



INTEGRATED HIV PREVENTION AND CARE PLAN/ STATEWIDE COORDINATED STATEMENT OF NEED

**Conducted under the auspices of the South Dakota Department of Health,
Ryan White Part B and HIV Prevention Division**

Submitted on:

April 25, 2016

LETTER OF CONCURRENCE

August 29, 2015

Jon Messick, Grants Management Specialist
ATTN: FOA 12-1201 HIV Prevention
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Atlanta, GA 30341

Mr. Messick,

On August 29th, 2015, the South Dakota HIV Prevention Planning Group (PPG) voted for concurrence with the state of South Dakota's HIV Prevention Plan. The planning group has reviewed the state's plan and finds it to be responsive to the priorities identified by the PPG.

We look forward to supporting the State's plan to reduce the spread of HIV/AIDS in South Dakota.

Sincerely,


Ron Wright
South Dakota Community Co-Chair


Susan Gannon
South Dakota DOH Co-Chair

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Section I: Statewide Coordinated Statement of Need/Needs Assessment

Introduction

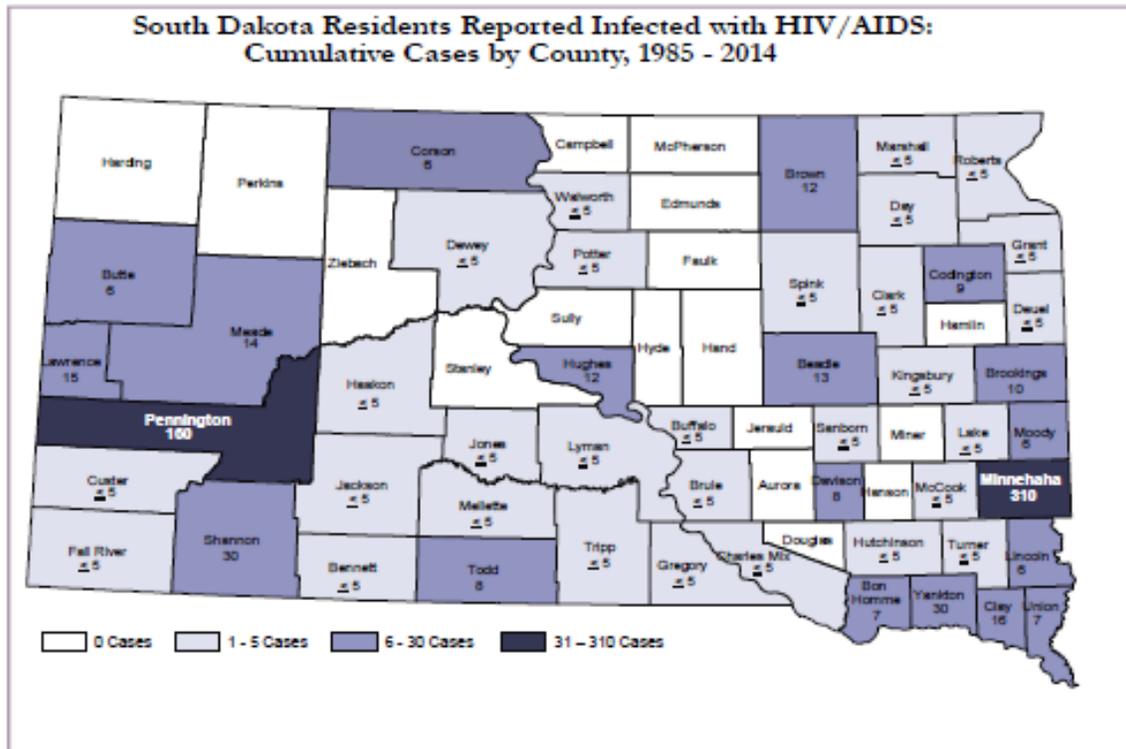
The goal of the HIV/AIDS Prevention and Ryan White B Programs under the South Dakota Department of Health Bureau of Disease Prevention, are to prevent primary HIV infection disease, reduce transmission of secondary HIV infection and treat HIV infection as early as possible to reduce the impact of the disease for the individual South Dakotan and the state at large, particularly those at high risk of acquisition. This document portrays the historic and current status of HIV disease in South Dakota, describes integrated needs assessment findings as part of a comprehensive look at the needs of individuals in South Dakota who are HIV positive and aware of their HIV status. It also explores the needs of those newly diagnosed and individuals who are out of care.

A. Epidemiologic Overview

HIV Epidemiology: As of December 31, 2014, a total of 550 persons were reported to be living with HIV/AIDS in the state of South Dakota. South Dakota’s PLWHA population includes 55% White non-Hispanics, 6% Hispanic/Other (includes Asian), 23% African American, and 16% American Indian. Of these PLWHA, 71% are male and 29% female. Age categories for South Dakota’s PLWHA include 2 years or less (1%, n = 1), 1-12 years (1%, n = 6), 13-24 years (1%, n=10), 25-44 years (35%, n = 193), 45-65 years (56%, n=310), and over 65 years (5%, n = 30).

a. Map of communities affected by HIV infection

Figure 1. South Dakota Residents – Cumulative Cases of HIV/AIDS, 1985-2014



Source: <http://doh.sd.gov/documents/Bulletin/March2015.pdf>

Figure 2. South Dakota County Map

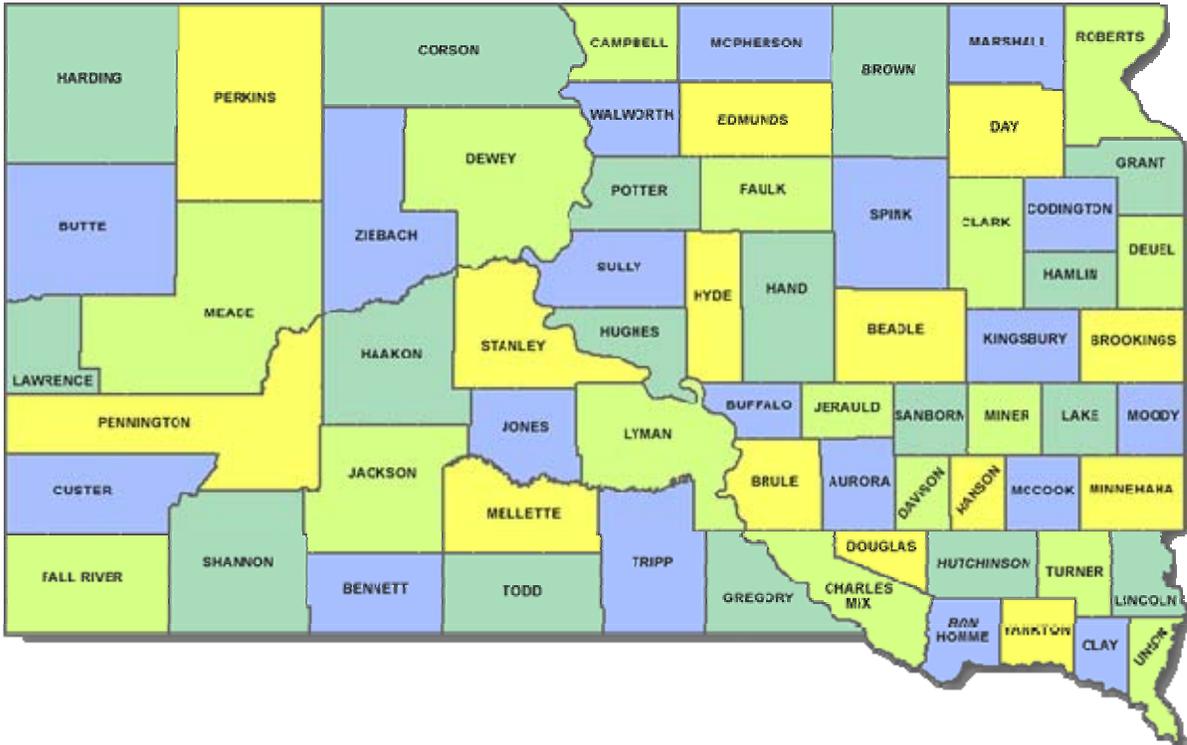


Figure 3. South Dakota by Planning Region, HIV Prevention



b. i. Demographic characteristic of South Dakota:

TABLE 1. HIV/AIDS Incidence (2010-2014) & Prevalence in South Dakota, as of December 31, 2014

Category of HIV Infection	# of Total Cases /PLWHA # of Cases in 2014	% of Cases/PLWHA
HIV Incidence (2010-2014)	31	79.5%
AIDS Incidence (2010-2014)	8	20.5%
TOTAL HIV/AIDS Incidence	39	100.0%
Total HIV Prevalence (2014)	313	56.9%
Total AIDS Prevalence (2014)	237	43.1%
Total HIV/AIDS Prevalence	550	100.0%

Source: South Dakota Department of Health, HIV/AIDS reporting as of December 31, 2014

HIV/AIDS Incidence: There were 152 newly diagnosed cases from 2010-2014 in South Dakota, with 63 or 41% White, 40 or 26% African American, 36 or 24% American Indian, and 13 or 9% Hispanic/Other. The gender split was 98 or 64% male and 54 or 36% female. Age categories include 3 cases or 2% among 2-12 year olds, 11 or 7% among 13-24 years of age, 86 or 57% among 25-44 years, 51 or 34% among 45-65 years of age and only 1 case constituting 1% among those over 65.

Transmission categories include 62 cases or 41% among heterosexuals, 44 cases or 29% among MSM, 22 cases or 14% among IDU, 9 cases or 6% among MSM/IDU, 3 cases or 2% among perinatal/pediatric and 12 cases or 8% that are unspecified. Geographic distribution was 90 cases or 59% in the Southeast region, 44 cases or 29% in the West region, 15 cases or 10% in the Northeast region and 3 cases or 2% in the Central region.

HIV/AIDS Prevalence: There were 550 people living with HIV/AIDS in South Dakota by the end of December 2014. Of those living with HIV/AIDS (PLWHA), 55% are White non-Hispanics, 23% African American, 16% American Indian and 6% Hispanic with 71% male and 29% female. Age categories for South Dakota's PLWHA include 2 years or less (1%, *n* = 1), 1-12 years (1%, *n* = 6), 13-24 years (1%, *n*=10), 25-44 years (35%, *n* = 193), 45-65 years (56%, *n*=310), and over 65 years (5%, *n* = 30). Transmission categories for PLWHA include 194 or 35% Males having Sex with Males (MSM), 163 or 30% Heterosexual, 83 or 15% Injection Drug User (IDU), 22 or 4% MSM/IDU, and 10 or 2% each perinatal/pediatric and transfusion/hemophilia. This leaves 68 or 12% PLWHA unspecified. Geographic distribution was 332 PLWHA or 60% in the Southeast region, 148 or 27% in the West region, 50 or 9% in the Northeast region and 20 or 4% in the Central region.

TABLE 2. Socio-demographic characteristics of Newly Diagnosed (2010-2014) and PLWHA 2014

	HIV/AIDS INCIDENCE (2010-2014)		HIV/AIDS PREVALENCE (2014)	
	Cases	Percent	Cases	Percent
TOTAL	152	100%	550	100%
<i>Gender</i>				
Female	54	36%	162	29%
Male	98	64%	388	71%
<i>Race/Ethnicity</i>	152	100%	550	100%
African American	40	26%	126	23%
American Indian	36	24%	88	16%
Hispanic/Other	13	9%	31	6%
White	63	41%	305	55%

<i>Country of Origin</i>	HIV/AIDS INCIDENCE (2010-2014)		HIV/AIDS PREVALENCE (2014)	
	Cases	Percent	Cases	Percent
United States	113	74%	444	81%
Other	39	26%	106	19%
<i>Age Group</i>				
< 2 years	0	0%	1	1%
2-12 years	3	2%	6	1%
13-24 years	11	7%	10	1%
25-44 years	86	57%	193	35%
45-65 years	51	34%	310	56%
> 65 years	1	1%	30	5%
<i>Exposure</i>				
Heterosexual	62	41%	163	30%
Injection Drug Use	22	14%	83	15%
MSM	44	29%	194	35%
MSM/IDU	9	6%	22	4%
Perinatal/Pediatric	3	2%	10	2%
Transfusion/ Hemophilia	0	0	10	2%
Unspecified	12	8%	68	12%
<i>Prevention Region</i>				
Central	3	2%	20	4%
Northeast	15	10%	50	9%
Southeast	90	59%	332	60%
West	44	29%	148	27%
	152	100%	550	100%

Source: South Dakota Department of Health, HIV/AIDS reporting as of December 31, 2014

High Risk Groups in South Dakota:

For persons at higher risk, the socio-demographic characteristics are displayed, with highest risk among those in the 25-44 years of age group for newly diagnosed, among heterosexuals and males having sex with males with a significant fraction for injection drug users; and in the Southeast and West regions of the State.

b. ii. Socio-economic Data for South Dakota:

Uninsured/Insurance Status: South Dakota's uninsured was estimated at 11.3% of the general population (n = 92,492).¹ Medicare and Medicaid recipients in South Dakota are estimated at 15% and 12% respectively, compared to the U.S. estimates of 13% and 19% respectively.²

Poverty: As reported by the U.S. Census Bureau in September of 2015, the U.S. poverty rate is estimated at 11.5% for all families and 15.6% for all people. South Dakota estimates in this same report indicated 9.2% of all families and 14.2% of all people had incomes in the past 12 months below the poverty level.³

According to the U.S. Census Bureau's 2010-2014 American Community Survey 5-year estimates report, the number of **Foreign Born** residents is 24,400 persons; **62.7%** are not U.S.

¹ U.S. Census Bureau 2010-2014 American Community Survey 5-year estimates, accessed June 2016.

² Kaiser Family Foundation, State Health Facts, accessed June 2016.

³ U.S. Census Bureau, ACS, accessed June 2016.

citizens. The numbers of foreign born reflect immigration policies in South Dakota, with a substantial refugee settlement initiative.

c. Burden of HIV in service area using surveillance data

i. Number of PLWH: There were 550 people living with HIV/AIDS in South Dakota by the end of December, 2014.

ii. Rate of HIV Incidence: 229 cases reported over the past ten (10) years, with 31 newly diagnosed cases reported in 2014. This represents a median of 32 cases per year with a rate of 2.5 incidence. The majority of cases in 2014 (19 or 61%) were among males with 39% (12) among females. This constitutes a rate of 4.1 per 100,000 that have an HIV diagnosis within 2014, compared to a rate of 16.5 per 100,000 in the United States. **Rate of HIV Prevalence:** The rate of People Living with an HIV Diagnosis was 71.3 per 100,000 in 2014 compared to 353.2 per the United States.

iii. Trends: The trend for HIV incidence or newly diagnosed cases is constant at a median of 32 cases per year over the past ten (10) years and 31 cases in 2014.

Figure 4. HIV Incidence Trends, South Dakota, 2010-2014

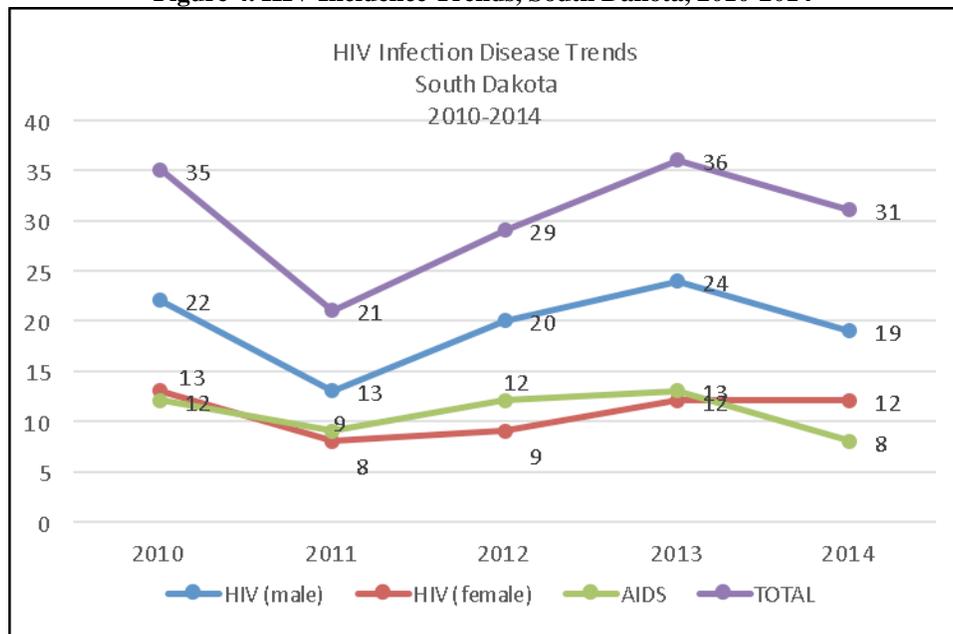
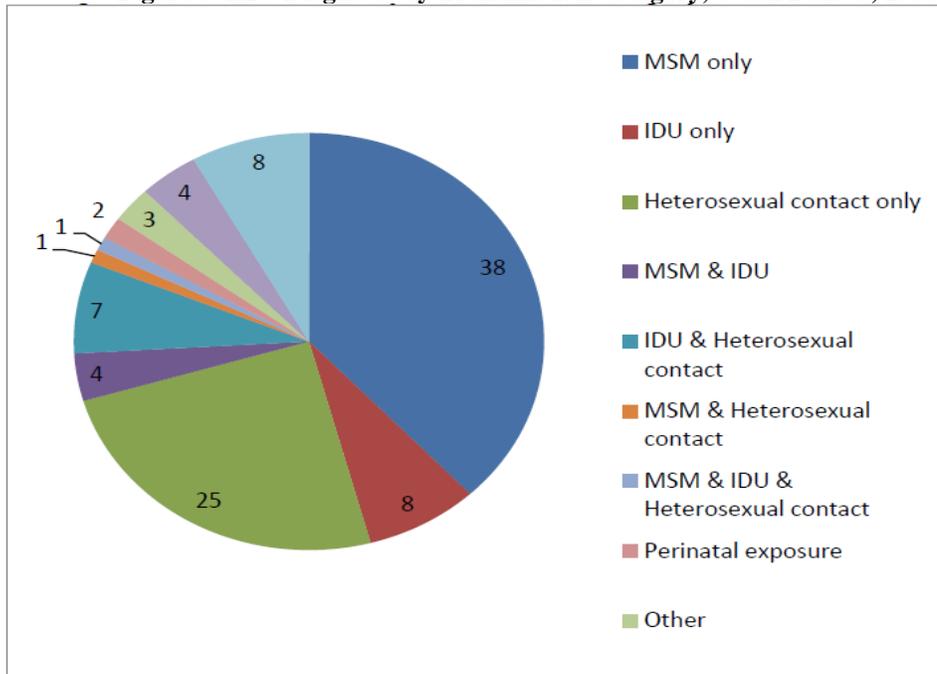


Figure 5. HIV Diagnoses by Transmission Category, South Dakota, 1985-2014



By transmission category over the past 29 years, 38% or 289 newly diagnosed persons were classified as male-to-male (MSM) sexual contact, 25% or 187 through heterosexual contact, and 8% or 59 through injection drug use comprising 70% of all cases for these three (3) main transmission categories. Racial distinction shows that among the 450 whites, 53% of cases were through MSM contact, with little reported heterosexual or injection drug use transmission (12% and 7%, respectively). The other racial groups report heterosexual contact as their predominant mode of transmission (Blacks at 55%, Asian and Hispanic each at 43% and American Indian at 31%).

The trend for HIV prevalence from 2010-2014 or those living with HIV as reported in Table 2 is predominantly male (71%) vs female (29%). White (55%) followed by Black (23%) and American Indian (16%) then Hispanic/Other (6%). The majority (81%) are born in the United States, but 19% are foreign born. Age composition is older, with 56% between 45 and 65 years of age, and 5% over 65. Slightly over a third (35%) are between 25-44 years of age with 1% each comprised of youth (13-24 years), children (2-12 years) and infant (< 2 years). Exposure is led by male-to-male sexual contact (35%), followed by heterosexual contact (30%), injection drug use (15%), MSM/IDU (4%) and 2% each perinatal/pediatric and transmission/ hemophilia transmission. A small but significant fraction (68 or 12%) have unspecified exposure. The four (4) HIV prevention regions show the same dominant Southeast (60%) and West (27%) correlation to the general population centers for People Living With HIV. Only 9% of PLWH reside in the Northeast and 4% in the Central regions of South Dakota.

iv. Populations most affected: The table below compares the demographics of the general population in South Dakota in 2014 to the characteristics of the newly diagnosed (incidence) and those living with HIV. This analysis shows that males, blacks, American Indians, foreign born,

the 25-44 and 45-65 age groups and the Southeastern and Western regions are disproportionately impacted by HIV. The rates represent the percentage variance in incidence or prevalence to their proportion in the general population.

TABLE 3. Comparison of Newly Diagnosed (2010-2014)/PLWHA (2014) to General Population (2014)								
CATEGORY	HIV INCIDENCE (2010-2014)		GENERAL POPULATION (2014)		HIV PREVALENCE (2014)		GENERAL POPULATION (2014)	
	Cases	%	%	Variance	Cases	%	%	Variance
<i>Gender</i>								
Female	54	36%	50%		162	29%	49%	
Male	98	64%	50%	14%	388	71%	51%	20%
<i>Race/Ethnicity</i>								
African American	40	26%	1%	25%	126	23%	2%	21%
American Indian	36	24%	9%	15%	88	16%	9%	7%
Hispanic/Other	13	9%	1.4%		31	6%	1.4%	
White	63	41%	86%		305	55%	86%	
<i>Country of Origin</i>								
United States	113	74%	97%		444	81%		
Other	39	26%	3%	23%	106	19%	3%	
<i>Age Group</i>								
< 2 years	0	0%	2.9%		1	1%	2.9%	
2-12 years	3	2%	15.1%		6	1%	15.1%	
13-24 years	11	7%	19.1%		10	1%	19.1%	
25-44 years	86	57%	27.4%	29.6%	193	35%	27.4%	7.6%
45-65 years	51	34%	21.2%	12.8%	310	56%	21.2%	34.8%
> 65 years	1	1%	14.3%		30	5%	14.3%	
<i>Prevention Region</i>								
Central	3	2%	19%		20	4%	19%	
Northeast	15	10%	17%		50	9%	17%	
Southeast	90	59%	42%	17%	332	60%	42%	18%
West	44	29%	22%	7%	148	27%	22%	5%
	152	100%			550	100%		

Source: South Dakota Department of Health, HIV/AIDS reporting as of December 31, 2014

v. Geographic concentrations: The heaviest concentration of cumulative case by county from 1985-2014 (past 29 years) is consistently Minnehaha County with 310 PLWH and Pennington County with 180 PLWH. These two counties represent the two largest population centers at the Eastern (Minnehaha) and Western (Pennington) edges of South Dakota.

vi. Deaths: The rate of deaths from HIV infection was 0.5 per 100,000 in 2013 (Centers for Disease Control and Prevention, [National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention \(NCHHSTP\) Atlas](#), accessed February 2016).

Correlating HIV/AIDS surveillance data to vital statistics records is difficult, with only 211 cases reported to the South Dakota Department of Health that were classified as dead by December 31,

2014. Of these 194 or 92% were linked with death certificate records, with 104 or 54% listing HIV as the cause of death. The two most common listed causes of death other than HIV were diseases of the circulatory system (26 or 13%) and malignant neoplasms (22 or 11%). The remaining 22% are scattered among a variety of illnesses as illustrated below. It is also noted that it was more common in the earlier reporting years (1985-1990) to list HIV/AIDS as a cause of death than in the past 15 years.

TABLE 4. Major Causes of Death for Patients with HIV/AIDS in South Dakota, 1985-2014

Causes of Death	Frequency	Percent
HIV/AIDS	104	54%
Diseases of circulatory system	26	13%
Malignant neoplasms	22	11%
Car accident	6	3%
Liver diseases, alcoholic liver, hepatic failure	6	3%
Diseases of respiratory systems, mainly pneumonia	6	3%
Alzheimer's Disease	4	2%
Diseases of endocrine, nutritional and metabolic	3	2%
Assault, poisoning	2	1%
Diseases of intestine and peritoneum	2	1%
Injury of nerves and spinal cord	2	1%
Sepsis	2	1%
Viral hepatitis	2	1%
Chronic viral hepatitis	1	1%
Parkinson's Disease	1	1%
Diseases of blood and blood forming organs	1	1%
Ill-defined or unspecified death	1	1%
Intentional self-poisoning	1	1%
Renal failure	1	1%
Unspecified fall	1	1%

Source: Vital Statistics data, Death Certificate, South Dakota Department of Health, December 2014

d. Indicators of risk for HIV infection

i. Behavioral surveillance data: The South Dakota Department of Health utilizes Maven, version 5.2.5 and eHARS for data collection and reporting for indicators of risk for HIV infection in the general population. Behavioral indicators specifically monitored are: 1) referrals to therapy services; 2) Mental Health appointment no show rates; 3) referrals to legal services; 4) and medical appointment adherence.

ii. HIV surveillance data: HIV surveillance is the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event. HIV surveillance collects, analyzes, and disseminates information about new and existing cases of HIV infection (including AIDS). HIV surveillance data shows that although a person can have multiple risk factors, for the purposes of analysis, the risk factor information on each surveillance record is summarized according to hierarchical categories. In descending order of priority, these hierarchical categories are:

- ❖ Male-to-male sexual contact

- ❖ IDU
- ❖ Male-to-male sexual contact and IDU
- ❖ HRH contact (contact with a person known to have, or to be at high risk for HIV infection)
- ❖ Other (much less prevalent and includes hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified)

This hierarchy is based on the probability of transmission per act as well as the prevalence of infection among people to whom these categories apply. For a classification of HRH contact, the case report form must bear an indication of a sex partner with, or at high risk for HIV infection.

Due to its low prevalence status for HIV infection disease, South Dakota does not currently participate in either the Medical Monitoring Project (MMP) nor the National Behavioral HIV Surveillance System project (NHBSS).

iii. Ryan White HIV/AIDS data report: The Ryan White Part B office utilizes the RSR and the ADAP Data Report (ADR) reports to provide client level data each calendar year. The RSR provides valuable data on all HAB performance measures, specifically the 5 Core measures for: 1) Viral Load Suppression; 2) Prescription of HIV Antiretroviral Therapy; 3) HIV Medical Visit Frequency; 4) Gap in HIV Medical Visits; and 5) Pneumocystic jiroveci Pneumonia (PCP) Prophylaxis. These measures provide data on all populations of PLWHA and aide the state in determining effectiveness of strategies for improving access to care, retention in care, and viral load suppression.

iv. Other relevant demographic data

Hepatitis B and C: Hepatitis B is a liver infection caused by the Hepatitis B virus (HBV). The virus is transmitted when bodily fluid from an infected person enters the body of someone not infected—this can occur through sexual contact, sharing needles/syringes/drug-injection equipment or from a mother at birth. HBV can be acute (short-term) or chronic with risk for chronic HBV tied to the age of initial infection. Chronic HBV increases the chance for related disease such as cirrhosis or liver cancer, with exposure linked to risk for HIV infection disease. The incidence of chronic HBV is slightly higher for males as represented by the median for the ten-year trend-line at 54% with females at 46%. Race/ethnic groups most at risk are Asian (34%), Black (26%), and White (21%). The age groups most impacted are those from 25-39 years (38%), followed by the 40-64 age band (28%). Geographic concentration is highest in Minnehaha County (48%), followed by Beadle County (8%), Pennington County (8%) then Yankton (2%) and Bon Homme, Brookings, and Lawrence counties (2% each). The incidence of chronic HBV in South Dakota in 2014 was 5.6 per 100,000. The trend-line for HBV in South Dakota for the past ten years is:

TABLE 5. Hepatitis B Virus: Ten-Year Trend-Line for South Dakota, 2005-2014											
HBV	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	MEDIAN
Chronic	34	17	36	48	33	51	51	51	80	58	50
Acute	8	6	6	0	4	2	2	2	5	3	4

Hepatitis C causes liver disease with the highest risk among baby boomers (ages 45-65). This poses a significant threat to form a long-term, chronic infection with frequent asymptomatic presentation. HCV is a blood-borne virus often associated with injection-drug use and tattoos.

There were 516 cases of HCV reported during 2014 in South Dakota, the most ever reported in a single year in the state. The counties with the highest rates were Corson, Bon Homme and Buffalo. The incidence for HCV in South Dakota in 2014 was 44.7 per 100,000.

TABLE 6. Hepatitis C Virus: Ten-Year Trend-Line for South Dakota, 2005-2014											
HCV	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	MEDIAN
	212	352	309	364	383	350	356	382	406	516	360

STD surveillance. Three (3) major Sexually Transmitted Diseases are reported: Chlamydia, Gonorrhea, and Syphilis.

TABLE 7. Sexually Transmitted Disease: Ten-Year Trend-Line for South Dakota, 2005-2014											
STD	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	MEDIAN
Chlamydia	2670	2612	2611	2917	3009	3175	3409	3925	3947	4129	3092
Gonorrhea	358	362	252	381	344	467	601	707	789	880	424
Syphilis (Primary, Secondary, Early Latent)	1	19	11	4	2	4	0	21	49	76	7.5
Congenital	0	0	0	0	0	0	0	0	0	3	0

Chlamydia. Chlamydia is one of the most common sexually transmitted diseases that affects both men and women, spread through sexual contact. The number of cases has steadily increased over the past decade in South Dakota, with 4,129 cases reported in 2014. The highest average annual incidence occurs in Dewey, Oglala Lakota and Todd counties with the age group from 15-24 years experiencing the highest rate. The incidence rate is 398.0 per 100,000. The national rate in 2014 was 456.1.

Gonorrhea. Gonorrhea is a STD that can cause infection in the genitals, rectum and throat and can advance to invasive, disseminated disease. It is most common among youth ages 15-24, and can result in pelvic inflammatory disease in women and possible infertility or sterility in men. Gonorrhea has also increased over the past decade in South Dakota with 880 cases reported in 2014. The counties with the highest rates of gonorrhea are Dewey, Oglala Lakota and Corson counties. The incidence rate is 63.1 per 100,000. The national rate in 2014 was 110.7.

Syphilis. Syphilis is a STD that can cause long-term complications if not treated early and correctly. Symptoms in adults are divided into stages: primary, secondary, early latent and late latent syphilis. It is spread by direct contact with a syphilis sore during vaginal, anal or oral sex. It can be spread from an infected mother to her unborn baby resulting in congenital syphilis. In 2014, South Dakota experienced its largest outbreak in over 40 years with 76 cases of early syphilis (primary and secondary, early latent) reported and 3 cases of congenital syphilis. Incidence was highest in Corson, Dewey, Oglala Lakota and Walworth counties with an incidence rate of 2.0 per 100,000. The national rate in 2014 was 6.3.

Tuberculosis surveillance. Tuberculosis or TB is caused by the *mycobacterium tuberculosis* bacteria. TB is spread through the air when an infectious person coughs, sneezes, speaks, talks or sings. Eight (8) cases of TB were reported in South Dakota in 2014. Counties with the highest TB incidence are Ziebach and Charles Mix.

TABLE 8. Tuberculosis: Ten-Year Trend-Line for South Dakota, 2005-2014											
Tuberculosis	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	

	16	14	13	16	18	15	15	19	9	8
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TABLE 9. HIV Co-Infection with Chlamydia, Gonorrhea, Hepatitis C, Syphilis & Tuberculosis by Gender and Age in South Dakota from 2010-2014

	Gender		Age Group			
	TOTAL	Female	Male	13-24	25-44	45-65
Chlamydia	18	10	8	5	9	4
Gonorrhea	11	5	6	2	8	1
Hepatitis C	26	11	15	1	13	12
Syphilis	20	1	19	1	8	11
Tuberculosis	4	4	0	0	2	2
TOTAL	79	31	48	9	40	30

Substance Abuse: Injection Drug Use/Substance Abuse Disorders account for 15% (n=83) of the total PLWHA population as of December 31, 2014. According to the National Survey on Drug Use and Health Report “Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings”, an estimated 24.6 million Americans aged 12 or older were current illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview⁴. This estimate represents 9.4% of the population aged 12 or older. The 2013 survey also revealed among adolescents aged 12 to 17, 2.2 million were current illicit drug users; representing 8.8% of adolescents.⁵ Further, the study showed in 2013, an estimated 20.3 million adults (8.5% of the population aged 18 or older) were classified with substance dependence or abuse in the past year based on the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV). HIV infected substance users require multiple levels of care and coordination to maintain treatment adherence. This population has a higher risk for developing bacterial infections, has higher rates of TB and HCV co-infections and is likely to be on a variety of medications which contribute to the cost and complexity of their care. IDU has contributed to the burden of medical conditions, including HIV/AIDS, Hepatitis B and C, tuberculosis, overdose, end-stage liver disease, endocarditis and other related bacterial infections.

v. Qualitative data

All focus groups were held on Tuesday, January 19, 2016 at the West River Case Management Office of Volunteers of America in Rapid City, SD. We hosted two sessions:

- 1 p.m. to 2 p.m.: 6 clients attended; 2 women and 4 men
We facilitated both Focus Group topic 1 Support Groups and Focus Group topic 2: Employment Opportunities. A lively discussion ensued and many suggestions were offered.
- 3 p.m. to 4 p.m.: 2 men attended, a married gay couple with 1 infected and 1 affected. We decided to address the needs of the affected, in this case a husband and caregiver and the needs, barriers and gaps presented were illuminating.

⁴ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (September 4, 2014). *The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*. Rockville, MD.

⁵ IBID

Both focus groups were facilitated by Casey Hoffman of Germane Solutions with Sarah Hewitt and Jessica Johnson, West River Case Managers, present. Refreshments were available and all participants received a \$10 Wal-Mart gift card for their time.

Focus Group 1: Support Groups

Let's start the discussion on your need for a support group and the best type of support group activities and also your opinion on in-person and online support groups.

- 1) Do you attend a support group for People Living with HIV/AIDS?
The West River Case Managers have tried many different types, times, days etc. for Support Groups with limited attendance and success. A survey was sent out in 2015 asking for feedback about support groups.
- 2) How important is it for you to discuss issues with other HIV individuals?
Most participants thought it was very important to discuss issues with other HIV individuals. One participant stated that it would be better to have a separate support group for Males having Sex with Males, one for heterosexual men and one for women. Another idea was to have the support groups in someone's home, but a drawback would be that Jessica and Sarah cannot attend. The group felt that an incentive of bus passes or gas cards to cover transportation to support groups would boost attendance, and that a monthly or quarterly meeting would work best, with a preference for Tuesday or Thursday.
- 3) Do you attend any retreats, social events or regular outings specifically targeted for People Living with HIV/AIDS?
A retreat, barbeque or social gathering was thought to be a good idea, but again transportation and probably lodging would need to be addressed.
- 4) Is geographic distance a factor in not attending support groups for People Living with HIV/AIDS? The distance was thought not to be a factor, but the cost of transportation definitely was.
- 5) If so, would you be interested in participating in an internet support group through Skype or some other online forum? Not one respondent reacted favorably to the idea of an internet support group or Skype meeting.
- 6) Other comments?
The issue of confidentiality, trust and respect was brought up, with Sarah stating that confidentiality had to be understood and stressed at each meeting. Support group attendees that could be proven had broken a confidence would not be allowed to attend future meetings.

Focus Group 2: Employment Opportunities

Let's start the discussion by talking about the opportunity for employment in South Dakota and how your HIV status affects your job outlook.

1. How does living with HIV/AIDS affect your job opportunities?
Participants felt that their HIV limited their job opportunities due to some disabilities, the problems with handling food safely and stigma.
2. Does working impact the medical care and appointments you need to take care of yourself while living with HIV/AIDS?
Not if an employer is sensitive to the need for medical care and appointments, but it is not easy.

3. Do you have specific problems with work and taking care of your health?
Disabilities limited the amount of time that could be spent on your feet.
4. Do you have specific suggestions on how to improve the coordination of work and living with HIV/AIDS?
Specific suggestions on finding and keeping employment while living with HIV/AIDS included:
 - a) Do Ask & Do Tell: Minimally alert your employer to your medical condition.
 - b) Know the Laws and your rights
 - c) Check out temporary jobs and part time work
5. Other comments?
The need for retraining and vocational rehabilitation was suggested, with LOVE, Inc. mentioned as a resource. <http://www.loveinonline.com/about/>

Focus Group 3: The Needs of Caregivers and of the Affected by HIV

A final focus group was held from 3 to 4 pm and we changed the topic due to the attendance of a married couple, one of whom was living with HIV/AIDS and the other his spouse who cared for him. The biggest needs were:

- a) Someone to help with chores:
 - Yard work
 - Painting the house
 - Cleaning the basement of old bottles and cans
 - Installing a new bathtub and repairing the floorboards and tiles in the bathroom
 - General maintenance
 Mentioned again was LOVE, Inc., Lutheran Social Services and other local organizations that could provide assistance with chores.
- b) A support group / support system for partners of Ryan White clients that could offer advice and possible respite care. (Sarah stated that currently respite care is paid for a Ryan White client but not their caregivers.)
- c) Knowledge of available services and how to access those services. The “affected” spouse was disabled, had lost his job due to a work-based accident and had qualified for disability but his former employer was fighting the worker’s compensation payments.
- d) The possibility of the affected spouse being paid by an insurance company to be the home health caregiver for the infected spouse was discussed.

Some states provide programs that pay family members to care for loved ones at home however they are usually somewhat limited. These programs vary widely from state to state and even within the same state. The possibility of using a disability eligibility coordinator to explore available services was discussed with Sarah providing the contact details of the applicable state agency in Pierre, SD.

Family Caregiver Support Program (FCSP): *Source for South Dakota information:*

https://www.caregiver.org/state-list-views?field_state_tid=100

FCSP services for family caregivers are provided through local Adult Services and Aging Offices (ASAs) and include: information; assistance; individual counseling, support groups and caregiver training; respite care; and limited supplemental services, such as transportation and home modifications. Care Recipient Eligibility requirements are adults age 60 and older with the

exception of Adults with dementia. Caregiver Eligibility requirements are as follows: anyone age 18 and older caring for someone who meets care receiver eligibility.

Special Populations: Adults age 55 and older who are caring for anyone (that is not their child) over 18 years old with developmental disabilities; Grandparents or other relatives age 55 and older caring for children (age 18 and under). South Dakota: To be connected to your local ASA within South Dakota, call: (866) 854-5465; Outside South Dakota, call: (605) 773-3656
<http://dss.sd.gov/elderservices/services/caregiver.asp>

vi. Vital Statistics data: The major correlation of HIV prevention and treatment to vital statistics was presented in the narrative and Table 4 on Mortality related to HIV infection disease or other causes.

vii. Other relevant program data: The HIV Prevention Planning Group (PPG) meets quarterly and provides an invaluable asset to the state partners in sharing data, collaboration efforts, and in brainstorming areas of need presented to all partners in all areas of healthcare. Community Health data specific to testing and outreach services is provided by Falls Community Health with discussion of high-risk population trends identified with testing events. Sexually transmitted disease (STD) data is presented by both Heartland Health and the Office of Disease Prevention to aide in developing improved prevention strategies amongst all partners in South Dakota.

B. HIV CARE CONTINUUM

South Dakota utilizes the *diagnosed-based* HIV Care Continuum model using the HHS indicators of: 1) HIV-diagnosed, 2) Linkage to Care, 3) Retained in Care, 4) Antiretroviral Use, and 5) Viral Load Suppression. Table 11 below is the South Dakota's 2014 Continuum of Care as of December 31, 2014.

a. HIV Care Continuum: The South Dakota Department of Health defined the five (5) stages of the HIV Continuum of Care starting with the estimated number of HIV-infected persons living in South Dakota as follows:

i. HIV-diagnosed: HIV-infected persons-estimated number of HIV-infected persons living in South Dakota as of December 31, 2014. This number equaled the number of persons with an HIV diagnosis plus a 1% adjustment for under-reporting and 20% for those who are infected but undiagnosed.

ii. Linkage to Care: Number of HIV-diagnosed persons with at least one reported CD4 or viral load test result ever.

iii. Retained in Care: Number of persons linked to care with at least one CD4 or viral load result during the calendar year 2014.

iv. Antiretroviral Use: Number of persons receiving medical care and who have a documented antiretroviral therapy prescription in their medical records in the measurement year.

v. Viral Load Suppression: Number of persons retained in care whose most recent viral load value in 2014 was less than 200 copies per milliliter (mL) of blood.

Based on these definitions, the South Dakota Department of Health reported 22% of PLWH in care were virally suppressed within the state in 2014. The number of persons receiving any form of medical care was reported at 265 PLWH with 245 PLWH prescribed ART (92.45%).

Linkage to Care and Outcome of Care: The HIV Continuum starts with an estimate of the number of HIV-infected persons living in a state at a specific point in time. The interim stages (Linkage, Retention, ART use) lead to the desired endpoint of Viral Suppression. This endpoint aims to control the disease state but also to reduce secondary HIV transmission and result in better health outcomes for PLWH. South Dakota’s HIV Continuum for 2014 is defined below.

TABLE 10. HIV Continuum of Care – South Dakota, 2014 – Linkage and Outcome

	Estimated number of HIV infected in SD	Number of HIV diagnosed persons living in SD	Linkage to HIV care: Number of HIV diagnosed in SD with at least 1 reported CD4 or Viral Load test result ever	Retained in Care: Number of HIV-positive persons in SD linked to care with at least 1 CD4 or Viral Load test result in CY 2014	Viral Suppression: Number of HIV positive persons in SD with most recent VL less than 200 copies per mL
DIAGNOSIS	663	549	491	228	121
PLWH	364	301	252 (84%)	132 (44%)	73 (24%)
PLWA	296	245	238 (97%)	95 (39%)	48 (20%)
UNKNOWN	3	3	1 (33%)	1 (33%)	0
GENDER	664	549	491	228	121
Male	467	386	339 (88%)	148 (38%)	78 (20%)
Female	197	163	152 (93%)	80 (49%)	43 (26%)
RACE	662	549	491	228	121
White	367	304	263 (87%)	113 (37%)	69 (23%)
Black	152	126	117 (92%)	55 (44%)	27 (21%)
Hispanic	29	24	21 (88%)	9 (38%)	4 (17%)
API	8	7	7 (100%)	2 (29%)	2 (29%)
American Indian	105	87	82 (94%)	48 (55%)	19 (22%)
Unknown	1	1	1 (100%)	1 (100%)	0
AGE	629	522	472	218	135
2-12 years	8	7	7 (100%)	3 (43%)	2 (29%)
13-24 years	12	10	8 (80%)	5 (50%)	1 (10%)
25-44 years	234	194	181 (93%)	85 (44%)	45 (23%)
45-64 years	361	299	264 (88%)	121 (40%)	86 (22%)
65+	14	12	12 (100%)	4 (33%)	1 (8%)
TOTAL	664	549	491 (89%)	228 (42%)	121 (22%)

Source: South Dakota eHARS data as of December 31, 2014

b. Narrative of how target populations (YMSM, AA women, Heterosexuals, IDU) are situated along Continuum. South Dakota is a low incidence/prevalence state where the number of reported cases remains stable despite increased sensitivity of case definitions and higher number of screened individuals. Although transmission rates have decreased over time, whites are more likely than other racial groups (black, Hispanic, API, American Indian) to acquire infection through Men having sex with Men (MSM) exposure. MSM remains the predominant risk exposure category of transmission (38% of all reported cases); however, more heterosexual and IDU transmission have been reported recently. Males are the predominate group with 74% of cases reported. Racial minorities continue to be disproportionately affected. All racial and gender groups appear to be diagnosed at almost the same age according to the data presented, yet Males ages 25-44 have the highest (47%) diagnosis rate.

c. Describe how the HIV Care Continuum may be or is currently utilized in:

i. Planning, prioritizing, targeting and monitoring available resources to respond to the needs of PLWH. The HIV Care Continuum is utilized during the Priority Setting and Resource Allocation (PSRA) process each year to assist in determining priority services, specifically targeted to improving engagement at each stage of the continuum with the ultimate goal of increasing viral suppression among PLWH. South Dakota data revealed 22% of PLWH in care were virally suppressed in 2014, and only 42% were retained in HIV care. The use of the Continuum data aided the FY2016 PSRA process in determining service priorities to align with the specific goals established for reducing the Unaware and Unmet need by 5% and 10% respectively. Outreach and Disease Intervention Specialists (DIS) have a dual goal of identifying those HIV+ yet Unaware of their status and re-engaging the Out of Care into HIV medical care, thus were funded through Part B to target these populations. South Dakota has dedicated significant resources to achieve success in each stage in the continuum to assist in informing, identifying, referring and linking PLWHA to medical care.

ii. Improving engagement and outcomes at each stage: Despite the low overall numbers of HIV-positive individuals in South Dakota with viral suppression, recently diagnosed cases are more likely to experience viral load value in 2014 with less than 200 copies per milliliters.

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

Overview: The Department of Health is responsible for administration of the Ryan White Part B Program, which funds services for people with HIV disease. A significant portion of the funding is designated for the AIDS Drug Assistance Program, referred to as ADAP. Eligible persons include residents of South Dakota that are diagnosed as HIV positive, have an income less than 300% of the federal poverty level and have no coverage through other health insurance or compensation vehicles including Medicaid, Medicare, private health insurance or other public programs.

TABLE 11. Income Limitations for Ryan White Part B Eligibility in South Dakota, April 1, 2015 to March 31, 2016								
Family size	1	2	3	4	5	6	7	8
Maximum Annual Income	\$35,310	\$47,790	\$60,270	\$72,750	\$85,230	\$97,710	\$110,190	\$122,670

Services include:

1. AIDS Drug Assistance Program (ADAP): up to \$10,500 per client per fiscal year
2. Patient Care (Home and Community Based Care): up to \$2,500 per client per fiscal year
 - 1) Home Health Care – Home health care visits up to 3 hours a day or 21 hours per week.
 - 2) By a home health aide employed by a certified home health agency and supervised by a registered nurse or physician. Skilled nursing visits may be provided up to 3 hours per day by a registered nurse as directed by a physician.
 - 3) Outpatient Primary Medical Care
 - i. Office visits or consultations from a physician, physician’s assistant or nurse practitioner
 - ii. Eye exams from an ophthalmologist
 - iii. HIV Viral Loads

- iv. CD4 counts
 - v. Genotyping/Phenotyping
 - vi. Durable Medical Equipment
 - vii. Nutritional services
- 4) Mental Health Therapy – provided to the client by a psychiatrist, psychologist, clinical nurse specialist, social worker, or counselor in private or public practice (not by a family member of the client)
 - 5) Dental Services – diagnostic, prophylactic, and restorative dental services provided by a dentist, dental hygienist, and similar professional practitioners paid at the current Medicaid rate. Services eligible are procedure codes currently allowed by Medicaid.
 - 6) Direct Emergency Financial Assistance – emergency expenses related to food, housing, rent, utilities, medications or other needs with assistance dependent on available funding.
3. Continuation of Health Insurance – evaluated for cost effectiveness on case by case basis
 4. Case Management – Services available for clients and those on a waiting list. Help to access available services from the Ryan White B and C programs, Medicaid, Medicare, insurance benefits, social security, drug manufacturer patient assistance programs, employment, unemployment, food stamps, food banks, housing, medical and dental care and transportation.

There is also a Ryan White Part C program operated by the City of Sioux Falls Health Department, Falls Community Health clinic.

a. Table of Public and Private Funding Sources

Funding Sources	Funding Amounts	Funded Service Providers	Services Delivered	HIV Care Continuum Steps Impacted
Ryan White Part B	\$889,849	South Dakota Department of Health (SDDOH)	Case Management, Health Insurance, Outpatient/Ambulatory Medical Care	Linkage to Care; Retained in Care; Viral Load Suppression
ADAP	\$389,849	SDDOH	HIV (ART) Medication	Antiretroviral Use
Medication Rebates	\$1,774,896	SDDOH	Medication Assistance	Antiretroviral Use
Ryan White Part C	\$370,500	Falls Community Health	Early Intervention Services, Case Management	Linkage to Care; Retained in Care; Viral Load Suppression
CDC	\$604,333	SDDOH	HIV Testing	HIV-Diagnosed

Funding Sources	Funding Amounts	Funded Service Providers	Services Delivered	HIV Care Continuum Steps Impacted
HOPWA	\$285,000	Sioux Falls Housing	Housing Services for PLWHA	Linkage to Care
SORH	\$172,000		Case Management	Linkage to Care
SHIP	\$321,463		Health Insurance	Linkage to Care
FLEX	\$611,253		Outreach	Linkage to Care
PCO	\$172,793		Outreach	Linkage to Care
IHS	52% of eligible patient	Indian Health Services	Outpatient/Ambulatory Medical Care	Linkage to Care; Retained in Care; Viral

	<i>encounters</i>			Load Suppression
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b. Narrative Description of HIV Workforce Capacity: The South Dakota Department of Health works collaboratively with partners in HIV Prevention, Ryan White Part B, HOPWA, Ryan White Part C, primary care providers, community health centers, the residency program and Infectious Disease physicians throughout the state. There are thirteen (13) Infectious Disease physicians within the state, yet with the growing needs of PLWH patients, South Dakota continues to experience high Out of Care population rates. South Dakota is a frontier state; many PLWH live hours from a primary care doctor, let alone the additional barrier to accessing an infectious doctor located further from rural areas. Other capacity barriers to care identified include: PLWH never seeing the same intern more than one at the residency clinic located in West River; High attrition in Indian Health Services (IHS) locum tenens; and Limited number of primary care physicians able to provide HIV medical care.

c. Narrative of how Funding Sources interact to ensure continuity of HIV prevention, care and treatment services: The Ryan White Part B, Ryan White Part C, HIV Surveillance, and Prevention partners work collaboratively on all projects to reduce barriers to care for PLWH throughout the state. Case managers and DIS staff coordinate services for clients along the care continuum to ensure clients access care. In addition, quarterly the HIV Prevention Planning Group meets to discuss challenges and solutions to reduce barriers to care.

d. Narrative identifying needed resources and/or services not provided and steps taken to secure them: Transportation, mental health, substance use, and infectious disease providers are consistently reported as needed resources in the state. As South Dakota is a low prevalence state, funding constraints make increasing capacity difficult, at best. Recently; however, in order to provide access to an Infectious Disease specialist in the West River region, one provider relocated, thus improving access to care and reducing the travel burden of PLWH in that region. DIS continues to work tirelessly to link newly diagnosed clients to case managers and infectious disease specialists to lessen the gap along the continuum. DIS also works with the Out of Care populations by re-engaging clients with services.

D. ASSESSING NEEDS, GAPS AND BARRIERS

a. Describe process used to identify HIV prevention and case service needs of people at higher risk for HIV and PLWH including strategies to target, recruit and retain participants in HIV planning process and other stakeholders. A comprehensive statewide needs assessment was conducted for the Ryan White Part B and HIV Prevention office of the South Dakota Department of Health starting in June 2015 and ending in March of 2016. The scope of the needs assessment included:

- 1) Consumer survey of In-Care and Newly Diagnosed and Out of Care Persons Living With HIV/AIDS (PLWHA) including data analysis, a report and presentation. Data from In-Care consumers, Out of Care consumers and Newly Diagnosed consumers are included in this needs assessment. In total, 202 In-Care surveys were collected, of which 12 or 6% were Newly Diagnosed. Twenty-five (25) Out of Care consumers participated in the study, and 21 providers.
- 2) Assessment of service needs among affected populations covered information provided by People Living With HIV/AIDS (PLWH/A), their families and their caregivers to synthesize common themes and trends. An in-care/newly diagnosed survey was conducted with South

Dakotans that are in care for their HIV/AIDS responding to one instrument, and another used for those meeting the HRSA out of care survey definition. All services in the Ryan White Continuum of Care were assessed. The report reflected statistical frequency data for in-care, newly diagnosed and out of care respondents. Co-morbidities including the incidence of tuberculosis, sexually transmitted disease, hepatitis, mental illness and substance use as well as other physical illnesses. Data analysis resulted in findings and recommendations to the South Dakota Department of Health Ryan White Part B office. These findings will be used to guide policies as to how to reduce or eliminate barriers to care access, and specifically integrated into the 2017-2021 Statewide Coordinated System of Care/ Integrated HIV Treatment and Prevention Plan.

- 3) The third deliverable, a resource inventory, captured all services available to PLWH/A regardless of funding source. The resource inventory encompasses the full scope of services available in South Dakota, eligibility requirements for those services and the location of these services. The resource inventory addresses coordination with HIV prevention programs, substance abuse prevention and treatment programs and linkage with outreach and early intervention services. This also assesses provider capacity and capability. The profile identifies services in the Resource Inventory that are accessible, available, appropriate and affordable to South Dakotans living with HIV /AIDS. *Capacity* estimate describes the scalability of the provider to deliver each Ryan White service. *Capability* assesses the accessibility and expertise of the agency staff. The provider profile incorporates the results of the most recent statewide client satisfaction survey and reported barriers to care and includes recommendations for capacity development.
- 4) Service gaps and unmet need in the services offered to South Dakotans living with HIV / AIDS were assessed, validated by qualitative and quantitative data on service needs, resources barriers and gaps. Recommendations to meet service needs and improve service delivery as well as strategies to reduce barriers to service and eliminate gaps in service were included

b. Describe HIV prevention and care service needs of persons at risk for HIV and PLWH: The 2015 Comprehensive Needs Assessment completed for the state of South Dakota by Germane Solutions, Inc. in 2015 was designed to ask questions specific to determining a person’s willingness or hesitation to: 1) test for HIV status; 2) enter into primary medical care; and 3) maintain medical treatment adherence. Results were shared with the HIV prevention partners in the state.

Question 85. As a person living with HIV/AIDS, what are your 5 most important needs?			
5 most important needs?	Newly Diagnosed (n=12)	In-Care (n=190)	Q. 86 Out of Care (n=25)
HIV doctor	11 (92%)	22 (12%)	
HIV medications	5 (42%)	17 (9%)	9 (36%) - 3
Housing support	6 (50%)	14 (7%)	
Food	3 (25%)	12 (6%)	
Transportation to HIV care	5 (42%)	10 (5%)	5 (20%) - 6
Money for rent/food	3 (25%)	10 (5%)	
Tribal healing		4 (2%)	
Ryan White B		3 (2%)	
<i>Case Management</i>			13 (52%) -1
<i>Health Insurance</i>			12 (48%) - 2

Education about HIV			8 (32%) - 4
Co-Payments for HIV care			7 (28%) - 5
Dental Care			5 (20%) - 6
Substance Abuse			5 (20%) - 6
Treatment			

Question 86. List the top 5 services you use to stay in care for your HIV		
5 services to stay in care?	Newly Diagnosed (n=12)	In-Care (n=190)
Doctor	10 (83%)	52 (27%)
Case Management	8 (67%)	41 (21%)
HIV Medications	8 (67%)	39 (21%)
Mental health counseling	6 (50%)	11 (6%)
Support groups	5 (42%)	6 (3%)
Food	4 (33%)	5 (3%)
Housing	2 (17%)	3 (2%)
Native Healing	1 (8%)	2 (1%)

Question 38. What services would have helped to better prepare you for your entry into HIV medical care? (Total >100%)			
What services would have helped to prepare for entry into HIV medical care?	Newly Diagnosed (n=12)	In-Care (n=190)	Out of Care (n=25)
More information at HIV+ dx	10 (83%)	114 (60%)	18 (72%)
Mental Health counsel at HIV+ dx	6 (50%)	76 (40%)	12 (48%)
Transportation to HIV medical	4 (33%)	57 (30%)	10 (40%)
Housing support when HIV+	2 (17%)	56 (30%)	8 (32%)
To be clean & sober	2 (17%)	38 (20%)	8 (32%)
Peer support to talk about HIV	5 (42%)	36 (20%)	6 (24%)
Advocate to come to first appt.	3 (25%)	35 (20%)	5 (20%)

FOR OUT OF CARE, the following questions assess their receptivity to re-engage in HIV medical care.

Q93. Are you ready to access medical care for HIV/AIDS?		
Ready to access HIV medical care?	#	%
Yes	20	80%
No	3	12%
Thinking about it	2	8%

Q94. Would you like to be connected with someone who can help you access HIV medical care?		
Like to be connected with someone to help you access HIV medical care?	# (n=20 from Q93)	%
Yes	17	85%
No	3	15%

Q92. What services would you need to enter or return to HIV medical care? <i>(Total >100%)</i>		
Services to enter or return to HIV medical care?	# (n=22 from Q93)	%
Transportation to HIV medical care	8	36%
IP Substance Abuse Treatment	6	27%
Employment	5	23%
Housing or Housing Assistance	4	18%
Mental Health Services	4	18%
None of Above - please list:	3	14%
Health Insurance (2)		
Translator (1)		

For all categories of respondents, the following questions assess Service Barriers ('need service and hard to get') and Service Gaps ('need service and can't get').

Question 87. What are services that are hard to get? <i>(Total >100%)</i>			
Services hard to get? (BARRIER)	Newly Diagnosed (n=12)	In-Care (n=190)	Q 86. Out of Care (n=25)
Transportation to care	6 (50%)	59 (31%)	3 (10%)
Support groups	2 (17%)	42 (22%)	
Housing assistance	4 (33%)	21 (11%)	5 (20%)
Doctor close to home	4 (33%)	18 (10%)	2 (8%)
Inpatient Substance Abuse	2 (17%)	11 (6%)	4 (16%)
Financial Assistance		10 (5%)	3 (12%)
Dental care		8 (4%)	
Co-payments			5 (20%)
Health Insurance			9 (36%)
Mental Health Counseling			3 (12%)
Safe Antiretroviral Drugs			6 (24%)

Why: Regarding inpatient substance abuse, lack of syringe exchange, parochial attitudes about injection drug use

Regarding 'Doctor close to home', long distances/long wait times to see ID doctor.

Question 88. What are services that you can't get? <i>(Total >100%)</i>			
Services you can't get (GAP)?	Newly Diagnosed (n=12)	In-Care (n=190)	Out of Care (n=25)
Support groups	4 (33%)	5 (3%)	
Doctor close to home	6 (50%)	4 (2%)	2 (8%)
Assistance with eligibility (SSI, disability)	2 (17%)	4 (2%)	
Housing assistance	2 (17%)	3 (2%)	5 (20%)
Employment help		3 (2%)	
Transportation to HIV medical care	4 (33%)	3 (2%)	3 (12%)
Health Insurance			9 (36%)
Safe Antiretroviral Drugs			6 (24%)

Out of Care were distinct in referencing cost, lack of health insurance and issues with ‘safe’ antiretroviral drugs indicating a lack of knowledge about advances and benefits.

The responses represent all respondents from their respective categories—Newly Diagnosed (in past 12 months), In Care and Out of Care (not in HIV medical care for over 12 months).

The findings become more customized when comparing ‘All’ respondents related to Service Need, Services used to Stay in Care, Services that are hard to get (barriers) and Services that are perceived as impossible to obtain (gaps).

The variance among race/ethnic, age group, exposure or transmission and geographic region are presented below.

Question 38. Services that would have helped better prepare PLWH for entry into HIV medical care

Newly Diagnosed (n=12)											
Services to help prepare for entry into HIV medical care	ALL	Race/Ethnic			Age Group				Exposure		
		White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
More information about HIV Diagnosis	83%	1	2		1	1	2	3	1	1	1
Mental Health Counseling at HIV Diagnosis	50%	2	3	5	4	2	1	2	2	2	2
Peer support to talk about HIV	42%		1	1	2	3	3	1	3	3	4
Transportation to HIV Medical Care	33%	3	4	2	3	4	5		5	4	3
Advocate to come to first appointment	25%	4	5	3		5		4	4	5	6
Housing Support when HIV+	17%	5	6		5		4				
To be clean & sober	17%	6		4				5		6	5
PrEP (1 write-in response)	8%	x							x		
In Care (n=190)											
Services to help prepare for entry into HIV medical care	ALL	Race/Ethnic			Age Group				Exposure		
		White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
More information about HIV Diagnosis	60%	1	1	5	1	1	2	1	1	2	2
Mental Health Counseling at HIV Diagnosis	40%	2	2	1	5	2	1	2	2	1	1
Transportation to HIV Medical Care	30%	3	3	2	3	3	3	3	3	5	4
Housing Support when HIV+	30%	4	3		4	4	4	4	4	4	4
To be clean & sober	20%		4	4		5		5	5		3
Peer support to talk about HIV	20%	5			2		5				5
Advocate to come to first appointment	20%	5	5	3						3	

Out of Care (n=25)	Race/Ethnic				Age Group				Exposure		
Services to help prepare for entry into HIV medical care	ALL	White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
More information about HIV Diagnosis	72%	1	1	3	1	1	1	1	1	1	1
Mental Health Counseling at HIV Diagnosis	48%	2	3	3	4	2	2	3	2	4	3
Transportation to HIV Medical Care	40%	3	4	1	4	3	3	4	3	2	4
Housing Support when HIV+	32%	4	2	4	2	4	4	2	4	3	5
To be clean & sober	32%	5		5	5	5			5	5	2
Peer support to talk about HIV	24%		5	2	3	6	5	5	6		
Advocate to come to first appointment	20%		6			6	6	6	6		

Services needed to Stay in Care

Newly Diagnosed		Race/Ethnic			Age Group				Exposure		
Top 5 services to stay in care	ALL	White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
Doctor	83%	1	1	1	1	1	1	1	1	2	1
Case Management	67%	2	2	2	2	2	2			1	4
HIV Medications	67%	2	3	2	3	3	3	2	2	3	2
Mental Health Counseling	50%	3	5	3		4	4	3	3	4	2
Support Groups	42%	4	4	4	4	4		4	4		5
Food	33%	5	4		5	5					
Housing	17%	6	4	5	4	5	5	5		5	3
Native Healing	8%			3							
In Care		Race/Ethnic			Age Group				Exposure		
Top 5 services to stay in care	ALL	White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
Doctor	27%	1	1	1	1	1	1	1	1	2	1
Case Management	21%	2	2		2	2	2	2	4	1	
HIV Medications	21%	3	3	2	3	3	3	3	2	3	2
Mental Health Counseling	6%	4	5	3	4	4	4			4	5
Support Groups	3%	5		4		4					
Food	3%		4		4						
Substance Abuse Treatment	2%			3					5		3
Housing	2%		4		5	5	5	4		5	4
Native Healing	1%			3							
Transportation	1%		3					5	3	3	4

c. Describe service gaps (prevention and treatment and support) for persons at higher risk of HIV and PLWH: Questions that indicated service gaps for HIV prevention included queries about general information/education, mental health, substance use (current or past), incarceration and delays in getting tested for HIV.

Question 39. What information do you need right now? <i>(Total >100%)</i>			
Information you need now?	Newly Diagnosed (n=12)	In-Care (n=190)	Out of Care (n=25)
None	2 (17%)	95 (50%)	12 (48%)
Side effects of HIV meds/help	8 (67%)	76 (40%)	10 (40%)
How to take care of myself	3 (25%)	57 (30%)	2 (8%)
Mental health counseling	4 (33%)	57 (30%)	2 (8%)
How to disclose HIV status	4 (33%)	55 (30%)	
How to take HIV meds	6 (50%)	38 (20%)	6 (24%)
Support groups	4 (33%)	35 (20%)	
Basic HIV education	2 (17%)	34 (18%)	
Substance abuse services	2 (17%)	29 (15%)	5 (20%)

Question 37. At the time of your diagnosis, were you referred to any of the following services? <i>(responses total more than 100%)</i>			
Referred to services at HIV diagnosis?	Newly Diagnosed (n=12)	In-Care (n=190)	Out of Care (n=25)
Medical Care for HIV	12 (100%)	114 (60%)	10 (40%)
Medical Care-Other	2 (17%)	95 (50%)	8 (32%)
Mental Health	1 (8%)	48 (25%)	5 (20%)
Case Management	10 (83%)	38 (20%)	8 (32%)
HIV Education	6 (50%)	105 (55%)	2 (8%)
Substance Abuse	2 (17%)	29 (15%)	1 (4%)

Question 82. When you were released from incarceration, were you offered help to get HIV medical care or other HIV related services?			
Help for HIV medical care or other related services?	Newly Diagnosed (n=3/12 = 25%)	In-Care (n=49/190 = 26%)	Out of Care (n=9/25 =36%)
Yes		10 (20%)	1 (11%)
No		38 (78%)	7 (78%)
Don't Know		1 (2%)	1 (11%)
Not Applicable	3 (100%)		

Question 83. How did you find out you were HIV positive?			
How did you find out you were HIV positive?	Newly Diagnosed (n=12)	In-Care (n=190)	Q 86. Out of Care (n=25)
When I requested HIV test	3 (25%)	27 (14%)	7 (26%)
Tribal or community outreach	1 (8%)	8 (4%)	4 (16%)
When I donated blood		6 (3%)	1 (5%)
When I went to hospital/ER	2 (17%)	55 (29%)	1 (5%)
Part of Physical exam or Dr visit	1 (8%)	40 (21%)	4 (16%)
Women – when I was pregnant	4 (33%)	10 (5%)	7 (26%)
When I was in jail/prison		8 (4%)	
Health Dept. notification	1 (8%)	2 (1%)	
Partner tested positive		32 (17%)	
Other		15 (8%)	

Question 84. If you delayed getting tested for HIV, what were the reasons for not getting tested? (responses total more than 100%)			
Reasons for Delayed HIV test	Newly Diagnosed (n=12)	In-Care (n=190)	Out of Care (n=25)
Did not delay testing	11/12 (92%)	158 (83%)	15 (58%)
Didn't think I was at risk	1 (8%)	9 (4%)	8 (32%)
Not ready to know		8 (4%)	2 (8%)
Confidentiality		8 (4%)	
Stigma		7 (3%)	

As a reminder, the services representing GAPS include:

Question 88. What are services that you can't get? (Total >100%)			
Services you can't get (GAP)?	Newly Diagnosed (n=12)	In-Care (n=190)	Out of Care (n=25)
Support groups	4 (33%)	5 (3%)	
Doctor close to home	6 (50%)	4 (2%)	2 (8%)
Assistance with eligibility (SSI, disability)	2 (17%)	4 (2%)	
Housing assistance	2 (17%)	3 (2%)	5 (20%)
Employment help		3 (2%)	
Transportation to HIV medical care	4 (33%)	3 (2%)	3 (12%)
Health Insurance			9 (36%)
Safe Antiretroviral Drugs			6 (24%)

Questions about specific gaps related to services are arrayed below to show the distinction between target populations.

Newly Diagnosed (n=12)											
HIV services that you can't get	Race/Ethnic				Age Group				Exposure		
	ALL	White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
Doctors close to home	50%	1	2	1	1	1	1	1	1	1	1
Support Groups	33%	2		5	2	2	4	3	2	3	4
Transportation to medical care	33%	3	1	2	3	3	2		3	4	2
Assistance with eligibility	2%	4		3	5	4	5		4	2	3
Housing assistance	2%	5	3	4	4	5	3	2	5	5	2
In Care (n=190)											
HIV services that you can't get	Race/Ethnic				Age Group				Exposure		
	ALL	White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
Support Groups	3%	1	2	1	1	1	1	1	1	1	1
Doctors close to home	2%	2		5	2	2	4	3	2	3	4
Assistance with eligibility	2%	3	1	2	3	3	2		3	4	2
Housing assistance	2%	4		3	5	4	5		4	2	3
Employment help	2%	5	4	5	5	5	6		4	5	5
Transportation to HIV Medical Care	2%	5	3	4	4	5	3	2	5	5	2
Out of Care (n =25)											
HIV services that you can't get	Race/Ethnic				Age Group				Exposure		
	ALL	White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
Health Insurance	36%	1	2	1	1	1	1		1	1	2
Housing assistance	20%	2	1	2	1	2	2	1	3	3	1
Safe Antiretroviral Drugs	24%	3	3	3	2		1	2	2	3	3
Transportation to HIV Medical Care	12%	4	4	5	3	4	4	3	4	4	4
PrEP (write in response by 3)	12%	x							x		

d. Describe barriers to HIV prevention and care services

Service Barriers from Client Survey (Needs Assessment)

Newly Diagnosed		Race/Ethnic			Age Group				Exposure		
HIV services that are hard to get	ALL	White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
Transportation to HIV Medical Care	50%	1	1	1	1	1	1	1	1	1	3
Housing Assistance	33%	2	2	4	2	2	2	2	2	3	4
Doctor close to home	33%	3	3	2	3	3	3	3	3	2	1
IP Substance Abuse	17%	4		3		4			4	4	2
In Care		Race/Ethnic			Age Group				Exposure		
HIV services that are hard to get	ALL	White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
Transportation to HIV Medical Care	31%	1	1	1	1	1	1	1	1	1	1
Support Groups	22%	2	2	2		2	2		2	2	5
Housing Assistance	11%	3	3	3	2	3	3	2	3	3	6
Doctor close to home	10%	5	4	5	3	4	5	3	5	4	3
IP Substance Abuse Tmt	6%	4	5	4		5	4		4	5	2
Financial Assistance	5%	6	6	6	4	6	3	4	6	6	4
Dental Care	4%	7	7	7			6	5	7	7	7
Out of Care		Race/Ethnic			Age Group				Exposure		
HIV services that are hard to get	ALL	White	Black	American Indian	13-24	25-44	45-64	65+	MSM	HET	IDU
Health Insurance	36%	1	1	1	1	1	2		1	2	3
Safe Antiretroviral Drugs	24%	2	2	2	2	2	1	1	3	4	1
Co-payment assistance	20%	3	3	3	3	3	3	3	2	3	3
Housing assistance	20%	4	4	4	4	4	4	2	4	1	2
IP Substance Abuse	16%	5	5	6	5	5				5	1
Mental Health Counseling	12%	6	6	5	6	6	5	4	5	6	4
Transportation to HIV Care	12%	7	2	2	7	7	6	5	2	3	5
Financial Assistance	12%	7	7	7	7	7	7	4	6	7	7
Doctor close to home	8%	8	8	8	8	8	8	6	7	8	8

d. i. Social and structural barriers: Medical costs for general healthcare continue to rise despite the strain of the nation’s economic state. For PLWH, these increased costs in medical services create a burden of stress and worry when faced with multifaceted issues of poverty and lack of insurance. The infrastructure of the region lacks a public transportation system to support the needs of PLWH to access specialized healthcare and is compounded by the expansive rural areas in the frontier state. Faced with these obstacles, many PLWH place priority on basic survival needs. Medication regimens, when discontinued, place PLWH at high risk for resistant strains and more complex therapies once care is initiated

d. ii. Federal, state or local legislative policies: There are no identifiable legal barriers preventing routine testing in South Dakota. The barriers faced are more specific to the lack of medical providers in the state.

d. iii. Health Department barriers: There are no identifiable barriers.

d. iv. Program barriers: Limited funding resources create barriers to increasing capacity among services needed for PLWH in the state.

d. v. Service Provider barriers: Capacity barriers related to the lack of specialty care providers throughout the state continue to present issues for clients needing medical care for their diagnoses.

d. vi. Client barriers: Stigma and fear of disclosing their status to family and friends continues to present barriers to care for clients. In a frontier state, access to care for their HIV diagnosis is limited with the resources available and the stigma of being associated with a “HIV clinic” presents very real issues for PLWH. Clients have expressed concerns with side effects of medications, thus their non-adherence to treatment regimens. Many PLWH are difficult to reach as their phone numbers and/or addresses continue to change too frequently. Barriers to obtaining insurance to aid in paying for healthcare include: lack of social security number and no call/no shows for appointments to enroll in coverage.

E. DATA: ACCESS, SOURCE AND SYSTEMS

a. Describe main sources of data: The South Dakota Ryan White Part B program works tirelessly to ensure the most up to date and accurate data is available in determining needs and resources available to PLWH. Epidemiological data pulled from Maven and eHARS are reviewed to determine trends in the epidemic, predict future needs and identify populations that are disproportionately affected. Surveillance data and the RSR data were utilized in developing strategies and activities specific to target populations. RSR data, eHARS, and data pulled from the MAVEN system is utilized in developing and refining the HIV Care Continuum annually.

b. Describe data policies that facilitated or served as barriers to needs assessment including development of the HIV Care Continuum: There were no specific data policies that served as a barrier to this developing this needs assessment, including the development of the HIV Care Continuum. The PPG partners assisted in facilitating data requests and coordination of collecting surveys to PLWH to better assess capacity, service needs, service barriers and gaps in services.

c. Describe data that the planning groups would like to have in conducting the Needs Assessment, developing the HIV Care Continuum and Plan, that was not available: Substance use data specific to numbers of PLWH that access inpatient services, with data on numbers of clients that complete detox programs, retention in support groups, and how many PLWH maintain sobriety.

Section II. Integrated HIV Prevention and Care Plan

A. INTEGRATED HIV PREVENTION AND CARE PLAN

The State will continue to utilize the High-Impact Prevention (HIP) evidence-based practice to inform and influence the development of the Integrated HIV Prevention and Care Plan. Using the HIP approach, the HIV Prevention and Ryan White Part B efforts are guided by the five major considerations as follows: Effectiveness and Cost; Feasibility of Full-Scale Implementation; Coverage in the Target Populations; Interaction and Targeting; and Prioritization. South Dakota partners through the HIV Prevention Planning Group (PPG), identified four (4) high-risk populations for this Plan: PLWH; MSM: High-risk Heterosexual PLWHA; and IDU. These populations continue to be identified as the most disproportionately impacted of the HIV epidemic. It is important to note that subpopulations such as Youth and Adults within each high-risk population are deemed as important to target as well.

a. Identify at least two (2) objectives that correspond to each National HIV/AIDS Strategy (NHAS) goal

NHAS GOAL 1: REDUCING NEW HIV INFECTIONS	
LOCAL GOAL 1: BY THE END OF 2021, LOWER THE NUMBER OF NEWLY DIAGNOSED INFECTIONS BY 2%.	
OBJECTIVE 1	OBJECTIVE 2
1. Identify at risk groups to determine HIV status/ Intensify HIV prevention in high-risk areas (high HIV/ STD).	2. Reduce secondary HIV transmission of HIV positives (Prevention for Positives)

NHAS GOAL 2: INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV	
LOCAL GOAL 2: BY THE END OF 2021, INCREASE VIRAL LOAD SUPPRESSION RATE BY 25%.	
OBJECTIVE 1	OBJECTIVE 2
1. Reduce Late to Care patterns in Newly Diagnosed through enhancement of existing care networks to increase referral system across SD	2. Ensure availability of quality medical care and support services by promoting availability of telemedicine for PLWH

NHAS GOAL 3: REDUCING HIV-RELATED DISPARITIES AND HEALTH INEQUITIES	
LOCAL GOAL 3: BY THE END OF 2021, INCREASE NUMBER OF PLWH RETAINED IN CARE BY 25%.	
OBJECTIVE 1	OBJECTIVE 2
1. Implement mechanisms to identify and re-engage Out of Care	2. Enhance coordination among providers of services to both PLWH and high risk individuals

Strategies (b), Activities, Targeted Populations, and Gaps Addressed (c), and Metrics (d) are included in the tables below for each NHAS goal:

NHAS GOAL 1: REDUCING NEW HIV INFECTIONS				
LOCAL GOAL 1: BY THE END OF 2021, LOWER THE NUMBER OF NEWLY DIAGNOSED INFECTIONS BY 2%.				
OBJECTIVE 1: Identify at risk groups to determine HIV status/ Intensify HIV prevention in high risk areas (high HIV/ STD)				
<p>S: Identify community settings, outreach events (health fairs, etc.), substance abuse centers, where target populations congregate to promote testing; M: Surveillance data, defined zip codes in SD by county using STD, TB, and HIV incidence; A: History of use of zip codes to target HIV risk areas; R: Sufficient resources available through collaborative efforts and use of existing information; T: 2017-2021 with monthly reporting of data to update information on “hot spots” by zip code</p>				
STRATEGIES	ACTIVITIES/ INTERVENTIONS	TARGET POPS	RESPONSIBLE PARTIES	TIME PHASED RESOURCES
a. Coordinate HIV testing efforts to match groups and geographies at high risk b. Maintain HIV prevention in populations at risk c. Expand access to PrEP	1. Provide culturally focused outreach efforts, specifically testing and locating high risk groups through appropriate community & medical centers 2. Enhance Prevention & DIS presence in populations at risk 3. Targeted messaging through known social networking sites reinforcing the need for testing, PrEP for negatives, and partner notification	PLWH, MSM, High-Risk Heterosexuals, IDU	HIV Prevention, DIS, Community Health Center (CHC) in Sioux Falls	DIS staff, MCM staff, Outreach staff, education materials, billboards, ads, social media sites (Facebook, Twitter, etc.)
OBJECTIVE 2: Reduce secondary HIV transmission of HIV positives (Prevention for Positives)				
<p>S: Inform HIV-positive, MSM, High-Risk Heterosexuals and IDU of status through use of Partner Notification, counselors reflective of their composition; M: Documented staff composition in programs through monitoring; A: Goal that reflects culturally appropriate staffing; R: Ensure trust of 4 target populations; T: Ongoing, continually monitored</p>				
STRATEGIES	ACTIVITIES/ INTERVENTIONS	TARGET POPS	RESPONSIBLE PARTIES	TIME PHASED RESOURCES
a. Work in areas with higher HIV prevalence and incidence to message about reduced risk behaviors b. Fully adopt test and treat upon diagnosis c. Expand access to PrEP	1. Target areas with higher HIV prevalence and incidence with enhancement of health education messages regarding risk reduction, secondary transmission education, 2. Provide health education and health access education to all PLWHA 3. Targeted messaging re: PrEP to reduce secondary HIV transmission through social networking sites, community centers, medical providers, outreach, health fairs	PLWH, MSM, High-Risk HET, IDU	HIV Prevention, DIS, Ryan White Part B and C providers for access to care	Health education materials, HIV Prevention staff, MCM staff, DIS and outreach, social media sites, ads, billboards
<p>METRICS TO MONITOR PROGRESS: 1) Number of HIV tests performed; 2) HIV Positivity Rate; 3) Number linked to HIV medical care.</p>				

NHAS GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PLWH				
LOCAL GOAL 2: BY THE END OF 2021, INCREASE VIRAL LOAD SUPPRESSION RATE BY 25%.				
OBJECTIVE 1: Reduce Late to Care patterns in Newly Diagnosed through enhancement of existing care networks to increase referral system across SD				
S: Expand on existing care networks to make more LBGT friendly referrals in South Dakota; M: Inventory referral and use as baseline for expansion; A: Possible given 'reach' of SD; R: Needed to enhance referral sources; T: Ongoing effort through 2021				
STRATEGIES	ACTIVITIES/ INTERVENTIONS	TARGET POPS	RESPONSIBLE PARTIES	TIME PHASED RESOURCES
a. Focus on expediting entry to HIV medical care b. Research pathways to care--needed services for newly diagnosed to enter care c. Promote availability of telemedicine for access to care	1. Utilize peer counselors to accompany newly diagnosed to initial appointments 2. Fast track appointments for newly diagnosed to minimize wait times 2. Provide education re: telemedicine and how to access, including assistance in accessing telemedicine	Newly Diagnosed PLWH, MSM, High-Risk Heterosexuals, IDU	Ryan White Part B and C providers, Ryan White Part B Office	Pathways to Care study; MCM staff, Medical care staff, Ryan White Part B office staff, education and marketing materials for telemedicine
OBJECTIVE 2: Ensure availability of quality medical care and support services by promoting availability of telemedicine for PLWH				
S: Promote information on telemedicine; M: Can track calls, request for information and referrals by date/time/referral source; A: Existing; R: Resource; T: Current use for "linkage"; will promote through referral				
STRATEGIES	ACTIVITIES/ INTERVENTIONS	TARGET POPULATIONS	RESPONSIBLE PARTIES	TIME PHASED RESOURCES
a. Increase the number of providers of HIV care for PLWH b. Prioritize service access identified in 2015-2016 Needs Assessment c. Creatively endeavor to resolve transportation and geographic accessibility issues	1. Increase linkage agreements/MOUs with key points of entry 2. Assess access issues/barriers identified in NA and develop action plan to address services needed in each Region—work with MCM teams to ensure all available resources are being utilized for PLWH 3. Provide transportation resources to rural communities AND promote telemedicine as means to decrease barrier of transportation in accessing care	All PLWH, MSM, High-Risk Heterosexuals, IDU	Ryan White Part B and C providers, FQHCs/CHCs, Ryan White Part B Office, State Medicaid partners	Capacity building with RW Part B staff working with FQHC/CHC, Linkage agreements with IHS and other key points of entry, MCM staff, marketing resources
METRICS TO MONITOR PROGRESS: 1) HIV Medical Visit Frequency; 2) Gaps in HIV Medical Care; 3) Viral Load Suppression; 4) Linkage to HIV Medical Care; 5) Inventory of HIV providers and capacity through Administrative Assessment				

NHAS GOAL 3: REDUCE HIV RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES				
LOCAL GOAL 3: BY THE END OF 2021, INCREASE THE NUMBER OF PLWH RETAINED IN CARE BY 25%.				
OBJECTIVE 1: Implement mechanisms to identify and re-engage Out of Care				
<p>S: Use Outreach staff, DIS counselors, MCM staff in SD for targeting Out of Care; M: Assign 2-3 high risk venues/areas per team/month; A: Yes, with collaboration of Part B and Prevention; R: Monthly targets set per venue based on data; T: Monthly visits, quarterly data review</p>				
STRATEGIES	ACTIVITIES/ INTERVENTIONS	TARGET POPS	RESPONSIBLE PARTIES	TIME PHASED RESOURCES
<p>a. Address outdated beliefs about ART (side effects, multiple doses)</p> <p>b. Educate Out of Care about Health Insurance and cost support for HIV care</p> <p>c. Fast track access to medical care and promote telemedicine, reducing barrier of transportation</p>	<p>1. Provide education and materials to PLWH out of care to reduce fears of ART issues, stigma</p> <p>2. Enhance messages through out SD to promote Health Insurance availability for PLWH</p> <p>3. Enhance efforts of promotion of telemedicine through social media venues, community centers, bars, churches, substance use centers, legal aide, etc. to decrease barrier s real or perceived for PLWH Out of Care</p>	<p>All Out of Care PLWH, MSM, High-Risk Heterosexuals, IDU</p>	<p>Outreach staff, MCM staff, HIV Prevention staff, Ryan White Part B Office, PPG partners</p>	<p>Education and marketing materials from pharmaceuticals re: ART, Ads and materials to promote access to insurance for care, system level design to fast track PLWH appointments, promotion of telemedicine through increased access in social media sites</p>
OBJECTIVE 2: Enhance coordination among providers of services to both PLWH and high risk individuals				
<p>S: Document follow-up of post-care entry at 3, 6, and 9 month intervals; M: Track using data entered monthly; A: Integrated into monthly data; R: Measure to gauge care linkage real-time (corroborate by SDDOH viral load); T: Provider data real time v. SD epi data</p>				
STRATEGIES	ACTIVITIES/ INTERVENTIONS	TARGET POPS	RESPONSIBLE PARTIES	TIME PHASED RESOURCES
<p>a. Blend funding and service access among providers of critical services referenced as gaps (IP Substance Abuse, Mental Health)</p> <p>b. Ensure linkage to care and enhance knowledge of Viral Suppression in clients and providers of all services</p> <p>c. Fast track appointments and use of telemedicine to reduce wait times</p>	<p>1. Develop MOUs with service providers among critical services referenced (IP SA, MH) to increase access to care</p> <p>2. MCM enhanced trainings in education of viral suppression</p> <p>3. Improve education and materials presented to PLWH that provide more information and resources available to ensure barriers are decreased for care entry/retention</p>	<p>All PLWH and High-Risk individuals throughout SD</p>	<p>FQHC, CHC, Ryan White Part B Office, Case Manager staff, DIS staff, Medical providers</p>	<p>Work with MH and SA systems to aide in bringing additional funding to the state, education materials and social media site access to increase awareness of viral load suppression, system design to fast track medical appointments, promote telemedicine through social sites</p>
<p>METRICS TO MONITOR PROGRESS: 1) HIV Medical Visit Frequency; 2) Gaps in HIV Medical Care; 3) Linkage to HIV Medical Care; 4) Number retained in care</p>				

d. Describe any anticipated challenges or barriers in implementing the plan: Anticipated challenges or barriers include lack of resource priority due to the low prevalence of HIV in South Dakota, reluctance to openly address risk behaviors due to stigma (includes male-to-male sex, injection drug use), and competing fiscal priorities requiring limited resources of a largely frontier state.

Specific challenges with, or opportunities for, working with the targeted pop: The disproportionate HIV/AIDS prevalence and incidence among HIV-positive persons, MSM, High-Risk Heterosexual Contact persons, and Injection Drug users (IDU) in South Dakota reflects the disproportionate representation among persons with adverse socio-economic indicators. **Challenges working with HIV-positive persons communities** include: stigma associated with the disease provides challenges to getting names of all sexual and needle-sharing partners. Some individuals have very little information about their sexual contacts as well, making it difficult to do case follow-up and to link those individuals into testing and care. **Challenges working with MSM communities** include: locating MSM in the rural areas in South Dakota presents as the largest challenge. Most outreach activities take place in the two largest cities in the state. There is still a large stigma associated with being MSM and strategies to find where MSM congregate in rural areas has become problem-some. **Challenges working with High-Risk Heterosexual communities** include: stigma associated with getting tested for HIV with the ‘old school’ thought process that many heterosexuals in the state still believe, in that HIV only affects the MSM communities. **Challenges working with IDU communities** include: locating this population to get tested. IDU is an important exposure risk for people living in all areas of the state, not only because of the increased risk of transmission, but because IDU individuals typically have co-occurring high-risk behaviors (multiple drug use or high-risk sexual contacts).

Means to address these challenges include ongoing education about the economic value of reducing HIV infection on the health related institutions, the societal costs and disability of HIV infection disease and the improved quality of life and reputation of a state that openly addresses what is now a manageable chronic disease, if infected. If not infected, the ability to proactively use PrEP or other risk reduction interventions to prevent secondary transmission of HIV is important to communicate as treatment and prevention efforts continue to advance.

B. COLLABORATIONS, PARTNERSHIP AND STAKEHOLDER INVOLVEMENT

a. Describe specific contributions of stakeholders and key partners to development of the Plan:

This plan is the result of hours of participation, input and effort by members of the HIV/AIDS community committed to improving the HIV care delivery system and advancing the treatment of ALL affected by this epidemic. The Ryan White Part B and Part C Case Managers were vital in providing access to PLWH to promote the Comprehensive Needs Assessment survey in order to gain insight to service needs, gaps and barriers for those Newly Diagnosed and Out of Care. The Statewide HIV Prevention Group provided valuable insight and data to testing and key points of entry for PLWH. The Ryan White Part B Office provided all epidemiological data for the Needs Assessment to ensure adequate surveys were collected for each representative group, including sex, age, risk factor/exposure, and region in the state. Consumers were the key to this plan and its development through participation in the Comprehensive Needs Assessment and in participation in the PPG meetings, providing insight to daily challenges presented to PLWH in a

frontier state. HOPWA representatives, as part of the PPG meetings, continued to provide information that would aid in assisting PLWH with housing needs, emergency financial assistance, and provided materials for case managers that South Dakota plans to incorporate as part of the education materials to be dispersed throughout the state. Lastly, the medical community provided capacity issues and possible solutions in developing the plan.

b. Describe stakeholders and partners not involved in the planning process, but needed to more effectively improve outcomes along the HIV Care Continuum: Mental Health and Substance Use providers, although not directly involved in the planning process, did aid the Case Managers in providing information of services available. Engaging these providers to participate in the PPG meetings quarterly is a high priority of the Ryan White Part B program this year.

c. Provide a Letter of Concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the co-chairs of the Planning Body and Health Department representatives: Please see Letter of Concurrence on page 3 of this Plan.

C. PEOPLE LIVING WITH HIV (PLWH) AND COMMUNITY ENGAGEMENT

a. Describe how people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic: Consumer surveys of In-Care and Newly Diagnosed and Out of Care Persons Living With HIV/AIDS (PLWHA) were utilized during the comprehensive statewide needs assessment conducted for the Ryan White Part B and HIV Prevention office of the South Dakota Department of Health. Data from In-Care consumers, Out of Care consumers and Newly Diagnosed consumers are reviewed, analyzed and shared with the PPG from this needs assessment to provide insight to consumer needs and provide PLWH an avenue of involvement in developing the Integrated HIV Prevention and Care Plan. In total, 202 In-Care surveys were collected, of which 12 or 6% were Newly Diagnosed. Twenty-five (25) Out of Care consumers participated in the study, and 21 providers participated. Survey respondent profiles for the 2015-2016 Needs Assessment were compared to the 2014 Epidemiological profile for PLWHA and 2010-2014 Newly Diagnosed presented the following involvement of consumers and their reflection to the epidemic.

190 PLWHA respondents and 12 newly diagnosed participants (202 In-Care):

- Respondents were slightly lower in female composition (25%) than in the epidemiologic profile (36%);
- African Americans and American Indians responded in higher percentages for newly diagnosed than in the Epi profile;
- A higher composition of Youth (13-14 years) responded than in the EPI;
- Higher respondents for newly diagnosed claimed Heterosexual exposure than the EPI;
- The Central and Northeast regions were slightly more represented among Newly Diagnosed respondents than the EPI.

For PLWHA in 2014, the response from survey participants slightly varied by:

- Gender: 41% of females responded vs. 29% in the EPI;
- Slightly more Hispanics, responded than in the EPI;
- A higher fraction of U.S. born citizens responded than in the EPI;
- A higher percent of Youth (13-24) responded than in the EPI;

- Almost twice as many In Care survey respondents claimed Heterosexual exposure than in the EPI (may indicate fear of risk exposure);
- Half of the respondents failed to declare IDU exposure compared to the EPI (disclosure);
- Twice as many Central region residents responded than indicated by the EPI.

TABLE 12. Comparison of 2010-2014 Incidence and 2014 Prevalence to Newly Diagnosed & In-Care Survey Response								
	HIV/AIDS INCIDENCE		2015-16 NA		HIV/AIDS PREVALENCE		2015-16 NA	
	Cases	Percent	#	%	Cases	Percent	#	%
TOTAL								
<i>Gender</i>								
Female	54	36%	3	25%	162	29%	80	41%
Male	98	64%	9	77%	388	71%	110	59%
<i>Race/Ethnicity</i>								
African American	40	26%	4	33%	126	23%	33	17%
American Indian	36	24%	5	42%	88	16%	38	20%
Hispanic/Other	13	9%			31	6%	19	10%
White	63	41%	5	42%	305	55%	100	53%
<i>Country of Origin</i>								
United States	113	74%	8	67%	444	81%	168	88%
Other	39	26%	4	33%	106	19%	22	12%
<i>Age Group</i>								
< 2 years	0	0%			1	1%		
2-12 years	3	2%			6	1%		
13-24 years	11	7%	4	33%	10	1%	10	5%
25-44 years	86	57%	2	17%	193	35%	67	35%
45-65 years	51	34%	5	42%	310	56%	105	56%
> 65 years			1	8%			8	4%
<i>Exposure</i>								
Heterosexual	62	41%	8	67%	163	30%	113	60%
Injection Drug Use	22	14%	1	8%	83	15%	16	8%
MSM	44	29%	3	25%	194	35%	59	31%
MSM/IDU	9	6%	-	-	22	4%	2	1%
Perinatal/Pediatric	3	2%	-	-	10	2%	-	-
Transfusion/Hemophilia	0	0	-	-	10	2%	-	-
Unspecified	12	8%	-	-	68	12%	-	-
<i>Prevention Region</i>								
Central	3	2%	1	8%	20	4%	16	8%
Northeast	15	10%	2	17%	50	9%	13	7%
Southeast	90	59%	6	50%	332	60%	110	58%
West	44	29%	3	25%	148	27%	51	27%
	152	100%	12	100%	550	100%	190	100%

b. Describe how inclusion of PLWH contributed to Plan development: The statewide comprehensive needs assessment commissioned a review of the In Care, Out of Care, and Newly Diagnosed surveys to be conducted throughout the State of South Dakota to better determine PLWH real or perceived service gaps, barriers and needs. Utilization of PLWH survey responses enabled the planning group and the Ryan White Part B Office in planning services, strategies and activities needed to decrease barriers and gaps and achieve optimal

success in viral load suppression and capacity building.

c. Describe methods used to engage communities, PLWH, those at significant risk of acquiring HIV infection and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area: Surveys were conducted in direct service provider locations, in zip codes where high prevalence epidemiological data indicated, at Indian Health Service facilities throughout the state, in local community agencies, bars, and places where PLWH congregate within the State. Assessment of service needs among affected populations covered information provided by People Living With HIV/AIDS (PLWH/A), their families and their caregivers to synthesize common themes and trends. An in-care/newly diagnosed survey was conducted with South Dakotans that are in care for their HIV/AIDS responding to one instrument, and another used for those meeting the HRSA out of care survey definition. All services in the Ryan White Continuum of Care were assessed. The report reflected statistical frequency data for in-care, newly diagnosed and out of care respondents. Co-morbidities including the incidence of tuberculosis, sexually transmitted disease, hepatitis, mental illness and substance use as well as other physical illnesses. Data analysis resulted in findings and recommendations to the South Dakota Department of Health Ryan White Part B office. These findings were utilized to guide policies as to how to reduce or eliminate barriers to care access, and are specifically integrated into the 2017-2021 Statewide Coordinated System of Care/ Integrated HIV Treatment and Prevention Plan.

d. Describe how impacted communities are engaged in the planning process to provide critical insight into developing solutions to health problems to assure the availability of necessary resources: All Ryan White Part B clients are invited to attend the South Dakota Ryan White Part B/ADAP Advisory Council meeting. For those clients that may not be able to attend, the RW Office encourages clients to submit comments, concerns, or questions to the program manager before the meeting. The RW Part B Advisory Council includes representatives from health care providers, community organizations, Medicaid, county welfare, housing, HIV Prevention, RW Part B, STD program, Community Health Centers, RW Part C, HOPWA, and those infected and affected by HIV/AIDS. The entire council is invited to take an active role in the development and implementation of Part B funding. The Part B Advisory Council discusses program areas to fund, services to provide, and funding allocations. In general, the Department of Health follows the Advisory Council's recommendations unless forbidden by federal guidelines. Data used to assist the Advisory Council includes: usage and expenditure reports for the current year, information on newly developed drugs, federal guidelines, and federal funding available. After the Advisory Council meeting and the draft grant application is written a public hearing is held for public comment prior to submission to the Health Resources and Service Administration (HRSA). Notice of the public hearing is placed in three of the larger newspapers in the state; Aberdeen Area News, Argus Leader, and Rapid City Journal.

SECTION III. MONITORING AND IMPROVEMENT

a. Describe the process for regularly updating planning bodies and stakeholders on the progress of the plan implementation, soliciting feedback, and using the feedback from stakeholders for plan improvement. The South Dakota Ryan White Part B Advisory Council includes representatives from health care providers, community organizations, Medicaid, county welfare, housing, HIV Prevention, RW Part B, STD program, Community Health Centers, RW Part C, HOPWA, and those infected and affected by HIV/AIDS. The Part B Advisory Council discusses program areas to fund, services to provide, and funding allocations. Although the Advisory Council is not integrated with the CDC HIV Planning Group, all members of the State HIV Planning Group are invited to attend the Advisory Council meetings. The HIV Prevention Program Manager is a member of the Advisory Council and attends both the Advisory Council meeting and the Public Hearings. PLWH are included in the Advisory Council meeting as well to gain feedback from the community with regard to service needs, barriers, and gaps. Meetings are held at a minimum of quarterly and all meeting minutes are kept on record and review the next meeting. All feedback is utilized to improve systems across the state and will continue to be utilized to improve strategies and activities throughout this 4-year Plan to improve health outcomes for all PLWH.

b. Describe the plan to monitor and evaluate implementation of the goals and SMART objectives from Section II: Integrated HIV Prevention and Care Plan. The plan to monitor and evaluate progress of the three (3) State goals, six (6) objectives, and eighteen strategies involves a coordinated review during each Fiscal Year of assigning implementation and oversight activities to the Advisory Council in conjunction with the HIV Prevention, the HIV Prevention Planning Group (PPG), and the Ryan White Part B Grantee operations through quality improvement, electronic database operations and fiscal oversight. Service gaps and barriers for the special populations, as well as the Out of Care population, must continue to be addressed to ensure optimal access to care and ultimately increase viral suppression rates throughout the State. Education, prevention and risk reduction efforts must continue to be enhanced within our MSM population to decrease stigma, increase medication compliance, and increase retention in care. Provider capacity with regard to services such as HIV specialty care, mental health, and substance abuse treatment facilities continue to taunt the State’s efforts in ensuring clients needing these services are able to readily attain care. The annual review of the goals, objectives and strategies from *Section II: Integrated HIV Prevention and Care Plan* will occur following the timeline and assigned responsibility for implementation and oversight as follows:

STRATEGIES/ACTIVITIES	Timetable				Responsible Party
	2018	2019	2020	2021	
GOAL 1: BY THE END OF 2021, LOWER THE NUMBER OF NEWLY DIAGNOSED INFECTIONS BY 2%.					
OBJECTIVE 1: Identify at risk groups to determine HIV status/Intensify HIV prevention in high risk areas (high HIV/STD)					
Strategies: a. Coordinate HIV testing efforts to match groups and geographies at high risk; b. Maintain HIV prevention in populations at risk; c. Expand access to PrEP	■	■	■	■	HIV Prevention RW Part B Advisory Council

STRATEGIES/ACTIVITIES	Timetable				Responsible Party
	2018	2019	2020	2021	
GOAL 1: BY THE END OF 2021, LOWER THE NUMBER OF NEWLY DIAGNOSED INFECTIONS BY 2%.					
<i>OBJECTIVE 1: Identify at risk groups to determine HIV status/Intensify HIV prevention in high risk areas (high HIV/STD)</i>					
Activities: Provide culturally focused outreach efforts, specifically testing and locating high risk groups through appropriate community & medical centers; enhance Prevention and DIS presence in populations at risk; targeted messaging through known social networking sites reinforcing the need for testing, PrEP for negatives, and partner notification.	■	■	■	■	Advisory Council RW Part B HIV Prevention DIS Outreach staff
<i>OBJECTIVE 2: Reduce secondary HIV transmission of HIV positives (Prevention for Positives)</i>					
Strategies: a. Work in areas with higher HIV prevalence and incidence to message about reduced risk behaviors; b. Fully adopt test and treat upon diagnosis; c. Expand access to PrEP	■	■	■	■	HIV Prevention RW Part B Advisory Council
Activities: 1. Target areas with higher HIV prevalence and incidence with enhancement of health education messages regarding risk reduction, secondary transmission education; 2. Provide health education and health access education to all PLWHA; 3. Targeted messaging re: PrEP to reduce secondary HIV transmission through social networking sites, community centers, medical providers, outreach, health fairs	■	■	■	■	HIV Prevention Advisory Council RW Part B

STRATEGIES/ACTIVITIES	Timetable				Responsible Party
	2018	2019	2020	2021	
GOAL 2: BY THE END OF 2021, INCREASE VIRAL LOAD SUPPRESSION RATE BY 25%					
<i>Objective 1: Reduce Late to Care patterns in Newly Diagnosed through enhancement of existing care networks to increase referral system across SD</i>					
Strategies: a. Focus on expediting entry to HIV medical care; b. Research pathways to care--needed services for newly diagnosed to enter care; c. Promote availability of telemedicine for access to care	■	■	■	■	RW Part B RW Part C Advisory Council
Activities: 1. Utilize peer counselors to accompany newly diagnosed to initial appointments; 2. Fast track appointments for newly diagnosed to minimize wait times; 3. Provide education re: telemedicine and how to access, including assistance in accessing telemedicine	■	■	■	■	RW Part B RW Part C Advisory Council

STRATEGIES/ACTIVITIES	Timetable				Responsible Party
	2018	2019	2020	2021	
GOAL 2: BY THE END OF 2021, INCREASE VIRAL LOAD SUPPRESSION RATE BY 25%.					
<i>Objective 2: Ensure availability of quality medical care and support services by promoting availability of telemedicine for PLWH</i>					
Strategies: a. Increase the number of providers of HIV care for PLWH; b. Prioritize service access identified in 2015-2016 Needs Assessment; c. Creatively endeavor to resolve transportation and geographic accessibility issues	■	■	■	■	RW Part B RW Part C Advisory Council FQHC
Activities: 1. Increase linkage agreements/MOUs with key points of entry; 2. Assess access issues/barriers identified in NA and develop action plan to address services needed in each Region—work with MCM teams to ensure all available resources are being utilized for PLWH; 3. Provide transportation resources to rural communities AND promote telemedicine as means to decrease barrier of transportation in accessing care	■	■	■	■	RW Part B RW Part C Advisory Council FQHC

STRATEGIES/ACTIVITIES	Timetable				Responsible Party
	2018	2019	2020	2021	
GOAL 3: BY THE END OF 2021, INCREASE THE NUMBER/PERCENT OF PLWH RETAINED IN CARE BY 25%.					
<i>Objective 1: Implement mechanisms to identify and re-engage Out of Care</i>					
Strategies: a. Address outdated beliefs about ART (side effects, multiple doses); b. Educate Out of Care about Health Insurance and cost support for HIV care; c. Fast track access to medical care and promote telemedicine, reducing barrier of transportation	■	■	■	■	Advisory Council HIV Prevention RW Part B PPG partners
Activities: 1. Provide education and materials to PLWH out of care to reduce fears of ART issues, stigma; 2. Enhance messages through out SD to promote Health Insurance availability for PLWH; 3. Enhance efforts of promotion of telemedicine through social media venues, community centers, bars, churches, substance use centers, legal aide, etc. to decrease barrier s real or perceived for PLWH Out of Care	■	■	■	■	Advisory Council HIV Prevention RW Part B PPG partners

STRATEGIES/ACTIVITIES	Timetable				Responsible Party
	2018	2019	2020	2021	
GOAL 3: BY THE END OF 2021, INCREASE THE NUMBER/PERCENT OF PLWH RETAINED IN CARE BY 25%.					
<i>Objective 2: Enhance coordination among providers of services to both PLWH and high-risk individuals</i>					
Strategies: a. Blend funding and service access among providers of critical services referenced as gaps (IP Substance Abuse, Mental Health); b. Ensure linkage to care and enhance knowledge of Viral Suppression in clients and providers of all services; c. Fast track appointments and use of telemedicine to reduce wait times	■	■	■	■	RW Part B Medical Providers PPG partners MCM staff
Activities: 1. Develop MOUs with service providers among critical services referenced (IP SA, MH) to increase access to care; 2. MCM enhanced trainings in education of viral suppression; 3. Improve education and materials presented to PLWH that provide more information and resources available to ensure barriers are decreased for care entry/retention	■	■	■	■	RW Part B Medical Providers PPG partners MCM staff

c. Describe the strategy to utilize surveillance and program data to assess and improve health outcomes along the HIV Care Continuum, which will be used to impact the quality of the HIV service. South Dakota’s Ryan White Part B and HIV Prevention programs utilize MAVEN and eHARS for data collection and reporting operations. Ryan White Part B can distinguish which clients are served, by each individual funding stream, with the program data collected. HIV Surveillance provides epidemiological data that will continue to be used to assess health outcomes along the HIV Care Continuum, thus utilizing these outcomes to impact the quality of the HIV service. For any newly identified (newly diagnosed) HIV positive individual referred into the Ryan White system of care, DIS staff and MCM staff can confirm HIV medical appointment attendance and care regimen adherence within one month of the referral. In addition to confirming a client’s attendance, DIS and MCM are able to confirm with HIV medical providers those that are ‘lost to care’ or ‘no shows’ for appointments to re-engage clients in a more rapid approach. This system of monitoring service utilization allows DIS and MCM the opportunity to ensure clients are engaged in and retained in their medical treatment regimens, preventing increases in Out of Care.

The Advisory Council, Ryan White Part B Office, HIV Prevention, HIV Surveillance, the Office of Disease Prevention, HOPWA, health insurance specialists, PLWH, the HIV Prevention Planning Group, Ryan White Part B and C providers, Infectious Disease providers, stakeholders, and other key staff to aiding in improving health outcomes along the HIV Care Continuum will utilize surveillance and program data to monitor specific indicators (metrics) aligned with the State goals, objectives, and strategies within the Plan. The metrics/indicators are in alignment with the HRSA HAB Core measures, as well as MCM performance measures, and system level performance measures, including the NHAS performance measures. The following indicators/metrics and baseline data is reported below and will be utilized to trend outcomes over the next four years, thus determining the effectiveness of the strategies and activities in the Plan,

and providing qualitative data to show improvements in health outcomes along the HIV Care Continuum for PLWH.

Baseline Performance Measures (Metrics) and Outcomes for South Dakota, 2017-2021	
METRICS/INDICATORS LISTED IN PLAN BY GOAL	BASELINE DATA (2015-2016)
GOAL 1: BY THE END OF 2021, LOWER THE NUMBER OF NEWLY DIAGNOSED INFECTIONS BY 2%.	
Number of HIV tests performed:	
HIV Positivity Rate: <i>Percentage of HIV positive tests conducted in the measurement year</i>	
Linkage to HIV Medical Care: <i>Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis</i>	100%
GOAL 2: BY THE END OF 2021, INCREASE VIRAL LOAD SUPPRESSION RATE BY 25%.	
HIV Medical Visit Frequency: <i>Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits</i>	94.1%
Gaps in HIV Medical Care: <i>Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year</i>	2.2%
Viral Load Suppression: <i>Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year</i>	81.3%
Linkage to HIV Medical Care: <i>Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis</i>	100%
Inventory of HIV providers and capacity through Administrative Assessment	
GOAL 3: BY THE END OF 2021, INCREASE THE NUMBER OF PLWH RETAINED IN CARE BY 25%	
HIV Medical Visit Frequency: <i>Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits</i>	94.1%
Gaps in HIV Medical Care: <i>Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year</i>	2.2%
Linkage to HIV Medical Care: <i>Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis</i>	100%
Number/percent retained in care: <i>Percentage of diagnosed individuals who had two or more documented medical visits, viral load or CD4 tests, performed at least 3 months apart in the observed year.</i>	94.1%