tr>
<tr>
<td></td>
<td>DHS begins processing BadgerCare applications for childless adults that are transferred from the Marketplace.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>11/23</strong></td>
<td>DHS notifies current BadgerCare members who do not meet new eligibility criteria of termination of coverage on 12/31/13.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DECEMBER</strong></td>
<td></td>
<td>✓ Host post-ACA implementation conference calls for case managers, LTCSs and other relevant staff to discuss ongoing questions related to enrollment.</td>
<td>Continue to monitor implementation of the ACA and provide ongoing technical assistance and education for providers and consumers.</td>
</tr>
<tr>
<td><strong>12/15</strong></td>
<td>Clients must be enrolled in plan and have first month’s premium paid for coverage to start on 1/1/14.</td>
<td>✓ Continue to monitor implementation of the ACA and provide ongoing technical assistance and education for providers and consumers.</td>
<td>Continue to monitor implementation of the ACA and provide ongoing technical assistance and education for providers and consumers.</td>
</tr>
<tr>
<td><strong>12/31</strong></td>
<td>HIRSP coverage ends.</td>
<td>✓ Continue to monitor implementation of the ACA and provide ongoing technical assistance and education for providers and consumers.</td>
<td>Continue to monitor implementation of the ACA and provide ongoing technical assistance and education for providers and consumers.</td>
</tr>
</tbody>
</table>
### How Will the Affordable Care Act and Changes to Badgercare Plus Affect Me?

#### Income: I am currently enrolled in BadgerCare Plus as the parent or relative caretaker of a dependent child.

<table>
<thead>
<tr>
<th>Income</th>
<th>Lose Current Coverage</th>
<th>Keep Current Coverage</th>
<th>Purchase Coverage through Marketplace</th>
<th>Eligible for Cost Sharing Subsidies</th>
<th>Eligible for Premium Tax Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100% FPL</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 101% and 250% FPL</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

#### Income: I am a childless adult currently enrolled in BadgerCare Core.

<table>
<thead>
<tr>
<th>Income</th>
<th>Lose Current Coverage</th>
<th>Keep Current Coverage</th>
<th>Purchase Coverage through Marketplace</th>
<th>Eligible for Cost Sharing Subsidies</th>
<th>Eligible for Premium Tax Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100% FPL</td>
<td></td>
<td>✓ Will have coverage under the Standard Plan starting in 2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 101% and 250% FPL</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

#### Income: I am currently enrolled in the HIRSP or HIRSP Federal Plan.

<table>
<thead>
<tr>
<th>Income</th>
<th>Lose Current Coverage</th>
<th>Eligible for BadgerCare</th>
<th>Purchase Coverage through Marketplace</th>
<th>Eligible for Cost Sharing Subsidies</th>
<th>Eligible for Premium Tax Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100% FPL</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 101% and 250% FPL</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Between 251% and 400% FPL</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>&gt; 400% FPL</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Wisconsin HIV/AIDS Strategy
2013 Focus Paper -- Affordable Care Act: Implications for Persons Living with HIV Infection

### Income

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am currently uninsured and lawfully present in the United States.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 100% FPL</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 101% and 250% FPL</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Between 251% and 400% FPL</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>&gt; 400% FPL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### Cost of Premium

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I will have access to insurance through my employer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My share of the premium for self-only coverage is less than 9.5% of my annual household income.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>OR</td>
</tr>
<tr>
<td>My share of the premium for self-only coverage is more than 9.5% of my annual household income.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

[^1]: Eligible for Cost-Sharing Subsidies — if you purchase a Silver Level plan through the Marketplace and do not have access to affordable employer-sponsored coverage, employer-sponsored coverage that meets minimum value, or other types of minimal essential coverage (Medicare, Medicaid, TRICARE, etc.) Employer-sponsored coverage is considered affordable if your share of the annual premium for self-only coverage is no greater than 9.5% of annual your household income. Employer-sponsored coverage meets minimum value if it’s designed to pay at least 60% of the total cost of medical services for a standard population.

[^2]: Eligible for Premium Tax Credits — if you purchase insurance through the Marketplace and do not have access to affordable employer-sponsored coverage, employer-sponsored coverage that meets minimum value, or other types of minimal essential coverage (Medicare, Medicaid, TRICARE, etc.)

[^3]: If you are enrolled in the HIRSP Medicare Supplement plan, you will not be able to purchase subsidized coverage in the Marketplace. Instead, you will have a 63 day guaranteed issue period into a traditional Medicare Supplement plan after HIRSP ends.
### Appendix B

#### Regional Enrollment Networks

**Wisconsin Department of Health Services Staff Contacts**

For additional information on Regional Enrollment Networks, contact the appropriate regionally based Department of Health Services staff listed below:

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties</th>
<th>Contact</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bay Lakes</td>
<td>Brown, Door, Marinette, Menominee Oconto, Shawano</td>
<td>Elizabeth Jungers</td>
<td><a href="mailto:Elizabeth.jungers@dhs.wisconsin.gov">Elizabeth.jungers@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>Capital</td>
<td>Adams, Columbia, Dane, Dodge, Juneau, Richland, Sauk</td>
<td>Amy Bell</td>
<td><a href="mailto:Amy1.bell@dhs.wisconsin.gov">Amy1.bell@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>Central</td>
<td>Langlade, Marathon, Oneida, Portage</td>
<td>Bill Hanna</td>
<td><a href="mailto:William.hanna@dhs.wisconsin.gov">William.hanna@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>East Central</td>
<td>Calumet, Green Lake, Kewaunee, Manitowoc, Marquette, Outagamie, Sheboygan, Waupaca, Waushara, Winnebago</td>
<td>Elizabeth Jungers</td>
<td><a href="mailto:Elizabeth.jungers@dhs.wisconsin.gov">Elizabeth.jungers@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>Great Rivers</td>
<td>Barron, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Pierce, Polk, St. Croix, St. Croix, St. Croix, St. Croix</td>
<td>Michelle Larson</td>
<td><a href="mailto:Michelle.larson@dhs.wisconsin.gov">Michelle.larson@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>Milwaukee</td>
<td>Milwaukee</td>
<td>Sarah Fraley</td>
<td><a href="mailto:Sarah.fraley@wisconsin.gov">Sarah.fraley@wisconsin.gov</a></td>
</tr>
<tr>
<td>Moraine Lakes</td>
<td>Fond du Lac, Ozaukee, Walworth, Washington, Waukesha</td>
<td>Angie Moran</td>
<td><a href="mailto:Angela.moran@dhs.wisconsin.gov">Angela.moran@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>Northern</td>
<td>Ashland, Bayfield, Florence, Forest, Iron, Lincoln, Price, Rusk, Sawyer, Taylor, Vilas, Wood</td>
<td>Melody Yeager</td>
<td><a href="mailto:Melody.yeager@dhs.wisconsin.gov">Melody.yeager@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>Southern</td>
<td>Crawford, Grant, Green, Iowa, Jefferson, Lafayette, Rock</td>
<td>Julie Milleson</td>
<td><a href="mailto:Julie.milleson@dhs.wisconsin.gov">Julie.milleson@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>Western</td>
<td>Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau, Vernon</td>
<td>Jamie Fawcett</td>
<td><a href="mailto:Jamie.fawcett@dhs.wisconsin.gov">Jamie.fawcett@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>WKRP</td>
<td>Kenosha, Racine</td>
<td>Sarah Fraley</td>
<td><a href="mailto:Sarah.fraley@wisconsin.gov">Sarah.fraley@wisconsin.gov</a></td>
</tr>
</tbody>
</table>
Special Project of National Significance: Linkage to Care

Background
In August 2011, the Wisconsin AIDS/HIV Program was selected to be one of seven states (Louisiana, Massachusetts, New York, North Carolina, Pennsylvania, Virginia, and Wisconsin) to participate in a four-year Special Project of National Significance (SPNS). SPNS grants are demonstration initiatives funded under Part F of the Ryan White Care Act. The projects focus on ways to support and improve requirements for Ryan White Parts A, B, C, and D. In this initiative grantee states are developing innovative and replicable models that will:

- Identify HIV positive individuals.
- Link HIV positive individuals to medical care.
- Retain HIV positive individuals in medical care.

Wisconsin’s model is being piloted where the majority of the state’s HIV cases reside; in the state’s southern and southeastern regions with the greatest emphasis in Milwaukee and Madison. After the project is completed, the information learned and the model developed can be adapted to work in other areas of the state.

The first two years of the initiative were devoted to testing model components and strategies to determine their effectiveness. This involved using Plan-Do-Study-Act (PDSA) cycles. The PDSA cycles work like a scientific hypothesis where a strategy is:

- Designed (Plan).
- Rested on a small scope (Do).
- Results evaluated (Study).
- Strategy is implemented or adjustments are made and the process starts anew (Act).

The information and lessons learned during the first two years determined the final initiatives that will be implemented in the final two grant years.

During the last two years of the grant, data will be collected for both local and project-wide evaluation. The evaluations will include both quantitative and qualitative components that examine how well an initiative works and why the initiative worked or did not work. The local evaluation will look only at Wisconsin data, while the project-wide evaluation will compare Wisconsin data with data from the other grantee states. At the end of the four years, each grantee will have a model that other states or providers can implement in total or in components.

Activities for Years 1 and 2
Four strategies were piloted during the grant’s first two years. Two of the strategies focused on HIV testing and making individuals aware of their HIV status. A third strategy focused working directly with HIV positive individuals to help them establish a routine of participating in medical care. The fourth strategy looked at applications that could be used to share data between providers and the AIDS/HIV Program to better track where and when individuals receive medical care.

Use of an HIV testing algorithm to detect Acute HIV Infection: Acute HIV Infection (AHI) is a highly infectious phase of HIV disease that typically occurs 1-4 weeks after infection and lasts a
few days to four weeks. It is characterized by nonspecific clinical symptoms often mimicking infectious mononucleosis, influenza, or other viral illnesses.\textsuperscript{27}

Individuals with AHI have a higher risk of transmitting HIV due to high levels of viremia (high viral loads) for up to 12 weeks following initial infection, a period when infection may be undetectable with traditional antibody tests. Identifying individuals with AHI and immediately connecting them to medical treatment can break the chain of HIV transmission. Medical treatment may also slow disease progression. The piloted algorithm encourages high risk individuals who have a negative rapid test and who have engaged in recent risk behavior to have additional testing done with the more sensitive antigen/antibody test. Using this algorithm, two individuals with AHI were identified.

The algorithm as designed is currently under review by the Centers for Disease Control and Prevention (CDC). As detailed in the June 21, 2013 \textit{Morbidity and Mortality Weekly Report},\textsuperscript{28} the CDC is developing a recommendation to make this new HIV diagnostic algorithm the national standard and thus is no longer an innovative model being tested in Wisconsin. Because of this, the piloted algorithm strategy will not continue as part of the SPNS initiative but will continue to be supported and implemented by the AIDS/HIV Program.

\textbf{Expansion of Social Networks Testing}

Social Networks (SN) testing utilizes HIV positive or high-risk negative individuals to recruit members of their social networks to be tested for HIV. The strategy recognizes that individuals are part of social networks and that infectious diseases often spread through these networks. Since the strategy was introduced to Wisconsin testing sites in 2008, the prevalence of new HIV cases identified through SN testing is 1.8\% versus 0.8\% with traditional testing. This finding is even greater in certain high risk populations like young Black men who have sex with men, where the prevalence of newly identified cases through SN testing is 11.5\% compared to 5\% with traditional testing methods.

To build on this success, the first two years of the initiative have focused on standardizing the SN testing process. This involved writing a protocol detailing:

- The four phases of SN testing.
- Testing agency core responsibilities.
- Recruiter responsibilities.
- Minimum standards.
- Documentation requirements.

All agencies that partner with the AIDS/HIV Program to provide SN testing are required to follow the established SN testing protocol and to design their testing implementation plans based on the protocol.


Developing Linkage to Care Specialists
The Linkage to Care Specialists (LTCS) serve as patient navigators or care coaches, helping clients connect to HIV medical care and providing the client with the knowledge and skills necessary to be an active participant in maintaining a healthy life. Working with a client for six to nine months, the LTCS ensures the client attends at least three routine HIV medical appointments while at the same time:

- Assisting with care coordination including coordinating needed supportive services.
- Helping the client develop a relationship with the care team.
- Ensuring a smooth transition from working with the LTCS to working with a case manager or being self-managed.

During the first two years, ten LTCS worked at five sites in the state’s southern and southeastern regions. The information gathered from their efforts led to the development of a protocol that will guide their work in the final years of the initiative. The protocol details:

- Specific LTCS responsibilities.
- Client eligibility criteria.
- Communication flows between LTCS, testing sites, partner services, and care team members.
- Documentation requirements.

All LTCS are required to follow the established protocol. The Program plans to incorporate the relevant aspects of the LTCS protocol into the case management protocol.

Development of an integrated data system
The AIDS/HIV Program researched development of a networked data system that would:

- Improve care coordination by allowing data sharing across agencies for common clients and by improving client referrals and transfer of client information.
- Reduce the agency reporting burden.
- Facilitate the monitoring of basic quality of care measures.
- Allow a system-wide assessment of the efficacy of the SPNS intervention.

The system had to allow both providers and the AIDS/HIV Program to maintain client data while adhering to client privacy laws and requirements.

The AIDS/HIV Program has been unable to identify an existing software package that can meet all of these objectives while ensuring client privacy. Because of this, the AIDS/HIV Program will continue to explore a networked data system but the activity will not continue as part of the SPNS initiative.

While the AIDS/HIV Program continues to explore an integrated data system for use with outside providers, it has developed a database to compile data from multiple internal databases. The AIDS/HIV Program is using the Analysis, Visualization and Reporting System (AVR) to compile data from the surveillance and AIDS Drug Assistance Program databases to identify clients who have never been linked to care or who have lapsed from care. The AIDS/HIV Program will then attempt to locate the client and help the client to become established in medical care either through a direct referral to care or by connecting the client to a LTCS.

Activities for Years 3 and 4
As detailed in the previous section, only two of the four initiatives will be continued into the final years of the initiative. The two activities support the full scope of the care continuum by identifying HIV positive individuals and helping them to establish HIV medical care.
Expansion of Social Networks Testing

Eight agencies will be participating in the SPNS Social Networks testing initiative:

- AIDS Network (Dane and Rock Counties)
- AIDS Resources Center of Wisconsin (Milwaukee)
- Diverse and Resilient (Milwaukee)
- Milwaukee Health Services (Milwaukee)
- Sixteenth Street Community Health Center (Milwaukee)
- STD Specialties (Milwaukee)
- UMOS (Milwaukee)
- Wisconsin Youth Services (Dane County)

These agencies will be conducting SN testing as defined in the newly developed protocol. They will be collecting and reporting data directly to the AIDS/HIV Program for inclusion in both the local and project-wide evaluations.

Next Steps:

- Implement finalized protocol.
- Approve agency target populations and implementation plans.
- Establish year 3 contracts.
- Modify the existing testing database to collect required evaluation variables.
- Begin collecting and submitting data.
- Monitor contracts.
- Provide technical assistance and ongoing training.
- Continue participation in cross-site meetings and trainings.
- Organize materials for presentation at 2014 Learning Session.
- Begin drafting cross-site manual.

Developing Linkage to Care Specialists: Ten LTCS will provide services at seven agencies:

- AIDS Network (Dane and Rock Counties)
- AIDS Resources Center of Wisconsin (Milwaukee)
- Milwaukee Health Services (Milwaukee)
- Milwaukee Public Health Department (Milwaukee)
- Outreach Community Health Center (Milwaukee)
- Sixteenth Street Community Health Center (Milwaukee)
- University of Wisconsin – HIV/AIDS Comprehensive Care Program (Dane and Rock Counties)

All LTCS were in place as of May 2013 and began submitting evaluation data in June 2013. The LTCS will continue with current efforts through the remainder of the initiative.

Next Steps:

- Establish year 3 contracts.
- Finalize database for data collection.
- Continue collecting and submitting data.
- Monitor contracts.
- Provide technical assistance and ongoing training.
- Continue participation in cross-site meetings and trainings.
- Organize materials for presentations at 2014 Learning Session.
- Begin drafting cross-site manual.
- Develop a sustainability plan.
Evaluation
Both the local and project-wide evaluation will be conducted in the project’s final two years. The Education and Technical Assistance Center (ETAC) at the University of California at San Francisco is leading the project-wide evaluation and advising grantees on local evaluation efforts. The AIDS/HIV Program staff has worked closely with the ETAC to develop an evaluation plan that will capture all relevant data for both local and project-wide evaluations. Additionally, the AIDS/HIV Program has contracted with two local organizations to lead local evaluation efforts and coordinate efforts with the ETAC. The Center for AIDS Intervention Research (CAIR) and the University of Wisconsin at Madison (UW) will be leading local evaluation efforts. CAIR is responsible for conducting the local qualitative evaluation while the UW is conducting the local quantitative evaluation. During the 2013 spring and summer, CAIR and AIDS/HIV Program staff conducted initial client and LTCS interviews to assist the ETAC’s qualitative evaluation. The interviews provided valuable feedback on how the LTCS strategy is working and what final modifications were needed before the initiative moved into the final two years.

Next Steps:
- Establish data baseline.
- Establish comparison data groups.
- Refine data collection and reporting process.
- Provide technical assistance for agencies/individuals submitting data.
- Submit required data to the ETAC.
- Continue participation in cross-site meetings and trainings.
- Organize materials for presentations at 2014 Learning Session.
- Begin drafting cross-site manual.
Wisconsin HIV Care Continuum

**Background**
The HIV/AIDS care continuum is a way to show, in visual form, the numbers of individuals living with HIV/AIDS who are actually receiving the full benefits of the medical care and treatment they need. In 2011, Gardener and colleagues published the first engagement in HIV care graph, in which the authors used published literature to estimate the number of people in the United States in various stages of the HIV care continuum (Figure 1).29

**Figure 1. HRSA continuum of HIV care, adapted by Gardener EM et al.**

As a follow-up to the Gardener findings, the CDC analyzed three surveillance datasets to estimate HIV testing and HIV prevalence among U.S. adults by state, and the percentages of HIV-infected adults receiving HIV care for whom ART was prescribed, who achieved viral suppression, and who received prevention counseling from health-care providers.30 In 2010, 9.6% of adults had been tested for HIV during the preceding 12 months. Of the estimated 942,000 persons with HIV who were aware of their infection, approximately 77% were linked to care, and 51% remained in care. Among HIV-infected adults in care, 45% received prevention counseling, and 89% were prescribed ART, of whom 77% had viral suppression. Based on these findings, the CDC estimated that 28% of all HIV-infected persons in the United States have a suppressed viral load. This low level of viral suppression is because optimal levels have not been reached for testing, ongoing HIV medical care, and adherence to medicine.

**Wisconsin HIV Care Continuum**
Since these articles were published, many jurisdictions have developed a local HIV care continuum to identify and depict gaps along the care continuum, set goals, and measure improvement. Using HIV surveillance data and HIV-related laboratory data as a marker of medical care, the AIDS/HIV Program has developed its first estimate of the HIV care continuum in Wisconsin (Figure 2).

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Definitions

**High risk for HIV**: Persons engaging in HIV risk behaviors including unprotected male-to-male sex, sharing of injection drug-using equipment, and heterosexual sexual contact with member of these groups or with an HIV-infected partner. The size of this population is not known.

**Living with HIV**: CDC estimates that 16% of persons living with HIV are unaware of their status. This bar shows both those aware and diagnosed, and those unaware of their infection.

**Diagnosed and Living with HIV**: Individuals reported with HIV in Wisconsin by the end of 2011 who were still alive and living in Wisconsin by the end of 2012.

**Linked to Care**: Individuals diagnosed during 2011 in Wisconsin who were linked to care within three months of HIV diagnosis.

**Care Visit**: Individuals living with HIV in Wisconsin who had at least one care visit during 2012.

**On ART**: Individuals with an active prescription for antiretroviral therapy. The proportion of individuals on ART in Wisconsin is not known.

**Retained in Care**: Individuals living with HIV in Wisconsin who had two or more care visits, at least three months apart, during 2012.
Suppressed Viral Load: Individuals living with HIV in Wisconsin whose last viral load test result during 2012 was ≤ 200 copies/mL.

Results and Interpretation

- HIV prevention efforts are crucial in preventing individuals from becoming infected with HIV and preventing infected individuals from transmitting the virus to others.
- Approximately 16% of all individuals living with HIV infection are unaware of their status. The CDC estimates that these individuals are responsible for half of new HIV infections.
- Among individuals diagnosed with HIV in Wisconsin during 2011, most (87%) were linked to care within three months HIV diagnosis.
- Among all individuals reported with HIV in Wisconsin by the end of 2011 and still living in Wisconsin at the end of 2012, 64% had at least one medical visit during 2012 and 51% were considered to be retained in care.
- Antiretroviral therapy (ART) is critical to reducing HIV transmission via viral load suppression and has a positive impact on individual morbidity and mortality.
- Less than half (47%) of people living with HIV in Wisconsin had suppressed viral load by the end of 2012.
- Engagement in HIV medical care after the initial linkage appears to be the step in the Wisconsin care continuum at which most individuals are lost.

Care Continuum Impact

An HIV care continuum can be useful in rapidly visualizing problem areas across the HIV care spectrum. Likewise it can be used for setting goals and for measuring progress toward those goals. Care continuums can also be developed for various subpopulations to determine where different groups may vary.

Locally and nationally, HIV care continuums can assist in measuring progress in meeting the goals established by the National HIV/AIDS Strategy for the United States (NHAS) which was released by the White House in July 2010.31 (See addendum for additional information regarding NHAS goals, performance measures targeting the continuum of care, and recent executive action regarding the care continuum.)

There are some important limitations to HIV care continuums that users should keep in mind. Due to differences in definitions and availability of data, users should limit comparisons of care continuums across jurisdictions. Instead, users should compare trends over time using their own continuum. In addition, laboratory data may not accurately reflect HIV medical care, as individuals may have a medical visit without laboratory results, and vice versa. The Wisconsin AIDS/HIV Program is currently evaluating how well laboratory data correspond to medical care. Despite these limitations, HIV care continuums still play an important role in providing a high level overview of a jurisdiction’s linkage and retention to HIV care and health outcomes.

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National HIV/AIDS Strategy and Executive Action Regarding the Continuum of Care

The National HIV/AIDS Strategy identified a variety of performance measures to be reached by 2015 in achieving the three primary goals of:

1. Reducing the number of people who become infected with HIV.
2. Increasing access to care and improving health outcomes for people living with HIV.

Examples of NHAS performance measures that are aligned with and support greater success along the HIV care continuum include the following:

**NHAS Goal 1: Reducing the Number of People Who Become Infected with HIV**
- Lower the annual number of new infections by 25 percent.
- Reduce the HIV transmission rate by 30 percent.
- Increase from 79 percent to 90 percent the percentage of people living with HIV who know their serostatus.

**NHAS Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV**
- Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65 percent to 85 percent.
- Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73 percent to 80 percent.
- Increase the percentage of Ryan White HIV/AIDS Program clients with permanent housing from 82 percent to 86 percent.

**NHAS Goal 3: Reducing HIV-Related Disparities and Health Inequities**
- Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.
- Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent.
- Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.
On July 15, 2013 President Obama signed an Executive Order creating the HIV Care Continuum Initiative. The Initiative directs federal agencies to prioritize addressing the continuum of HIV care by accelerating efforts and directing existing federal resources to increase HIV testing, services, and treatment, and improve patient access to all three. To ensure this effort is successful, the President’s Executive Order establishes an HIV Care Continuum Working Group. The group will coordinate federal efforts to improve outcomes nationally across the HIV care continuum, and will be co-chaired by the White House Office of National HIV/AIDS Policy and HHS’s Office of the Assistant Secretary for Health. The working group will provide annual recommendations to the President on actions to take to improve outcomes along the HIV care continuum.
Community Engagement: A Process and Outcome for HIV Services

Needs Assessment and the Wisconsin HIV/AIDS Strategy
Community Engagement: A Process and Outcome for HIV Services

Community engagement is…
…the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. …It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices.

Community engagement is both a process and a guiding principle of public health. As a process, community engagement is the active participation of community members and stakeholders in decision making and action directed at improving the health of communities. As a guiding principle of public health, community engagement is a commitment and belief that community involvement is fundamental in identifying health concerns and implementing interventions.

For purposes of engagement, “community” can be defined as:
1. **Community Members** -- individuals and groups affected by health issues.
2. **Stakeholders** -- individuals and groups such as academics, health professionals, policy makers, and others who are committed to and engaged in promoting the health and well-being of affected communities.

**HIV-Related Community Engagement**
Priority populations identified for HIV-related community engagement are members of communities that are disproportionately affected by the HIV epidemic. This includes:
- Sexually active gay, bisexual and other men who have sex with men (MSM).
- Persons who have had unprotected sex with someone infected with HIV.

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Wisconsin HIV/AIDS Strategy

2014 Focus Paper -- Community Engagement: A Process and Outcome for HIV Services

- Women who have had unprotected sex with bisexual males or who have exchanged sex for money or drugs.
- Persons who have shared injection drug equipment (such as needles, syringes, cotton, water) with others.
- Persons living with HIV.

Stakeholders engaged in promoting HIV-related prevention and care services and related support services are also included as priority participants for community engagement.

Community engagement plays a critical role in the HIV/AIDS epidemic. Early grassroots organizing and mobilization within affected communities, especially within the gay community, was successful in raising awareness about health concerns of persons living with HIV and those at risk of HIV infection. It is now an expectation and best practice that members of affected communities be actively involved along with stakeholders in addressing HIV-related health concerns of communities.

Community engagement is a requirement and a goal of federally supported HIV prevention and care programs. The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) are major sources of federal support for HIV services. Both agencies require health departments to work collaboratively with affected communities and key stakeholders in planning, implementing and evaluating services and activities supported by federal funds.

**AIDS/HIV Program Community Engagement Activities**

The Wisconsin AIDS/HIV Program promotes community engagement with members of affected communities and stakeholders through a variety of activities and venues. Examples of community engagement activities undertaken by the AIDS/HIV Program include:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Action Planning Group (SAPG)</td>
<td>In Wisconsin, community engagement is a major focus of statewide planning for HIV services. The Wisconsin Statewide Action Planning Group (SAPG) is the primary HIV-related statewide planning body that advises the Wisconsin AIDS/HIV Program on the development, implementation and prioritization of HIV prevention and care services in Wisconsin. The advisory group is comprised of twenty-five to thirty members who are broadly representative of affected communities and key stakeholders. The SAPG meets for day-long meetings 5-6 times per year to provide input to the AIDS/HIV Program. SAPG members also facilitate communication and expanded engagement in the five regions of the state. A major product of statewide planning is the Wisconsin HIV/AIDS Strategy, the comprehensive plan for HIV services, which is developed collaboratively by the Wisconsin AIDS/HIV Program and the SAPG.</td>
</tr>
</tbody>
</table>
Regional Provider Groups

The AIDS/HIV Program convenes meetings throughout the state with agencies funded by the program for purposes of exchanging information, providing training and fostering collaboration in the delivering of HIV prevention and care services. Regional provider groups include HIV prevention grantees and Partner Services providers.

Minority Community-Based Organizations Meetings

The AIDS/HIV Program convenes bimonthly meetings of HIV prevention service providers for purposes of facilitating communication and program collaboration in delivering HIV prevention and care services to minority communities throughout Wisconsin.

Tribal AIDS Coordinators Meetings

The AIDS/HIV Program facilitates quarterly meetings of the Tribal AIDS/HIV Coordinators throughout the state for purposes of exchanging information, providing programmatic updates, and facilitating collaboration in the delivery of HIV prevention services to the Native American communities in Wisconsin.

The AIDS/HIV Program engages with a variety of community partners and stakeholders from academia, state and local governmental agencies, private nonprofit and other community-based organizations, individual services providers, and consumers. Engagement activities include formal and informal communication exchange; consultation, training, and technical assistance of service providers and consumers; and direct financial support of agencies conducting community engagement activities at local and regional levels.

Community Engagement Activities of Grantees

The Wisconsin AIDS/HIV Program promotes and ensures local community engagement through contracts and grants established with local agencies and other institutions. Examples of grantee community engagement include:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Local Community Collaborative Planning</td>
<td>Local agencies are funded to implement HIV prevention and care initiatives that are informed and guided by consumer involvement in program planning and implementation. Examples include the collaborative planning process coordinated by Diverse &amp; Resilient in response to the HIV epidemic among YBMSM in Milwaukee and quarterly meetings of community groups in Appleton/Fox Valley and Madison/Dane County focusing on HIV prevention efforts directed at young MSM.</td>
</tr>
</tbody>
</table>
### Activity Description

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
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<tbody>
<tr>
<td>Consumer Advisory Groups</td>
<td>AIDS Service Organizations and other community-based agencies have consumer advisory groups/boards as a way to obtain input from members of affected communities regarding agency policies, services, and HIV-related materials.</td>
</tr>
<tr>
<td>Direct Client Feedback</td>
<td>Agencies conduct client satisfaction surveys and focus groups to assess client satisfaction and to obtain consumer input in designing, implementing and evaluating agency services and initiatives.</td>
</tr>
<tr>
<td>Community Mobilization</td>
<td>Agencies engage consumers, members of target populations, and stakeholders in planning and implementing special community HIV events. Examples include HIV prevention education and testing activities at PrideFest and other local LGBT community celebrations, and mobilization of faith community leaders in supporting HIV awareness activities.</td>
</tr>
</tbody>
</table>

For local agencies and institutions, ongoing community involvement is an essential element and critically important part of successfully developing and implementing of services that are tailored to the needs of affected communities.

**Summary**

Community engagement is a process and principle of public health. It is built on trust and respect between community members and stakeholders. It involves a commitment from service providers and other stakeholders to engage community members in ongoing dialogues and active participation in decision-making. Because many factors influencing health are increasingly recognized as complex and socially determined, community perspectives and the voices of community members are important considerations in implementing services that meet the needs and expectations of communities affected by health challenges, including the challenge of HIV infection.

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Needs Assessment and the Wisconsin HIV/AIDS Strategy

The Wisconsin HIV/AIDS Strategy (WHAS) is a planning document that is required as a condition of funding by two federal agencies, the Health Resources and Services Administration (HRSA), for Part B of the Ryan White CARE Grant, and the Centers for Disease Control and Prevention (CDC), under Program Announcement PS12-1201: HIV Prevention Cooperative Agreement. The Strategy addresses CDC’s requirement for an HIV Jurisdictional Plan and HRSA’s requirement for a Ryan White HIV/AIDS Comprehensive Plan.

One of the challenges in developing the Strategy as a consolidated document is in meeting CDC’s and HRSA’s separate and distinct requirements for this planning document. In general, HRSA’s requirements for a comprehensive planning document are more detailed and prescriptive than CDC’s.

Needs Assessment Cycle
Needs assessment is a pivotal part of the comprehensive HIV planning process. It is the basis for identifying gaps in services, developing comprehensive plans, establishing annual implementation plans, and strategies for addressing needs. Needs assessment results can provide baseline data for evaluation and help providers improve services.

Figure 1. Strategic Planning Needs Assessment Cycle
HRSA's focus on needs assessment
Ryan White legislation establishes specific requirements that must be met by federal agencies and their contractors in providing Ryan White funded services. HRSA emphasizes the importance of needs assessment when developing the Ryan White HIV/AIDS Comprehensive Plan to ensure that the needs identified by persons living with HIV are assessed and evaluated against existing resources in order to identify gaps and priorities for resource allocation.

For Ryan White Part B, states and territories are required to conduct needs assessment, priority setting and resource allocation as part of the Ryan White planning process. HRSA notes that the needs assessment process is time consuming, can be taxing for agencies and planning groups, and draws on limited resources. HRSA recommends that a comprehensive needs assessment be conducted every three years, that annual updates should be made where needed, and that epidemiologic profiles should be updated annually.

HRSA identifies four parts to a needs assessment, which are listed below. Wisconsin has excelled at the development of epidemiologic profiles and analyses (Part 1) that facilitate the HIV planning process. Parts 2, 3, and 4 are the areas that might be developed and expanded in Wisconsin in an effort to develop a more comprehensive needs assessment consistent with HRSA’s expectations.

1. Assessing data on HIV cases and AIDS cases.
HIV/AIDS epidemiologic data indicate the current size and characteristics of the populations living with HIV and AIDS as well as trends in newly diagnosed cases.

2. Assessing needs of PLWHA in and out of care.
Needs may be assessed through analysis of co-morbidity (e.g., hospitalization analysis, Medicaid analysis, HCV and TB co-morbidity) and socioeconomic (e.g., insurance analysis, zip code/socioeconomic mapping, housing), profiling client needs collected by case managers and Linkage to Care Specialists, capturing input from consumer advisory bodies of HIV service agencies, data and methods such as surveys, focus groups, community meetings, individual interviews of PLWHA.

3. Developing a resource inventory of services and assessing provider capacity/capability.
A resource inventory (e.g., inventories of grantee agencies and services; profiling and geocoding physicians, MATEC input captured from providers) demonstrates what services and organizations currently exist. An assessment of provider capacity/capability determines provider ability to deliver HIV/AIDS care overall and to specific populations. The resource inventory and provider profile should include HRSA defined core and support services.

4. Identifying unmet needs/service gaps Ryan White projects should address.
Unmet needs and service gaps are identified by comparing available services to identified needs. This should include an examination of unmet needs for HIV-positive individuals who know their status but are not in care; service gaps for those who are currently in care; disparities in care; and capacity development needs of providers and the overall system of care. Analysis
of unmet needs/service gaps might include not only a determination of overall needs but also identification of particular service needs for specific PLWHA populations.

HRSA’s [Ryan White AIDS/HIV Program Part B Manual (revised 2013)] further details requirements for needs assessments (see Section X -- Planning and Planning Bodies, Chapter 10 -- Needs Assessments, page 149).

**CDC’s focus on needs assessment**

Compared to HRSA’s guidance and requirements for the comprehensive plan, the CDC provides more general guidance for the PS12-1201 Jurisdictional HIV Prevention Plan. CDC’s HIV Planning Guidance released in July 2012 noted that, as part of the efforts to reduce reporting documentation for HIV Planning Groups (HPGs), the Community Services Assessment was no longer required and that it is now listed as an activity for the health department in Funding Opportunity Announcement (FOA) PS12-1201.

In summarizing requirements for the Jurisdictional HIV Prevention Plan, the CDC indicates that grantees should:

- Include a brief overview of epidemiological data, existing quantitative and qualitative information, and emerging trends/issues affecting HIV prevention services in the jurisdiction.

- Utilize the epidemiologic profile, HIV surveillance, and other available data sources to identify those populations with the greatest burden of the epidemic and those populations at greatest risk for HIV transmission and acquisition.

- Ensure that existing prevention resources are allocated and disseminated locally to the areas with the greatest HIV burden, to include populations identified at greatest risk for HIV transmission and acquisition.

The CDC identifies “need” as one area that should be included in the jurisdictional plan and gives the examples of “resources”, “infrastructure” and “service delivery” as topical areas that could be addressed in assessing need. The CDC does not prescribe how this should be done, leaving it to the discretion of the state to justify how resources are allocated and disseminated to areas with the greatest HIV burden.

**What others have done for needs assessments**

The end of this summary includes brief synopses as examples of what some states and localities have done to address needs assessments. Most needs assessments focus primarily on needs identified by persons living with HIV and their service providers rather than the prevention needs of individuals at risk for HIV infection. The assessment activities draw heavily on surveys, focus groups, key informant and individual interviews, and community forums as the primary data collection efforts. Some include resource inventories that assess the range of services available and service provider capacity and capability of service expansion. Some include gap analyses, comparing identified needs with available resources.
Several years ago HRSA contracted with agencies to develop the Ryan White CARE Act Needs Assessment Guide. This resource is comprehensive in scope and covers a broad range of topics regarding needs assessments for Ryan White funded services. The consulting and strategy planning firm John Snow Inc. was a partner in developing the Needs Assessment Guide and is noted to have been involved in conducting several of the needs assessments listed at the end of this summary.

Wisconsin’s needs assessment activities
The AIDS/HIV Program funded a HIV Care and Treatment Needs Assessment in 2000 through a contract with Aurora Health Care (Department of Academic Affairs) in Milwaukee. The statewide Needs Assessment was developed and implemented in collaboration with the former regional HIV CARE Consortia. The Needs Assessment utilized epidemiologic data, information from consumers, communities and providers, and other health care data. A self-administered, mailed survey was the primary method of data collection and was sent to 588 unduplicated clients obtained through a combined mailing list from the Wisconsin AIDS Drug Assistance (ADAP) Program and the Wisconsin Insurance Continuation Program. A total of 355 (60.4%) surveys were returned. Two focus groups were conducted in each of the six HIV CARE Consortia regions – one for service providers and HIV CARE Consortia members and one for consumers. The assessment staff gathered additional information at Consortia meetings and telephone interviews with Consortia members. Final data analysis and assessment findings addressed the areas of client utilization of services, client satisfaction, identification of unmet needs, barriers to services, and provider needs.

Over the past several years, Wisconsin has been engaged broad range of qualitative and quantitative needs assessments (Appendix 2). These assessments are broadly focused on statewide surveillance and epidemiology as well as special studies and targeted assessments of groups and communities at highest risk for HIV infection. The AIDS/HIV Program, in collaboration with community partners and other state agencies, maintains comprehensive databases and client-level data on Program funded prevention and care services. The Program engages with community partners in a variety of meetings and forums, including the Statewide Action Planning Group, local and statewide task forces, meetings fostering collaboration and coordination among prevention and care service providers, and forums soliciting direct input from communities and individuals disproportionately affected by HIV infection. The Program collaborates with other state agencies and partners in assessing needs regarding the larger context of health risk behaviors and social determinants that intersect with HIV infection and other health conditions.

The next steps for Wisconsin: considerations, proposed activates and timelines
The following are considerations that may help in planning for future HIV-related needs assessments in Wisconsin.

Framing and focusing needs assessment efforts
- The HIV continuum of care should be used as a framework for planning, implementing and analysis of needs and identification of service gaps.
Because of limited resources, needs assessments activities should be focused on priority areas rather than being broadly focused or attempting to be all-inclusive, e.g., assessment activities might focus primarily on linkage to and retention in care and prevention services and interventions for young Black MSM.

Because the focus of service delivery and expectations of the federal funding agencies differ, needs assessment activities involving care services and prevention services will be planned and implemented independent from each other.

**Fiscal and contractual considerations**

- New needs assessment activities require additional resources from outside the AIDS/HIV Program, through contractual arrangements with entities like individual consultants, private nonprofit agencies, or arrangements with academic institutions.

- Consideration should be given to utilizing available fiscal resources that support certain Program priorities (e.g., Linkage to Care), resulting in needs assessment activities that support the priority area as well as the Program’s overall needs assessment activities.

- Implementing needs assessments through surveys, key informant and individuals interviews, group interviews and/or community meetings requires a contractor with a proven record and expertise in survey design, analysis, and synthesis of assessment results (preferably with experience with Ryan White services). Consideration should be given to utilizing or adapting successful needs assessments conducted in other states. Time, effort, and costs need to yield meaningful and useful results -- not just additional data.

**Other considerations**

- The timing of needs assessments is important. The impact of the Affordable Care Act may result in certain systems changes in the delivery of HIV services. Assessments at the front end of ACA could assist in establishing a baseline of need that could be reassessed in several years. On the other hand, a comprehensive needs assessment might be best conducted after there is more experience with ACA implementation.

- A comprehensive needs assessment could be a joint activity of all Ryan White grantees in Wisconsin, with Ryan White grantees taking lead for specific assessments that contribute to the comprehensive needs assessment and Statewide Coordinated Statement of Need (SCSN).

- The Program should discuss ways to optimally integrate results from various ongoing data collection efforts, many of which are identified in the current Strategy (and which are listed in Appendix 2) in order to presents a coherent synthesis of results of needs assessment activities.
The narrative on identified gaps listed in the WHAS could be expanded by further substantiating or justifying the identification of the gap, i.e., how and what assessment efforts/measures were used in identifying the gap.

**Assessment Activities**

In 2011, Gardener and colleagues published the first engagement in HIV care continuum and used published literature to estimate the number of people in the United States in various stages of the HIV care (Figure 2). Many jurisdictions and planning groups are now utilizing the HIV care continuum as a framework to visually portray and estimate the proportion of persons in various stages of HIV care in an effort to identify needs and gaps in services.

![Figure 2. HIV Care Continuum](image)

In prioritizing needs assessment efforts within context of the HIV care continuum, the Wisconsin AIDS/HIV Program will focus needs assessment activities on the following priority populations:

- HIV+ persons unaware of their infection.
- HIV+ persons aware of their infection but not linked to HIV medical care.
- HIV+ persons not retained in HIV medical care.
- HIV+ persons who are eligible but not enrolled in health insurance.

Needs assessment activities will include:

1. Analysis and synthesis of:
   - HIV surveillance and epidemiologic data.
   - Sociodemographic data of persons living with HIV.
   - Client level data from HIV counseling and testing, HIV Partner Services, and Ryan White services funded by the Wisconsin AIDS/HIV Program.
   - Current research conducted by academic staff and others regarding HIV-related prevention and clinical services in Wisconsin.

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Data Sources to be Utilized in the Initial Phase of Assessing Priority Population

<table>
<thead>
<tr>
<th>Focus of Data Sources</th>
<th>HIV+ unaware</th>
<th>HIV+ never linked</th>
<th>Not retained in care</th>
<th>ADAP/HRSP not enrolled in health insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publically-funded CT</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PS – not located/located but refused PS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>HIV/HCV co-infected</td>
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<td>X</td>
<td></td>
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<tr>
<td>Syphilis &amp; GC HIV+ and -</td>
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<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Surveillance data – regional analyses</td>
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<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated HIV+ and unaware</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linked to care by facility of dx</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact with HIV+ never linked</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not in care; VL not suppressed</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results of summative qualitative evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local survey – barriers to engaging in care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADAP &amp; HRSP clients not enrolled in insurance</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Findings and outcomes from the data analyses will help identify what additional information is needed and what methods might be used in assessing service utilization and service needs of the priority populations.

2. Development of an inventory of HIV-related health and support services available to persons living with HIV in Wisconsin.

3. Collection and synthesis of information regarding client needs and service gaps identified by consumers, service providers, community agencies serving unserved populations, key informants, and AIDS/HIV Program staff. Data collection efforts will be conducted through:
   - A comprehensive client survey of a representative sample of clients living with HIV in Wisconsin.
   - Focus groups of persons living with HIV in Wisconsin.
   - Focus groups of HIV service providers in Wisconsin.
   - Interviews with community leaders, key informants, and AIDS/HIV Program staff.
Need Assessment Implementation Timelines

February 20, 2014
Present plan for implementing needs assessment to SAPG.

April 1, 2014
LTE hired.

September 30, 2014
Review of internal data completed.

March 31, 2015
Survey tools and focus group materials developed.

June 30, 2015
Focus groups and surveys conducted.

August 31, 2015
Analysis of focus group and survey data completed.
Needs assessment report drafted.

September 2015
Initial findings presented to SAPG.

December 1, 2015 – February 28, 2016
Draft Wisconsin Strategy (combined HRSA and CDC document).

February 2016
Present draft Wisconsin Strategy to SAPG.

March 1, 2016 – May 30, 2016
Finalize Wisconsin Strategy.

May 2016
Present finalized Wisconsin Strategy to SAPG.

September 2016
Submit Wisconsin Strategy to HRSA & CDC.
Appendices

The following appendices to this paper include:

- **Appendix 1: Brief Highlights of Select Needs Assessments Conducted by Other Jurisdictions**

- **Appendix 2: Excerpts from Chapter III of the *Wisconsin HIV/AIDS Strategy 2012-2015, Revised September 2013***
  The excerpts include content addressing needs assessments and service gaps, including a listing of a variety of past activities the Program has undertaken or participated in to assess needs and identify service gaps.
Appendix 1: Brief Highlights of Select State and Local HIV Needs Assessments

2008 Wyoming Comprehensive Statewide HIV/AIDS Prevention and Treatment Needs Assessment

http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=10357&lid=3

Methods -- analysis of secondary data from previous years as well as primary data collected through the following assessments:

1. Survey of HIV positive individuals residing in Wyoming.
2. Focus groups with various key groups identified by the Needs Assessment Advisory Committee, a subset of the Wyoming Care and Prevention Planning Alliance (the Wyoming CPG).
3. Key informant interviews with service providers and other key stakeholders throughout the state and other states with extensive rural communities.

Primary data was collected through 52 surveys, 8 focus groups and over 20 key stakeholder interviews, including stakeholders in other state HIV/AIDS Programs.

2010 Comprehensive HIV Needs Assessment Ryan White Planning Council of Dallas Area


Methods:
1. Detailed survey of 618 PLWHA, 433 in-care and 185 out-of-care.
2. Seven focus groups with PLWHA and one with case managers.
3. Two surveys of Ryan White funded providers including:
   a. A short care coordination survey.
   b. A detailed profile of provider capacity with additional care coordination evaluation questions.
4. Analysis of surveillance and sociodemographic data.
5. Inventory of non-Ryan White funded local providers.

2011 Houston Area HIV/AIDS Needs Assessment


Methods:
- Survey of a convenience sample of persons living with HIV (N=924) in a 10-county area. Survey locations included clinics, agencies and outreach vans targeting the homeless population. Participants were queried on 11 topics related to HIV services, including service usage history for medical and social services, barriers to seeking or receiving services, and co-occurring health conditions. A $20 gift card was provided for completion of each survey.
- Focus groups with HIV service providers.
Appendix 1: Brief Highlights of Select State and Local HIV Needs Assessments

2011 Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study

Methods – data collection and analysis conducted primarily through surveys:
- First phase: short-form survey distributed by mail, reaching large number of individuals and gathering a limited set of data focused on HIV service needs and barriers. Phase 1 incentive: $3 Dunkin Donut gift card.
- Second phase: long-form survey to small subset of respondents to larger survey, delving more deeply into broad range of topics. Phase 2 incentive: $25 CVS gift card.

2009/2010 Assessment of Minnesota HIV/AIDS Prevention Services for MSM
http://www.health.state.mn.us/divs/idepc/diseases/hiv/preventionssessmentmsm022011.pdf

Methods:
1. Fifteen key informant interviews with leadership and staff from community-based organizations, AIDS service organizations, county and state health officials, academics and political leadership.
2. Online survey of members of community-based organizations. Survey consisted of 44 questions regarding demographics, knowledge and information sources regarding HIV/AIDS, current sexual activity, safer sex practices, use of prevention services, perceived barriers to using prevention services and perceived impact of prevention services.
3. Seven focus groups held with gay, bisexual, transgender males and other MSM, with a special effort on reaching men who were younger, African American, Latino/Hispanic and transgender males.
4. Telephone interviews clients of the Partner Services program, including clients accepting and declining PS.
III. Needs Assessment and Services Gaps

The Wisconsin AIDS/HIV Program identifies HIV service priorities through needs assessments and gap analyses, conducted both formally and informally through multiple venues. Identification of needs and service gaps is obtained through ongoing surveillance, epidemiologic investigations, surveys, special studies, community dialogues, contract monitoring, feedback from service providers and consumers, and input from individuals and communities at risk for HIV or related health disparities. The AIDS/HIV Program collaborates with community partners in identifying and prioritizing service needs and planning interventions to address service gaps.

A. Needs Assessment

The AIDS/HIV Program conducts many activities that address the five primary components of a comprehensive needs assessment, as defined by HRSA:

- An epidemiologic profile and monitoring of trends in HIV infection.
- Assessment of service needs, including barriers to receiving needed services.
- Assessment of resource capacity, including available services and number of clients served.
- Assessment of service accessibility, availability and appropriateness for persons living with HIV and AIDS.
- Assessment of unmet needs and service gaps.

The following table highlights the activities conducted by the AIDS/HIV Program or in collaboration with partners to assess needs and identify service gaps.

<table>
<thead>
<tr>
<th>Category</th>
<th>Data source/activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveillance &amp; Epidemiology</td>
<td>HIV surveillance data</td>
<td>Collection, analysis, and dissemination of HIV case data.</td>
</tr>
<tr>
<td></td>
<td>Hepatitis C, STD, TB</td>
<td>Collection, analysis, and dissemination of data for co-morbid diseases.</td>
</tr>
<tr>
<td></td>
<td>Cluster investigations</td>
<td>Special investigations of clusters of HIV, syphilis, and hepatitis C (6 cluster investigations 2009-2012 to date).</td>
</tr>
<tr>
<td></td>
<td>Milwaukee EpiAid</td>
<td>Investigation by CDC in Milwaukee regarding increasing rates of HIV in young Black MSM.</td>
</tr>
<tr>
<td></td>
<td>Geocoding, GIS</td>
<td>Geographic analysis of data and comparison to data on social determinants of health.</td>
</tr>
<tr>
<td>Other special studies</td>
<td>Native American needs assessment</td>
<td>Structured key-informant interviews with 11 tribal coordinators regarding HIV prevention and care issues for tribal members.</td>
</tr>
<tr>
<td></td>
<td><em>PrideFest</em></td>
<td>HIV counseling and testing and structured surveys on key topics such as the home test kit.</td>
</tr>
<tr>
<td></td>
<td>in+care campaign</td>
<td>Grantee assessment of clinical retention in HIV care.</td>
</tr>
</tbody>
</table>
### Wisconsin HIV/AIDS Strategy

#### 2014 Focus Paper -- Needs Assessment and the Wisconsin HIV/AIDS Strategy

<table>
<thead>
<tr>
<th>Category</th>
<th>Data source/activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent diagnoses</td>
<td>Review of the first 50 cases of HIV diagnosed from 6/1/11: in care status and health outcomes; evaluation of linkage to care service system.</td>
<td></td>
</tr>
<tr>
<td>Community Readiness Assessment</td>
<td>Assess readiness of Black community in Milwaukee to address anti-gay discrimination in preparation for Acceptance Journeys social media campaign.</td>
<td></td>
</tr>
<tr>
<td>Center for AIDS Intervention Research</td>
<td>Various HIV prevention and care research and evaluation studies.</td>
<td></td>
</tr>
<tr>
<td><strong>Databases</strong></td>
<td><strong>EvaluationWeb</strong></td>
<td>Client-level counseling &amp; testing and prevention data services data; aggregate data for condom distribution, capacity-building, and harm reduction.</td>
</tr>
<tr>
<td></td>
<td><strong>Partner ServicesWeb</strong></td>
<td>Client-level partner services data.</td>
</tr>
<tr>
<td></td>
<td><strong>Laboratory</strong></td>
<td>Client-level laboratory data.</td>
</tr>
<tr>
<td></td>
<td><strong>AIDS Drug Reimbursement Program</strong></td>
<td>Client-level ADAP utilization data.</td>
</tr>
<tr>
<td></td>
<td><strong>Insurance</strong></td>
<td>Client-level data for clients whose insurance premiums are covered by AIDS/HIV Program funds.</td>
</tr>
<tr>
<td></td>
<td><strong>Medicaid</strong></td>
<td>Claims data for HIV positive individuals.</td>
</tr>
<tr>
<td></td>
<td><strong>PeriDataNet</strong></td>
<td>Client-level data regarding births to HIV positive women.</td>
</tr>
<tr>
<td></td>
<td><strong>CareXML</strong></td>
<td>Ryan White service utilization data.</td>
</tr>
<tr>
<td><strong>Community meetings and forums</strong></td>
<td><strong>Statewide Action Planning Group</strong></td>
<td>HIV consumers and providers meet for day-long meetings 5-6 times per year to provide input to the Wisconsin AIDS/HIV Program; meeting notes and documents prepared for the group’s review.</td>
</tr>
<tr>
<td></td>
<td><strong>Topic-specific</strong></td>
<td>Meetings focused on specific topics such as the linkage to care grant, HIV cluster and coordination of services for young Black MSM (YBMSM).</td>
</tr>
<tr>
<td></td>
<td><strong>Geographic area-specific</strong></td>
<td>Periodic meetings in the Madison, Appleton, and La Crosse areas to foster coordination among providers.</td>
</tr>
<tr>
<td></td>
<td><strong>Black Health Coalition</strong></td>
<td>Task force meetings – PLWHA and community members.</td>
</tr>
<tr>
<td></td>
<td><strong>ENDHIV</strong></td>
<td>Planning process led by Diverse &amp; Resilient, resulting from EpiAid regarding HIV in YBMSM in Milwaukee.</td>
</tr>
<tr>
<td><strong>Feedback from grantees and other service providers and their clients</strong></td>
<td><strong>HIV case managers</strong></td>
<td>Quarterly meetings of HIV case managers.</td>
</tr>
<tr>
<td></td>
<td><strong>CBOs providing HIV prevention services</strong></td>
<td>Periodic meetings of HIV prevention service providers.</td>
</tr>
<tr>
<td></td>
<td><strong>Public counseling and testing site providers</strong></td>
<td>Annual meetings of counseling and testing providers and social networks testing staff.</td>
</tr>
<tr>
<td></td>
<td><strong>HIV partner services (PS)</strong></td>
<td>Annual meetings and trainings of PS providers.</td>
</tr>
<tr>
<td></td>
<td><strong>Linkage to Care grantees</strong></td>
<td>Story boards prepared by LTC grantees; regular</td>
</tr>
</tbody>
</table>
Wisconsin HIV/AIDS Strategy
2014 Focus Paper -- Needs Assessment and the Wisconsin HIV/AIDS Strategy

<table>
<thead>
<tr>
<th>Category</th>
<th>Data source/activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>meetings of LTC grantees.</td>
<td></td>
</tr>
<tr>
<td>Client satisfaction surveys,</td>
<td>Identification of issues from client perspectives.</td>
<td></td>
</tr>
<tr>
<td>implemented by grantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer Advisory Boards</td>
<td>Consumer input and advisories for direct service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>organizations.</td>
<td></td>
</tr>
<tr>
<td>HIV Treaters Meetings</td>
<td>Case presentations and discussions evaluating</td>
<td>clinical best practice.</td>
</tr>
<tr>
<td></td>
<td>clinical best practice.</td>
<td></td>
</tr>
<tr>
<td>Grantee Monitoring</td>
<td>Annual site visits</td>
<td>Assessment of grantee capacity, progress toward goals, fiscal assessment,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and need for technical assistance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beyond HIV</td>
<td>Reports regarding related health issues</td>
<td>Reports on HIV-related behavioral risk factors and health outcomes; e.g.,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reducing Wisconsin’s Prescription Drug Abuse.</td>
</tr>
<tr>
<td></td>
<td>Meetings regarding related health issues</td>
<td>For example, the Dane County Drug Poisoning Summit regarding prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>drug abuse.</td>
</tr>
<tr>
<td>Healthiest Wisconsin 2020</td>
<td>The Healthiest Wisconsin 2020 planning process</td>
<td>and upcoming baseline data report.</td>
</tr>
<tr>
<td></td>
<td>and upcoming baseline data report.</td>
<td></td>
</tr>
<tr>
<td>Lesbian, gay, bisexual and</td>
<td>LGBT health team in the AIDS/HIV Program,</td>
<td>addresses issues beyond HIV. Data analysis and dissemination, cultural</td>
</tr>
<tr>
<td>transgender (LGBT) activities</td>
<td>addresses issues beyond HIV. Data analysis and</td>
<td>competence training, web site management, and input from staff from a broad</td>
</tr>
<tr>
<td></td>
<td>dissemination, cultural competence training,</td>
<td>range of health areas.</td>
</tr>
<tr>
<td></td>
<td>web site management, and input from staff from</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a broad range of health areas.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Behavioral Risk Factor Survey/Youth Risk Behavior</td>
<td>Population health data analyzed by the 12 HW2020 focus areas to identify</td>
</tr>
<tr>
<td></td>
<td>Survey data analysis</td>
<td>health disparities by race/ethnicity, sexual minority status, disability,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and socio-economic status.</td>
</tr>
</tbody>
</table>

B. Client Needs and Service Gaps

Based on the needs assessment mechanisms described above, high priority barriers and service gaps were identified and are described below. The responsible parties for carrying out activities to address each gap are identified and a general timeline for addressing these large scale barriers is provided in Addendum VI of the WHAS.

Unaware of HIV infection

The CDC estimates that 16% of individuals infected with HIV do not know that they are infected. Data suggest that the percentage of individuals unaware might be even greater in some populations, specifically MSM and MSM of color. This is also true in Wisconsin, as evidenced by the high proportion of individuals concurrently diagnosed with HIV and AIDS or progressing to AIDS within one year of HIV diagnosis. Contributing factors for being unaware of HIV infection include the lack of adoption and implementation of the CDC’s routine HIV testing recommendations by some providers and the under-representation of MSM in some testing programs (e.g. social networks testing) despite an increasing number of infections in this population.
Increasing HIV transmission among young MSM of color
Reported cases of HIV infection among young Black MSM have tripled over the past decade and an estimated one-in-three Black MSM is HIV positive. Contributing factors include complacency and continued risk behavior among MSM and difficulty reaching young MSM of color for prevention interventions and certain testing strategies (as mentioned above). In addition, several providers lack knowledge about the scope of Partner Services activities and are not re-engaging Partner Services when patients identify risk behaviors or new partners.

Social barriers to HIV prevention, testing and care
The rate of HIV infection and the prevalence rate in Milwaukee County are more than three times that of the statewide rates. Most cases of HIV infection among young Black MSM are also from Milwaukee County. Contributing factors to high rates of HIV infection in Milwaukee include anti-gay discrimination (especially in the Black community), patient fear of disclosure and distrust of providers, immigration concerns, and low health literacy.

Improved linkage to HIV care
An estimated 80% of individuals newly diagnosed with HIV infection during 2010 were linked to HIV care within three months of diagnosis (based on the presence of laboratory data), which is below the 85% linkage to care benchmark established in the NHAS. In addition, the presence of laboratory data does not necessarily mean that the individual followed through with the clinical appointment. Contributing factors to a failed linkage to care include a long wait time prior to the initial appointment, inability among publically funded test sites to link individuals to care when they do not return to the test site for the confirmatory test results, limited providers in rural areas, and lack of knowledge of referral resources among low volume, non-clinical test sites.

Improved retention in HIV care
Among prevalent HIV cases in Wisconsin as of the end of 2010, only 46% had the recommended two HIV care visits during 2011, meaning that retention in care is poor. Retention is even worse among some subgroups. Poor retention in care is a result of both client-level and system-level barriers. Client barriers include alcohol and drug abuse, mental health issues, fear and distrust of medical providers, and homelessness. Systems barriers include lack of health insurance, limited resources for those who are under-insured, lack of youth-focused facilities, lack of “off peak” clinic hours, and lack of transportation. Current systems are also inadequate for identifying people who are at risk of falling out of care, identifying people who have fallen out of care, and for finding and re-engaging individuals in care.

Limited access to ancillary services
Patient and provider input indicates difficulty in accessing certain services, such as mental health, alcohol and drug abuse, dental, and housing services. Access issues include workforce shortfalls (described below), lack of providers accepting medical assistance (especially dental care and psychiatric services), lack of insurance coverage for needed medications, and lack of transportation. In addition, a lack of regular screening for other service needs (e.g. regular mental health and AODA screenings) has also become a barrier to accessing services.
Workforce shortfalls
There are workforce shortfalls in the areas of clinical care, dental care, mental health, and AODA services. Some shortfalls are characterized by an actual lack of providers or provider types (e.g. psychiatrists), especially in rural areas. Other provider shortfalls are characterized by a lack of cultural competence, especially bilingual providers and those competent in issues unique to HIV, minorities with HIV, and lesbian, gay, bisexual and transgender (LGBT) health.

Incarceration
Incarceration in county jails, short-term detention centers, or state correctional institutions presents a barrier to continuity of care. While HIV care in state correctional institutions is a covered service, transition to community care after discharge can be difficult. Individuals who are difficult to locate often have unstable housing and competing priorities. Due to the short-term nature of county jails, access to and coordination of care is difficult.

Health disparities
Based on analyses of 2007-2011 Youth Risk Behavior Survey, there are significant disparities in the health and wellness of LGB youth, including higher likelihood of mental health and AODA issues, partner violence, early initiation of risk, and lower likelihood of protective factors, such as feeling supported by family. While HIV infection was not addressed in these surveys, the high risk activities reported by LGB youth put them at higher risk for HIV infection. Health outcomes also vary by demographic group. Overall, 40% of prevalent cases of HIV infection in Wisconsin have suppressed viral load. However, this number is lower among certain subgroups, including those with unknown risk and male and female PWID of color. Other groups with traditionally worse health outcomes include those with low socioeconomic status, communities of color, immigrants and refugees, persons with disabilities, and those living in very rural areas.

Health literacy
Health literacy, the degree to which individuals can understand basic health information and services needed to make appropriate health decisions, is key to one’s ability to understand risk and make decisions about needed behavior change. Persons with limited education, limited literacy skills, and whose primary language is other than English may be challenged in several ways, especially in understanding the complexities of HIV infection, HIV-related risks behaviors and risk reduction methods, the medical management of HIV, and ways to access needed HIV-related health and support services.

Increase of hepatitis C among young people
During 2011 there were two cluster investigations of hepatitis C (HCV) infection among individuals under age 30 that were conducted by the AIDS/HIV Program and the CDC. The results of these cluster investigations highlighted a growing HCV epidemic among young adults, especially in rural areas of the state, due to an increase in injection drug use, a lack of HIV testing, and a knowledge gap about community HCV resources.
## ADDENDUM XI

### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAP</td>
<td>AIDS Drug Assistance Program</td>
</tr>
<tr>
<td>ADR</td>
<td>ADAP Data Report (client level data report beginning in 2013)</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AN</td>
<td>AIDS Network</td>
</tr>
<tr>
<td>AODA</td>
<td>Alcohol and Other Drug Abuse</td>
</tr>
<tr>
<td>ARCW</td>
<td>AIDS Resource Center of Wisconsin</td>
</tr>
<tr>
<td>ARRA</td>
<td>American Recovery and Reinvestment Act of 2009</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral medications</td>
</tr>
<tr>
<td>ASL</td>
<td>American Sign Language</td>
</tr>
<tr>
<td>ASO</td>
<td>AIDS Service Organization</td>
</tr>
<tr>
<td>ATEC</td>
<td>AIDS Training and Education Center – See MATEC</td>
</tr>
<tr>
<td>AZT</td>
<td>Azidothymidine (chemical name for zidovudine, brand name is Retrovir)</td>
</tr>
<tr>
<td>BHC</td>
<td>Black Health Coalition</td>
</tr>
<tr>
<td>BRFSS</td>
<td>Behavioral Risk Factor Surveillance Survey</td>
</tr>
<tr>
<td>CADR</td>
<td>CARE Act Data Report renamed in 2007 – see RDR</td>
</tr>
<tr>
<td>CAIR</td>
<td>Center for AIDS Intervention Research</td>
</tr>
<tr>
<td>CAPS</td>
<td>Center for AIDS Prevention Studies (University of California, San Francisco)</td>
</tr>
<tr>
<td>CB</td>
<td>Capacity Building</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention (Federal)</td>
</tr>
<tr>
<td>CDCLI</td>
<td>Condom Distribution as a Community Level Intervention</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centers</td>
</tr>
<tr>
<td>CLD</td>
<td>Client Level Data</td>
</tr>
<tr>
<td>CLI</td>
<td>Community Level Intervention</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services (Federal)</td>
</tr>
<tr>
<td>COBRA</td>
<td>Consolidated Omnibus Budget Reconciliation Act of 1986</td>
</tr>
<tr>
<td>CPG</td>
<td>Community Planning Group</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
</tr>
<tr>
<td>CTR</td>
<td>Counseling, Testing, and Referral</td>
</tr>
<tr>
<td>D&amp;HH</td>
<td>Deaf and Hard of Hearing</td>
</tr>
<tr>
<td>DD</td>
<td>Developmental Disabilities</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Health Services (Wisconsin)</td>
</tr>
<tr>
<td>DNA</td>
<td>Deoxyribonucleic acid</td>
</tr>
<tr>
<td>DOC</td>
<td>Department of Corrections</td>
</tr>
<tr>
<td>DPH</td>
<td>Division of Public Health</td>
</tr>
<tr>
<td>DPI</td>
<td>Department of Public Instruction</td>
</tr>
<tr>
<td>DVH</td>
<td>Division of Viral Hepatitis</td>
</tr>
<tr>
<td>DWD</td>
<td>Department of Workforce Development</td>
</tr>
<tr>
<td>EBIs</td>
<td>Effective Behavioral Interventions</td>
</tr>
<tr>
<td>EC</td>
<td>Emerging Communities</td>
</tr>
<tr>
<td>EFA</td>
<td>Emergency Financial Assistance</td>
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<tr>
<td>EIIHA</td>
<td>Early Identification of Individuals with HIV/AIDS</td>
</tr>
<tr>
<td>EIS</td>
<td>Early Intervention Services</td>
</tr>
<tr>
<td>EMA</td>
<td>Eligible Metropolitan Area</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>EPSC</td>
<td>Evaluation and Program Support Center</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>FOA</td>
<td>Funding Opportunity Announcement</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>FTM</td>
<td>Female to Male (Transgender)</td>
</tr>
<tr>
<td>GAMP</td>
<td>General Assistance Medical Program (Replaced in January 2009 by BadgerCare Plus Core Plan for Childless Adults)</td>
</tr>
<tr>
<td>GLBT</td>
<td>Gay, Lesbian, Bisexual, Transgender</td>
</tr>
<tr>
<td>GLBTQ</td>
<td>Gay, Lesbian, Bisexual, Transgender, Questioning</td>
</tr>
<tr>
<td>GLI</td>
<td>Group Level Intervention</td>
</tr>
<tr>
<td>GPR</td>
<td>General Purpose Revenue (State funds)</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Therapy</td>
</tr>
<tr>
<td>HAB</td>
<td>HIV/AIDS Bureau (Office within the federal Health Resources and Services Administration)</td>
</tr>
<tr>
<td>NAHS</td>
<td>National AIDS/HIV Strategy</td>
</tr>
<tr>
<td>HAV</td>
<td>Hepatitis A Virus</td>
</tr>
<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
</tr>
<tr>
<td>HC/PI</td>
<td>Health Communication / Public Information</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
</tr>
<tr>
<td>HIRSP</td>
<td>Health Insurance Risk Sharing Plan</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HIV-positive</td>
<td>HIV-infected, person has tested positive on standard HIV-antibody test</td>
</tr>
<tr>
<td>HOH</td>
<td>Hard of Hearing</td>
</tr>
<tr>
<td>HOPWA</td>
<td>Housing Opportunities for People With AIDS</td>
</tr>
<tr>
<td>HRH</td>
<td>High Risk Heterosexual</td>
</tr>
<tr>
<td>HRSA</td>
<td>Health Resources and Services Administration (Federal)</td>
</tr>
<tr>
<td>HUD</td>
<td>Housing and Urban Development (Federal)</td>
</tr>
<tr>
<td>IDU</td>
<td>Injection Drug Use/Injection Drug User</td>
</tr>
<tr>
<td>ILI</td>
<td>Individual Level Intervention</td>
</tr>
<tr>
<td>IQ</td>
<td>Intelligence Quotient</td>
</tr>
<tr>
<td>IRC</td>
<td>(Wisconsin HIV/STD/HCV) Information Referral Center</td>
</tr>
<tr>
<td>LCS/EI</td>
<td>Mike Johnson Life Care and Early Intervention Services Grants (state-funded case management, core medical and support services)</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual, Transgender</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>Lesbian, Gay, Bisexual, Transgender, Questioning</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health Department</td>
</tr>
<tr>
<td>LLEGO</td>
<td>National Latina/o Lesbian, Gay, Bisexual &amp; Transgender Organization</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>MA</td>
<td>Medical Assistance, also called Medicaid</td>
</tr>
<tr>
<td>MAI</td>
<td>Minority AIDS Initiative</td>
</tr>
<tr>
<td>MATEC</td>
<td>Midwest AIDS Training and Education Center</td>
</tr>
<tr>
<td>MCSM</td>
<td>Men of Color who have Sex with Men</td>
</tr>
<tr>
<td>MMWR</td>
<td>Morbidity and Mortality Weekly Report</td>
</tr>
<tr>
<td>MSA</td>
<td>Metropolitan Statistical Area</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>MSM/IDU</td>
<td>Men who have Sex with Men and are also Injection Drug Users</td>
</tr>
<tr>
<td>MTF</td>
<td>Male to Female (Transgender)</td>
</tr>
<tr>
<td>NAHOF</td>
<td>National Association on HIV Over Fifty</td>
</tr>
<tr>
<td>NASTAD</td>
<td>National Alliance of State and Territorial AIDS Directors</td>
</tr>
<tr>
<td>NCHSTP</td>
<td>National Center for HIV, STD, and TB Prevention</td>
</tr>
<tr>
<td>NEP</td>
<td>Needle Exchange Programs</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>NGLTF</td>
<td>National Gay and Lesbian Task Force</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organizations</td>
</tr>
<tr>
<td>NHAS</td>
<td>National HIV/AIDS Strategy</td>
</tr>
<tr>
<td>NNRTI</td>
<td>Non-Nucleoside Reverse Transcriptase Inhibitor – “Non-Nukes”</td>
</tr>
<tr>
<td>nPEP</td>
<td>Use of post-exposure prophylaxis in persons with non-occupational HIV exposure</td>
</tr>
<tr>
<td>NRTI</td>
<td>Nucleoside Analog Reverse Transcriptase Inhibitor – “Nukes”</td>
</tr>
<tr>
<td>OMB</td>
<td>Office of Management and Budget (Federal)</td>
</tr>
<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction (test or assay)</td>
</tr>
<tr>
<td>PCSI</td>
<td>Program Coordination and Service Integration</td>
</tr>
<tr>
<td>PEMS</td>
<td>Prevention Evaluation Monitoring System</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure Prophylaxis - use of PIs in persons who have had an occupational, drug use or sexual exposure to HIV in order to reduce the risk of infection.</td>
</tr>
<tr>
<td>PHIP</td>
<td>Prevention for HIV Infected Persons</td>
</tr>
<tr>
<td>PHS</td>
<td>Public Health Service (Federal)</td>
</tr>
<tr>
<td>PI</td>
<td>Protease Inhibitor</td>
</tr>
<tr>
<td>PIR</td>
<td>Parity, Inclusion, and Representation (Older language within CDC for prevention)</td>
</tr>
<tr>
<td>PLWA</td>
<td>Person Living with AIDS</td>
</tr>
<tr>
<td>PLWH</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>POL</td>
<td>Popular Opinion Leader</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-exposure Prophylaxis - use of PI's in persons at risk for HIV to reduce the risk of infection if they are exposed</td>
</tr>
<tr>
<td>PTLT</td>
<td>Prevent, Test, Link, and Treat</td>
</tr>
<tr>
<td>PSE</td>
<td>Public Sex Environment</td>
</tr>
<tr>
<td>PWID</td>
<td>People Who Inject Drugs</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>QM</td>
<td>Quality Management</td>
</tr>
<tr>
<td>RDR</td>
<td>Ryan White Program Data Report (Replaces the CADR in 2007)</td>
</tr>
<tr>
<td>RFP</td>
<td>Request For Proposals</td>
</tr>
<tr>
<td>RNA</td>
<td>Ribonucleic Acid</td>
</tr>
<tr>
<td>RSR</td>
<td>Ryan White Services Report (client-level data report beginning in 2009)</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration (Federal)</td>
</tr>
<tr>
<td>SAPG</td>
<td>Statewide Action Planning Group</td>
</tr>
<tr>
<td>SCSN</td>
<td>Statewide Coordinated Statement of Needs</td>
</tr>
<tr>
<td>SEP</td>
<td>Syringe Exchange Programs</td>
</tr>
<tr>
<td>SI</td>
<td>Structural Interventions</td>
</tr>
<tr>
<td>SIECUS</td>
<td>Sexuality Information and Education Council of the United States</td>
</tr>
<tr>
<td>SPNS</td>
<td>Special Projects of National Significance</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TGA</td>
<td>Transitional Grant Area</td>
</tr>
<tr>
<td>TTY</td>
<td>Text Telephone</td>
</tr>
<tr>
<td>UMOS</td>
<td>United Migrant Opportunities Services</td>
</tr>
<tr>
<td>WAPC</td>
<td>Wisconsin Association for Prenatal Care</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>WHAS</td>
<td>Wisconsin HIV/AIDS Strategy</td>
</tr>
<tr>
<td>WSLH</td>
<td>Wisconsin State Laboratory of Hygiene (also referred to as SLH)</td>
</tr>
<tr>
<td>WSW</td>
<td>Women who have Sex with Women</td>
</tr>
<tr>
<td>YAC</td>
<td>Youth Advisory Council</td>
</tr>
<tr>
<td>YMSM</td>
<td>Young Men who have Sex with Men</td>
</tr>
<tr>
<td>YRBS</td>
<td>Youth Risk Behavior Survey</td>
</tr>
<tr>
<td>ZDV</td>
<td>Zidovudine (generic name for Azidothymidine, brand name is Retrovir)</td>
</tr>
</tbody>
</table>