

New Mexico



Combined

Statewide Coordinated Statement of Need (SCSN)

& Comprehensive HIV Services Plan

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Persons living with HIV/AIDS, their family members and community advocates were key informants throughout the planning process. These consumers engaged in all phases of the needs assessment such as expert interviews and focus groups, as well as the HIV Services Advisory Council. This ensured that the priorities and resulting plan reflect a participatory research and planning process that is thoroughly informed by the diverse populations impacted by HIV in New Mexico.

New Mexico Combined Statewide Coordinated Statement of Need (SCSN) & Comprehensive HIV Services Plan

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New Mexico Combined Statewide Coordinated Statement of Need & Comprehensive HIV Services Plan

SECTION 1: PLAN OVERVIEW/PURPOSE

New Mexico has a statewide system of HIV care that is effective at providing state-of-the-art HIV medical care and comprehensive support services for a large proportion of persons living with HIV/AIDS in the state. However, there continue to be some gaps and weaknesses that need to be improved if the system of care is to be characterized as truly excellent. The purpose of this Plan (as we will refer to the combined Statewide Coordinated Statement of Need and Comprehensive Plan) is to take an unflinching look at the realities – good, bad and everything in-between – with the goal of moving methodically towards a better system of care.

Strengths contributing to a highly functional system of care are:

- Far-sighted state legislators created the New Mexico Medical Insurance Pool (NM-MIP) in 1987. HIV/AIDS care was later designated as one of the eligible conditions to allow individuals to secure insurance coverage despite having a pre-existing condition. This greatly lowers the cost of providing HIV medications and provides access to the multiple benefits associated with full health insurance coverage. Because of this insurance-based model of care, New Mexico has never been forced to have a waiting list or dramatically reduce the formulary or eligibility for AIDS Drug Assistance Program (ADAP) services.
- The state provides a reasonable level of financial support through the legislature. Therefore, the HIV Services Program within the New Mexico Department of Health (NMDOH) has dollars from three different sources: Ryan White Part B, state general funds, and program revenue generated by purchasing medications covered by NM-MIP.
- Because New Mexico has a small population (roughly 2 million residents) and is a moderate-low HIV morbidity state (about 150 new cases diagnosed annually), the HIV care network and system is neither overwhelmed by new patients nor is excessively complex. In each public health region, there is one or more HIV Service Provider (HSP) organizations that serves as a “one stop” link to a comprehensive continuum of HIV care and support services.

- Overall, the highly coordinated system produces good adherence to treatment. A large percentage of clients who are receiving HAART through Part B services achieve an undetectable viral load (90.4% of those on HAART in the most recent quarter).

Key gaps and weaknesses in the system include:

- Unmet need, according to the NMDOH HIV and Hepatitis Epidemiology Program, is 42% of the total number of diagnosed cases. While this is likely overstated due to lack of resources to investigate whether people are still in the state, the number is large. Regardless of the exact number of persons not in care, linkage to care is a key area for improvement and priority for New Mexico. Case finding, linkage to care and retention in care are all areas in which services must be expanded and enhanced.
- Regional inequalities exist. Santa Fe, Albuquerque and areas near these urban centers have several choices for excellent care. In contrast, rural regions including the Southeast, Southwest and Northwest quadrants of the state are more poorly resourced and HIV providers are scarcer. Due to a loss of one agency several years ago, Ryan White Part C funding for clinical services is entirely absent from the southern half of the state. In the Northwest, it is critical to have culturally appropriate care and case management for Native American clients, which requires coordination with the Indian Health Service (IHS) and other providers.
- Case management, while excellent in many cases, is uneven in quality. There is currently no systematic training or certification program for HIV case managers in the state. As the front-line workers and key entry points for the system, these individuals wield a large influence on whether clients are satisfied and whether they remain in care. Medical and non-medical case management also need enhancement to ensure that treatment adherence and retention to care are always a key focus and outcome.

The broad goals discussed in this plan include:

- Bring into care people who are currently not in care. This breaks down into sub-goals, including EIIHA – finding more HIV-infected persons who are not aware of their status; linkage to care for those aware of their status; and retention in care for those already in care or recently dropped out.
- Improve the quality of care for all, particularly the 20% of patients in the care network who are currently less than fully satisfied according to findings of the

needs assessment conducted in 2011-2012. This encompasses a variety of strategies, including case manager training and expanded support services to address the issues of social isolation, communication and trust barriers. Lightening the bureaucratic burden was requested by providers and clients, and the NMDOH HIV Services Program will look for ways to do that while still meeting the needs of its funders.

- Overall improvement of communication, between the Part B Program and clients, between sub-grantees and clients, and between the Program and sub-grantees. Continuation of the newly developed HIV Services Advisory Council, local/regional planning and an ongoing and improved feedback loop are means to this end.
- Another cross-cutting issue in the state is the need to maximize **coordination**, **integration** and **effective linkages** across Program Parts. We have begun to do this, but there is still much work to do to break down divisions and enhance constructive connections. This plan envisions this happening mostly on a regional level where local/regional planning can create linkages between entities that mutually improve services and complementary relationships are developed.
- Health workforce shortages need to be addressed where they exist and future ones averted by training, mentorship and recruiting.

Ideally, in the next three years, the HIV care system will:

- Serve more people who need care, through the variety of EIIHA linkage to care, retention and re-engagement efforts.
- Continue access to care through changes in the health care system, provider changes in strategies, and demographic, epidemiological or medical developments.
- Provide better and more consistent care.

This Plan is to be a living document, and is to be updated as needed. The HIV Services Advisory Council will continue meeting and serving as the sounding board for the NMDOH HIV Services Program. The contracted evaluators from the UNM Needs Assessment team will track changes and measure progress towards the stated goals, and continue to channel information from their interviews and surveys with clients that help inform the process. New Mexico will benefit from having an effective and ongoing mechanism to allow critical feedback and consultation from the communities of consumers and providers in the state.

SECTION 2: PURPOSE AND PROCESS FOR SCSN AND COMPREHENSIVE PLAN

A. Statewide Coordinated Statement of Need (SCSN) – Legislative Requirements and Purpose

The Ryan White HIV/AIDS Treatment Modernization Act requires Ryan White grantees to conduct activities to enhance coordination across Ryan White programs by mandating participation in the development of a Statewide Coordinated Statement of Need (SCSN). Legislative language requires further that the Part B grantee develop the SCSN and that grantees under all Parts participate in the SCSN process. In addition, applicants for Ryan White funds are required to submit evidence that the proposed program is consistent with the SCSN.

According to the federal Health Resources and Services Administration (HRSA), the purpose of the SCSN is to provide a collaborative mechanism to identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA), and to maximize coordination, integration and effective linkages across Ryan White HIV/AIDS Program Parts related to such issues.

As the Ryan White Part B grantee, the New Mexico Department of Health, Public Health Division, Infectious Disease Bureau, HIV Services Section (NMDOH) is responsible for the preparation of the SCSN document based on HRSA guidelines. Such guidelines were updated and issued in 2011. HRSA encourages the use of the SCSN for statewide HIV/AIDS planning, and each state has the flexibility to adapt the SCSN preparation process to its particular circumstances. The guidelines state that the SCSN is not intended to replace local program planning and priority setting. Grantees under all Parts must participate through a representative process.

An important element in assessing statewide need includes describing the needs of individuals who are unaware of their HIV status. The early intervention of individuals living with HIV/AIDS (EIIHA) Initiative supports all three of the National HIV/AIDS Strategy (NHAS) goals: 1) reducing the number of people who become infected with HIV; 2) increasing access to care and optimizing health outcomes for people living with HIV; and 3) reducing HIV-related health disparities.

The outcome of the SCSN process is a written document that summarizes needs and service barriers across the state. HRSA guidelines indicate that the SCSN must reflect, without replicating, a discussion of existing needs assessments and should include a brief overview of epidemiological data, a description of the process used to develop the SCSN, information on participants in the process, and a description of service needs and identified gaps. In addition, the guidelines state that the SCSN should include broad goals, and these goals should not be prioritized but assessed equally.

B. Comprehensive Plan – Legislative Requirement and Purpose

The Ryan White HIV/AIDS Treatment Modernization Act requires Part B grantees (States) to develop and implement a comprehensive plan, including a description of HIV-related services in the State, available resources, epidemiological data, service needs, goals and strategies. The original HRSA guidelines relating to this legislative requirement indicate that comprehensive planning should result in a road map for the incremental development of a system of care over the long term. The guidelines state further that the plan should address disparities in HIV care, access and services among affected subpopulations and historically underserved communities, and the needs of those who know their HIV status and are not in care, as well as the needs of those who are currently in the care system.

Many of the topics to be covered in the comprehensive plan are the same as those required to be addressed as part of the SCSN. Therefore, to eliminate duplication, in both the process of providing input and in preparation of the final document, New Mexico has combined the SCSN and Comprehensive Plan into one document. This approach allows for the preparation of a broad document that describes service needs and barriers drawing from input received at forums throughout the State, a collaborative HIV Services Advisory Council process and needs assessments data collected through a Needs Assessment Project led by the University of New Mexico Research Team. This statewide summary of needs and barriers forms the basis of goals, strategies, and priority setting that are part of the statewide Comprehensive Plan included as Section V of this document.

C. Description of the 2012 SCSN Process

The SCSN and Comprehensive Plan were developed collaboratively with the input of a broad spectrum of HIV/AIDS stakeholders and consumers in New Mexico. This input was provided in a variety of ways. First the NMDOH created the HIV Services Advisory Council to serve as an inclusive planning body, which would include representatives from NMDOH, PLWH/A, providers, public agency representatives such as State Medicaid Officials and Officials from local public health agencies, and representatives from Native American providers. Monthly participatory video conferencing meetings were convened from September 2011 through June 2012. For a complete list of participants and whom they represent please see Appendix A.

Second, NMDOH contracted with the University of New Mexico Research Team to conduct a needs assessment regarding HIV Services. This project is just completing its second year. For a complete explanation of the methods used to complete this needs assessment please see Section III. Data from the first year and preliminary themes and findings from year two were analyzed and compiled into the SCSN and Comprehensive Plan.

The actual combined SCSN and Comprehensive Plan document was drafted by NMDOH staff using historical resources, surveillance data, program management experience and all of the community input received via the HIV Services Advisory Council and UNM Needs Assessment Project.

This Section describes the resources utilized and the steps taken to complete the 2012 version of the SCSN. A six-step process, described below, was used to gather information, extract relevant data, obtain additional input, and complete the document.

Step One: Contract with UNM to conduct statewide Needs Assessment.

In 2010, NMDOH contracted with the UNM Research Team to conduct a Needs Assessment Project in New Mexico. A series of listening forums was convened throughout New Mexico with the express purpose of informing NMDOH of needs and barriers related to HIV/AIDS services as well as provider, clinician and consumer issues and concerns related to the programs and services administered by the NMDOH and its contractors. This information was also solicited via one-on-one interviews, phone interviews and written surveys. Clients from throughout the State offered a wide range of comments, suggestions and recommendations, which were documented and are summarized in the *Service Needs and Barriers* section of this document. This input served as the primary source of information for the SCSN.

Step Two: Summarize HIV/AIDS epidemiological data.

The HIV and Hepatitis Epidemiology Program (HIVEPI) of the NMDOH Epidemiology and Response Division produced data on reported HIV and AIDS cases and persons living with HIV and AIDS, which are presented in Section III of this document. This data highlights variables such as mode of transmission, race/ethnicity, gender, and age, and displays trend data on cases and deaths. The information is presented on a statewide basis, and by region across New Mexico.

Other comparative and interpretive data is presented throughout the document to characterize the nature of the epidemic across the State. In addition to HIVEPI, the sources of this data include reports issued by the federal Centers for Disease Control and Prevention.

Step Three: Adopt Guiding Principles; develop Prioritization Model; analyze emerging trends and special populations.

The HIV Services Advisory Council created an ad-hoc Planning Committee to propose a list of Guiding Principles and a Prioritization Model to help guide the group in the creation of this document. This committee met during December 2011 and January 2012 to produce these materials and proposed them to the full Council in January 2012 before adoption in February 2012.

Key environmental considerations and emerging trends that impact the HIV/AIDS epidemic are summarized in Section V of this document. While not an exhaustive list, the issues discussed in this section are cross-cutting and must be considered in the planning and implementation process:

- High rates of Unmet Need
- Continuing Disproportionate Impact of the Epidemic on Communities of Color, particularly among Blacks and Hispanics and American Indians
- Late Diagnosis and/or Entry into Care
- Effective linkage, access and retention in care
- Stigma and Discrimination

Step Four: Summarize findings and prepare the SCSN and Comprehensive Plan document.

The information gathered in the first three steps was organized and summarized in the respective Sections of this document. An attempt was made to present the most up-to-date information in a clear, easy-to-access format. The document is drawn almost in total from the input received from the Needs Assessment Project, and input received from the HIV Services Advisory Council.

The Comprehensive Plan, contained in Section IV and V of this document, was prepared by NMDOH and based on the information and data described above, and on-going strategic planning processes that are informed by various workgroups of PLWHAs and providers, as well as formal advisory and coordinating bodies, including the HIV Services Planning Council, and the HIV Prevention Planning and Action Group (NMCPAG).

Step Five: Distribute the draft document and conduct community forums.

The draft document was broadly distributed to the HIV Services Advisory Council along with an invitation to attend the June Video Conference meeting where the draft document was discussed and additional input obtained before the document was finalized. While the forums that were held in 2012 assured broad input on the draft Prioritization Model so that it accurately represents current needs, issues and concerns, the videoconference meeting provided the opportunity for stakeholders and consumers to comment specifically on the document.

Step Six: Incorporate findings and distribute the 2012 SCSN and Comprehensive Plan.

The final step in the process was the incorporation of comments and recommendations from the videoconference meeting to produce the final 2012 SCSN and Comprehensive Plan. The final document was submitted to HRSA and broadly disseminated statewide.

SECTION 3: EXPECTATIONS

B) Needs which obstruct access to care for PLWH, Gaps and Overlaps in Care, and Priorities in Addressing Underserved Populations.

In support of the 2012 Statewide Coordinated Statement of Need (SCSN), the UNM research team completed two years of assessment research to understand needs, barriers to care, gaps and priorities in addressing underserved populations. The section describes the purpose of the assessments and the methods used to address the purpose. Then, the findings of the assessments are presented around the areas of obstructing factors, gaps, and priorities for addressing underserved populations.

Purpose/Methods

The purpose of the first year of needs assessment was threefold: (a) Explore utilization and evaluation of services; (b) Identify factors that facilitate and obstruct access to care; and (c) Identify gaps in care. The methods included focus groups and survey questionnaires of clients and providers. For the clients, we conducted 7 focus groups with 50 clients at the six HIV Service Provider (HSP) clinics. In addition, we conducted 12 one-on-one interviews or informal conversations via the phone. Additionally, 344 clients completed a survey including questions about the following: (a) where they get services and their satisfaction in general with services, (b) use and satisfaction with specific services; (c) barriers faced in seeking services; (d) their interaction with their providers; (e) medication adherence; (f) perception of social support and social undermining; (g) self-rated health and quality of life (including physical and mental health); (h) risk factors; and (i) demographics.

For providers, we conducted 6 focus groups with 53 providers at five of the six HSP clinics. In addition, we did a one-on-one interview with one provider. Additionally, 47 providers completed a survey that included questions about the following: (a) their role and where they provide services; (b) their perceptions of services offered, their need for training, and satisfaction with services; (c) their perception of barriers faced by clients; (d) their interaction with their clients; (e) perception about specific at-risk client populations; (f) medication adherence and perception of co-morbid medical conditions; (g) perceptions about their interactions in their organizations; (h) self-rated health and burnout; and (i) demographics.

The purpose of the second year of the needs assessment was twofold: (a) Identify the reasons that people living with HIV have unmet need; and (b) Explore six issues with clients currently in care related to findings from the first year of the assessment or the state-wide planning process: (a) social isolation; (b) willingness to pay; (c) alternative medicine; (d) why clients don't use services they say they need; (e) perceptions of quality of care; and (f) three-tiered model of funding HIV services. The methods included focus groups and in-depth interviews. A total of 10 focus groups and 10

interviews with 80 participants were conducted. Of these participants, 15 had unmet need at some time in their life.

Findings

The findings from year 1 and year 2 are combined in this section. Specially, we organize the findings around the issues requested for the report: (a) obstructing factors; (b) gaps/overlaps; and (c) priorities in underserved populations.

Obstructing Factors

The obstructing factors are organized around three categories: (a) factors related to satisfaction with services and health outcomes; (b) mental health, and (c) other themes. The first section is the broadest and includes a description of those who are doing well (about 80% of the sample) and those who aren't doing well (about 20% of the sample).

First, the needs assessment examined a variety of factors related to satisfaction with services, medication adherence, and quality of life. We used these health outcomes as indicators of desired states and then examined the degree to which factors such as barriers to care, interaction with providers, social support and social undermining from social networks, and depression were obstructions or facilitators. Barriers to care are those factors that inhibit clients from seeking services and include several categories: desire for privacy, communication/trust with providers, and transportation. Interaction with providers includes several factors including whether providers share information with clients (information), whether they share information with providers (communication), and the degree of respect providers show clients (respect). Social support is the communication factors that show support including emotional support and instrumental support (tangible help). Social undermining are the negative communication factors in interacting with others including feeling isolated and being criticized (critical appraisal).

Clients are generally quite satisfied with their services and self-report positive health outcomes. Specifically, the system is working well for about 75-80% of clients—77% report good-to-excellent health, 83% agree or strongly agree that they are satisfied with their services, and 71% report complete medication adherence. Further, there is satisfaction with specific services utilized for the most part and in particular medications and medical treatment. Additionally, this portion of clients reports positive perceptions about their interactions with providers and in their own social networks. Specifically, they report receiving good social support, have low levels of social undermining, and low barriers to seeking services. These are facilitating factors for services for the majority of clients.

At the same time, there are about 20% of the clients for whom the system is not working (i.e., low satisfaction or low utilization), have poor health outcomes, and/or poor psycho-

social variables. We identified some patterns for this portion of the population and these factors serve as obstructing factors:

- Overall satisfaction is lower for people who perceive negative interaction with providers.
- Medical adherence and efficacy is lower for people who have low satisfaction with services and face isolation from their social networks.
- Quality of life in terms of self-rated health is lower for people who face isolation from their social networks and have communication/trust barriers with providers (it is higher for those who received adequate information from providers). People who were unemployed had a lower quality of life.
- Quality of life in terms of physical health is lower for people who perceive not receiving instrumental (tangible) support from their social networks, not receiving respect from their providers, and receiving critical appraisal from their social networks. People who were unemployed had a lower quality of life.

Thus, unemployment, negative interaction with providers, low trust of providers, and negative interaction with social networks are obstructing factors for good health outcomes.

Second, mental health was identified by providers and clients in focus groups as an obstructing factor for HIV services. We also examined the extent of depression in the survey sample and how it relates to health outcomes. About 22% of the survey met the criteria for depression. In addition, depression was a factor for reduced quality of life and medication adherence. Thus, depression is also an obstructing factor.

Third, we identified other obstructions to using services including structural/funding concerns and social isolation/stigma. The first theme related to funding issues. Concerns surrounding funding were frequently discussed at the focus groups. PLWH had questions about how funding was allocated amongst the clinics, as well as what the CARE Act funding would pay for. Transparency about funds was requested. Many of the clients in Las Cruces communicated being charged for services that they thought were covered under the CARE Act, only to find out later that they would be required to pay for services out of pocket. The financial burden of extra medical costs was clearly an issue for these clients. The same clients in Las Cruces also expressed frustration with what they considered funding discrepancies between the southern and northern portions of the state. They felt as though the clinics in Santa Fe and Albuquerque were given preference in terms of both money and attention.

The second theme identifies the basic issues of isolation and stigma associated with HIV/AIDS. These issues address the need for social support in order to remain in care. One participant noted his reaction when he was first diagnosed: "And they told me that if I don't get anything done with it, it might get worse. Or I might die from it, they told me. And I was so scared. And I just started cussing my family, because they don't love me

no more because of what I had. And I used to cry and cry in bed.” A female participant “shared the urban isolation and loss of family “mi hija me dejo, me abandono” “my daughter disowned me”. “Others also shared “that no one knows we have it or that we come here.” Essentially, these quotes demonstrate that many PLWH have been abandoned by families or stigmatized and thus feel alone. Without a good social support network, some of these individuals will not be retained to care.

In summary, the obstructions to care include the following issues: (a) social isolation and stigma, (b) negative communication and low trust with providers, (c) negative communication from social networks, (d) unemployment, and (e) depression. These are factors that make it difficult for some people to be retained to care. Despite these obstructions, the vast majority of clients (about 80%) identify mainly facilitators to care in the system.

Gaps

Service gaps provide a measure of all support services not being currently met for PLWH. Services include both primary health care and additional support services. Clients and providers identified key services that are needed and are not being provided to the level desired. Before presenting the gaps, we present the service needs reported by clients in the survey and in focus groups. The first table identifies the top 10 service needs of clients in the survey.

Table 1. Top Ranked Service Needs

Rank	Reported Service Needs of Clients	Percentage Reporting Need
1	Help paying medical bills	67%
2	Advice and help getting medical, social, community, legal, financial or other needed services	57%
3	Emergency help paying for food, housing or medicine	45%
4	Making a plan for health care	45%
5	Outpatient medical care	41%
6	Support groups or counseling	38%
7	HIV testing and diagnosis	36%
8	Mental health services	32%
9	Medical transportation services	28%
10	Legal services	25%

During the focus groups, and regardless of region or clinic, HIV-related medication and medical treatment were the most cited needs for PLWH in New Mexico. Clients who attended the focus groups overwhelmingly expressed the importance of being able to receive their medication in a timely and cost effective manner. The focus group findings corresponded with the survey for the most part except for this focus on medication/medical treatment (i.e., outpatient medical care). This was due to uncertainty about what outpatient medical care involved and that medical care is highly rated and thus not a need in some people's mind (i.e., it doesn't need improvement).

Clients also indicated that they were pleased overall with the majority of the medical services received through the clinics. The survey found medical services were highly

rated with most clients being satisfied. The highest rated services were testing, premium assistance, medical case management, and outpatient medical treatment. The lowest rated service was for alcohol and drug treatment (2.6 out of 4.0). In contrast, social services were rated lower than medical services with only translation receiving a rating of 3.0 or above. The remaining services were rated between dissatisfaction and satisfaction with the lowest being legal services at 2.3 (out of 4.0).

While medical related services were consistently mentioned as the primary need for PLWH and generally of high quality, clients also identified gaps in services. The table below displays the service gaps identified in the needs assessment.

Table 2. Top Ranked Service Gaps

Rank	Service Gaps
1	Case management including medical case management
2	Social support groups/counseling
3	Coordination of care including help with health care costs
4	Dental services /oral health care
5	Mental health services including substance abuse
6	Cultural competence including translational /linguistic services
7	Medical transportation services
8	Food bank/nutritional services
9	Outreach and education including special needs population (homeless, undocumented)
10	Legal services

Case management was a repeated theme across both years during focus groups, especially for the clients served in the Gallup, Las Cruces, and Roswell regions. This need presented itself among individuals who had a long-term diagnosis, as well as individuals who were newly diagnosed with HIV. These focus groups revealed that case managers are frequently the client’s main point of contact regarding their HIV services. The high turnover rate within case management was a great concern in the focus groups because clients develop strong trusting relationships with most case managers; almost all of the clients expressed anxiety about this lack of consistency. Despite this apprehension, case managers are viewed as an invaluable resource, as

professionals who can orient individuals and help them navigate resources, including a variety of organizations and services within the community.

In summary, medical needs are rated as the most important for clients and generally these services are rated very high. Other social services are also rated as important and these are seen as good and yet with room for improvement. The most important gap in service is case management. Good case managers are sought after by clients and information about them is traded like currency. Turnover among case manager is a challenge to effective services.

Priorities in Underserved Populations

Two aspects of underserved populations were considered in the needs assessment: (a) ethnic/cultural differences in gaps and obstacles and (b) rural/urban differences.

First, the needs assessment considered whether ethnicity was a factor related to obstacles or gaps in services. Given the multicultural nature of the state, it is very important to ensure that there is no differential levels of care that contribute to health disparities. We considered data from the year 1 survey and both year 1 and year 2 focus groups to identify potential issues.

The survey allowed an examination of the influence of ethnicity on satisfaction with services, barriers to care, medication adherence, and quality of life. There were no differences in these outcomes by ethnic group and thus ratings of services are consistent.

The focus groups did identify some potential issues among specific ethnic groups that the survey could not capture. Several participants noted specific concerns about Native American and Hispanic/Latino populations. Specifically, they reported that services often do not take into account the multiple populations that they are being offered to, leaving some clients feeling alienated from care. Lack of linguistic services and culturally competent care were noted as being important within the focus groups particularly at clinics which serve high levels of Spanish-speaking and Native American clients. Overall, these clients were not dissatisfied with the services; rather they noted cultural competence was something that could be improved to enhance the quality of services and thus retain people in care.

In addition, we explored alternative medicine and structural/funding issues specifically for Native American clients. Many Native clients supported the importance of alternative and spiritual medicine as a complement to medical treatment. While one clinic (First Nations) does offer alternative and spiritual medicine, rural Native clients are not always able to drive to Albuquerque to access these services. In addition, some Native clients could not get covered for services because they were sent back to their pueblos, IHS, and Albuquerque clinics for different services. They are caught in a complex web of

IHS, pueblos who have used PL 638 to set up their own services, and the HIV clinics and thus appear to be disadvantaged in accessing certain services.

Second, we considered the access and quality of services between rural and urban populations. Rural populations reported that they are more isolated and feel more stigmatized than people living in urban areas. In addition, despite the positive review of the medical services, some participants indicated that some clinic staff in rural clinics could make them feel more welcoming instead of being judged. Further, rural participants noted that it is difficult to find some specific services such as dental care.

In summary, there are generally no differences across ethnic groups in the rating of the quality of HIV services. There are some specific service needs/gaps for Spanish-speaking clients and Native clients. In addition, there are some obstacles to services for rural clients, particularly around stigma, isolation, and access to certain medical services.

Needs of PLWH who are aware of HIV-positive status but are not in care

A key priority for New Mexico is identifying the reasons why people with unmet need are not seeking services or are in and out of services. According to the epidemiological profile completed by the state, there were 1,293 people who know they are living with HIV/AIDS and are not currently receiving services during 2011. This represents 40.8% of the total cases in New Mexico.

As part of the needs assessment, we sought out people with unmet need to better understand their reasons for not being in care. This section identifies four core reasons.

The first reason focuses on the fact that some people want to live in denial of their condition. They figure if they do not acknowledge it, they don't have to live with HIV/AIDS. Related to this, some participants simply were not aware/educated on the importance of getting services. Finally, some people were still in a grief phases after being diagnosed; they were not ready to address their condition and rather stayed grieving about their condition.

The second reason that people do not get services is fear and stigma associated with HIV/AIDS. Most participants in the groups seemed to feel the reason that "those with unmet need" go unmet is that they are afraid of the stigma, ashamed and humiliated about needing services, or unable to connect with the agency or case managers. The fear and stigma relates partly to the condition itself, but more importantly about how others react to them. They are afraid of the stigma and being isolated or shunned. Stigma is perceived to be an issue for all groups and yet more for certain groups than others: gays (rather than straights), older, and Native and Hispanic communities.

The third theme is that there are co-occurring conditions that inhibit seeking of services for their HIV/AIDS condition. A number of people in the groups said that if you want to

find people with unmet need, you need to look for the homeless as this is the reason they are not getting services. Another factor repeatedly noted was the lack of transportation for some that results in not being able to access services. Finally, a number of people also identified substance abuse and mental health (i.e., depression) as the reason(s) for lack of compliance and dropping out of care.

The final theme is the feeling of invulnerability. As one participant noted, “They don’t care if they get infected because it’s no longer a death sentence.” This feeling was attributed to young positive as some people perceive that young people also don’t take compliance as seriously as the older generation because they feel there are medications that will take care of and treat the problem.

In summary, four themes were identified about why PLWH have unmet need: (a) denial/lack of awareness, (b) fear and stigma, (c) co-occurring conditions, and (d) invulnerability.

Needs of Individuals who are Unaware of their HIV-Status-Prevention including Special Populations

Heterosexuals at Risk:

Challenges include:

- Heterosexuals at Risk (HARs) do not identify as “HAR”
- Don’t know if partner is positive, MSM or IDU
- Lack of epidemiology data on HARs
- Whoever captures data must identify what CDC defines as HAR so we can pull data
- Lack of knowledge, resources, testing, and supplies, e.g. “clean works”
- Lack of condom negotiation skills
- HAR criteria is limited
- Sex workers, survival sex
- IDU (including prescription and over-the-counter drugs)
- Prescription or over-the-counter drugs containing Opiates, that are injected are more accessible
- Increasing use of Methamphetamines and Heroin

Successful interventions include:

- Syringe Exchange services
- Counseling and testing services
- Addressing women’s needs (active referrals)
- Effective Interventions - SISTA, Community Promise, Street Smart, Safety Counts, Voices//Voces (Commercial Sex-Workers, Incarcerated women)
- Access to local training on DEBI Interventions and adaptations (and support for adaptations)
- STD trainings

- Domestic Violence trainings
- Syringe exchange trainings
- HIV testing booth at the NM State Fair
- Cultural sensitivity trainings
- HIV testing booth at the Flea Market
- Message posters in bathroom stalls of clubs, bars, laundry mats, etc.
- PRIDE (existing)
- CTR outreach at truck stops
- Presence of HIV programs and handing out condoms during Fall Crawl, Spring Crawl and Summer Fest
- Providing support and information to Family Planning Program and parenting classes

Transgender:

Challenges include:

- A lack of Epidemiological data for the transgender population both locally and nationally.
- Survival Sex due to discrimination in both the housing and job markets
- Transgender individuals are not clearly defined – CDC is just now changing MSM-T to separate transgender population
- Silicone use/needle sharing
- Just learning about emerging trends as we only have anecdotal evidence and starting to get info from other sources
- The continued rise of survival sex in the transgender populations.

Successful interventions include:

- Continued Syringe exchange programs with targeted exchange sites for transgender populations
- Male to Female Transgender targeted testing and partner services
- Evidence based (DEBI) interventions adapted for the population i.e. Nizhoni SISTA, 3MV

Men who have sex with men:

Challenges:

- Rise in syphilis rates among Hispanic MSM which indicates higher rates of unprotected sex.
- Of the 2305 MSM tested in 2010 1770 (76.79%) reported sex without a condom, 45% of them with partners of unknown status.
- Mental Health, self-esteem, stigma, and historical trauma.
- Increasing use of Internet and mobile apps for hook ups. Making anonymous hookup easier and partner services more challenging.
- Increasing social isolation from community information resources for gay men.
- Increasing co-infections with HIV and Syphilis.
- Increasing rates of HIV infections in both younger and older MSM.

- Increased use of Facebook and Craigslist for hookups.

Successful interventions:

- Targeted HIV testing.
- Internet presence on popular MSM sites and mobile Apps. Including Partner Services awareness.
- NMPower
- Many Men, Many Voices
- Health Forums specific to gay men.
- Collaboration with local Gay Straight Alliance and other LGBTQ groups.
- Many Men Many Voices.
- Cultural sensitivity training.
- Sex Positivity Training.
- Public Sex Environment Outreach Training.
- Internet Intervention Training.
- Personal Safety and Self Defense Training.
- Gay Pride
- Zia Regional Rodeo
- HIV testing and outreach at local gay bars.
- UNM LGBTQ center events.
- Gay Straight Alliance events.
- Web presence
- Drag Shows.
- Target MSM of color for testing.
- Increase the numbers of all gay and bisexual men accessing HIV testing.
- Create a Mentoring or Buddy program for those folks that had been in HIV services and dropped out of treatment or were lost to follow up that will help them re-enter services and help address the reasons why they were unable to stay in treatment.

Homeless:

In the 2011 survey, there were 20 individuals identified as being homeless in the past six months. Comparisons between these 20 individuals and those of the larger sample were made. Overall, people who said they were homeless during the last six months tended to have lower satisfaction with services, reported more barriers to care, less support from their social networks, more undermining from their social networks, and lower medical adherence than people who were not homeless.

However, only two means were statistically significant because there is a small sample size for the homeless population. The barrier of transportation had a mean of 3.13 in the homeless PLWH sample while only 2.02 in the general PLWH sample. In addition, the mean for self-rated health was lower within the homeless PLWH sample at 2.81 compared to 3.40 in the general PLWH sample.

Thus, homelessness provides some unique obstacles to care, particularly in the areas of transportation and self-rated health.

We also examined people who identified as transgender and IV drug users. There was only one person who identified as transgender thus the needs assessment cannot offer any conclusive information about this population. There were six IV drug users, which also makes drawing conclusions difficult. The means for people who were IV drug users is overall quite consistent with that of the general population so no additional obstacles are apparent for this special population.

Shortfalls in Healthcare Workforce

The needs assessment did not directly address shortfalls in the healthcare workforce. However, it did provide data about issues related to burnout and frustration of providers that may contribute to them leaving the workforce or at least this specialty. Providers face many day-to-day challenges. These challenges may come from other providers, clients, and organizational/structural related issues.

We found that 30% of providers surveyed agree or strongly agree with feeling burned out at work. We also considered factors that might explain burnout for providers. One of these factors is the quality of communication with co-workers and within the organization. We considered three variables: teamwork (the degree to which co-workers collaborate), critical appraisal (the degree to which co-workers are critical and negative during their interactions), and involvement (the degree to which the organization involves providers in decisions). Overall, providers reported a high level of teamwork and involvement and low levels of critical appraisal in their organizations. We also found that teamwork and involvement were negatively related to burnout and callousness. Thus, the more teamwork and involvement providers reported, the less likely they were to report burnout.

We also identified several focus group themes related to challenges care workers face in doing their work.

- The first are structural/funding concerns that create frustration for providers. Specifically, the pipeline of services has become too formalized for providers to be able to efficiently expedite services to clients. Paperwork, funding constraints, and leadership within agencies lead to disparities of services provided and clients served.
- The second is overload of providers. The disproportionate burden of services to PLWH creates an unending demand for services that is not currently being met. Diminishing resources contribute to a service situation where the needs can never be met, resulting in increased waiting periods for client services and frustration within the agencies. Their potential to maximize services is limited by this overload.

- The third is lack of specialists/specific providers or limitations in quality of care. The majority of concerns pertain to case management, provider availability, mental health services, support services, dental care, and other general services (i.e., nutrition and pain management).
- The fourth is limitations in inter-organizational collaboration. Interagency communications are complicated by perceptions of agency roles, responsibilities, and expectations. The lack of a centralized model of care leads to miscommunication and strained relationships. Project ECHO is a model of effective interagency collaboration that the clinics can implement.

In summary, the needs assessment showed that providers working in the federally funded HIV clinics in NM are quite satisfied with the care being provided in their clinic and enjoy their job. There are issues that frustrate them and nearly 30% are feeling some levels of burnout. We found that higher levels of teamwork and involvement led to less provider burnout.

Anecdotally, in some communities we find it very difficult to identify HIV care providers, or even a provider who is interested in gaining expertise and becoming active in the field. The Southeast – Region 4 – is the most difficult, but Region 5 (Southwest) and Region 1 (Northwest) are also thinly staffed with HIV care providers. Just for example, we have one physician in Farmington who is nearing retirement (Four Corners area) who has about 30 clients in his practice. He will not be in practice forever, and currently there are no providers waiting to fill his shoes. This points to the need for planning and involvement in workforce development.

SECTION 4: PLAN COMPONENTS

A. Where are we now? (Overview of current system and needs)

Calendar Year 2010 Epidemiological Profile

New Diagnoses of HIV Infection and AIDS (Incidence)

From 1983, when AIDS first became reportable in New Mexico, through year-end 2010, a cumulative total of 6,538 persons with HIV and/or AIDS have been reported to the Program. As of year-end 2010, 3,318 people were known to still be living with HIV in New Mexico. Of these, 2,025 people were living with AIDS.

During 2010, 152 new persons infected with HIV were identified, leading to an incidence rate of 7.4 per 100,000 population (Table 1.1); this rate decreased from the 2009 rate of 8.2, in which 166 people were diagnosed. These rates are well below the national 2009 incidence rate of 17.4 per 100,000 population. Additionally, in 2010:

- More males (86%) were diagnosed with HIV than females (14%). In the U.S., males accounted for 76% of estimated new HIV infections in 2009.
- Hispanics make up about 43% of New Mexico's population, and in 2010, Hispanics represented the greatest burden of new diagnoses, accounting for 48% of all new HIV infections. In comparison, in 2009, Hispanics represented 16% of the U.S. population but accounted for 20% of new HIV infections in the U.S.
- The rate of new HIV diagnoses among African Americans (AA; 21.0 per 100,000 population) was the highest among the New Mexico race/ethnicity categories; this rate is approximately five times that of Whites and nearly three times that of Hispanics (Table 1.1).
- American Indians / Alaska Natives (AI/AN) comprise about 11% of New Mexico's population. In 2010, they accounted for 18% of newly reported HIV infections and had the second highest rate (12.0 per 100,000 population). Incidence rates continue to rise in the New Mexico AI/AN population, and the current rate is double that of the 2006 rate (Table 1.1).
- The most frequent age group for new HIV infections was persons between the ages of 25-34 years (37%), followed by those in the 35-44 age category (20%). U.S. HIV diagnosis data show that, in 2009, the 25-34 and 35-44 age categories had equally high percentages (26%).
- The rate of new HIV infections for New Mexico adolescents and young adults (13-24 age category) was 7.6 persons (per 100,000), whereas in the U.S. this rate was 20.6 persons (per 100,000, in 2009).
- Men who have sex with men (MSM) continued to be the most heavily impacted transmission risk group, representing 55% of new HIV diagnoses. The CDC estimates that MSM account for just 2% of the U.S. population, but accounted for 55% of all new HIV infections in the U.S. in 2009.
- The second most common transmission risk group (11%) was high-risk heterosexuals (HRH). In the U.S., high-risk heterosexuals represented 37% of new HIV infections in 2009.

- The third most common transmission risk group was injection drug users (IDU; 4%). In the U.S., injection drug users represented 9% of new HIV infections in 2009.
- 27% of people newly diagnosed with HIV infection had “no identified risk” (NIR).

Table 1.1. Incidence of HIV Infection by Year of Diagnosis and Selected Characteristics, New Mexico 2006-2010

	2006			2007			2008			2009			2010		
	N	Rate	% of Total	N	Rate	% of Total	N	Rate	% of Total	N	Rate	% of Total	N	Rate	% of Total
TOTAL	153	7.9	100%	145	7.4	100%	156	7.8	100%	166	8.2	100%	152	7.4	100%
Male	130	13.6	85%	124	12.8	86%	137	14.0	88%	136	13.7	82%	130	12.8	86%
Female	23	2.3	15%	21	2.1	14%	19	1.9	12%	30	2.9	18%	22	2.1	14%
African Am.	10	18.8	6%	8	14.8	6%	13	23.7	8%	13	23.3	8%	12	21.0	8%
AI/AN	13	6.1	8%	14	6.5	10%	19	8.7	12%	26	11.8	16%	27	12.0	18%
Asian/PI	2	5.9	1%	3	8.8	2%	0	0.0	0%	0	0.0	0%	1	2.8	1%
Hispanic	78	9.5	51%	71	8.6	49%	75	8.9	48%	80	9.4	48%	73	8.4	48%
White	47	5.7	30%	46	5.5	32%	48	5.7	31%	43	5.0	26%	36	4.1	24%
Multi-race	3	-	3%	3	-	2%	1	-	1%	4	-	2%	3	-	2%
< 13 years	2	0.5	1%	1	0.3	1%	1	0.3	1%	1	0.3	1%	0	0.0	0%
13-24	20	5.7	13%	30	8.5	21%	25	7.0	16%	23	6.4	14%	28	7.6	18%
25-34	45	17.9	29%	35	13.7	24%	42	16.3	27%	46	17.6	28%	56	20.9	37%
35-44	44	14.5	29%	36	11.7	25%	46	14.8	29%	49	15.6	30%	31	9.7	20%
45-54	27	10.3	18%	30	11.2	21%	30	11.1	19%	31	11.3	19%	23	8.2	15%
55+	15	3.8	10%	13	3.2	9%	12	3.0	8%	16	3.9	10%	14	3.3	9%
MSM	85	-	54%	81	-	56%	81	-	52%	82	-	49%	83	-	55%
IDU	14	-	9%	11	-	8%	13	-	8%	14	-	8%	6	-	4%
MSM/IDU	5	-	3%	9	-	6%	9	-	6%	9	-	5%	5	-	3%
HRH	21	-	14%	10	-	7%	15	-	10%	12	-	7%	17	-	11%
Pediatric	2	-	1%	2	-	1%	0	-	0%	1	-	1%	0	-	0%
Other	2	-	1%	0	-	0%	0	-	0%	0	-	0%	0	-	0%
NIR	24	-	17%	32	-	22%	38	-	24%	48	-	29%	41	-	27%

Due to rounding, percentages may not total to 100%.

The number and rate of persons diagnosed with AIDS have declined from 2009 to 2010 (Table 1.2). Additionally, in 2010:

- 82% of people diagnosed with AIDS were male.
- The AIDS incidence rate among AA declined to 3.5 per 100,000.
- Adults aged 45-54 comprised the largest proportion of people diagnosed with AIDS (31%).
- The AIDS diagnosis rate among NM adolescents and young adults (13-24) was small (0.4 per 100,000) relative to the rate among U.S. adolescents and young adults (5.1 per 100,000 in 2009).
- Men who have sex with men (MSM) continued to be the largest transmission risk group (48%) among people who were diagnosed with AIDS. The second most common was IDU (12%), including those who are in both groups (MSM/IDU). The third most common (11%) was high-risk heterosexuals (HRH).
- 29% of people diagnosed with AIDS had “no identified risk” (NIR); this percent is an increase relative to previous years.

Table 1.2. Incidence of AIDS by Year of Diagnosis and Selected Characteristics, New Mexico, 2006-2010

	2006			2007			2008			2009			2010		
	N	Rate	% of Total	N	Rate	% of Total	N	Rate	% of Total	N	Rate	% of Total	N	Rate	% of Total
TOTAL	91	4.7	100%	113	5.7	100%	93	4.7	100%	94	4.7	100%	91	4.4	100%
Male	80	8.4	88%	97	10.0	86%	85	8.7	91%	81	8.2	86%	75	7.4	82%
Female	11	1.1	12%	16	1.6	14%	8	0.8	9%	13	1.3	14%	16	1.5	18%
African Am.	7	13.2	8%	7	13.0	6%	4	7.3	4%	2	3.6	2%	2	3.5	2%
AI/AN	7	3.3	8%	5	2.3	4%	10	4.6	11%	16	7.2	17%	16	7.1	18%
Asian/PI	1	3.0	1%	3	8.8	3%	0	0.0	0%	1	2.8	1%	0	0.0	0%
Hispanic	40	4.9	44%	54	6.5	48%	45	5.4	48%	49	5.8	52%	41	4.7	45%
White	36	4.4	40%	41	4.9	36%	34	4.0	37%	24	2.8	26%	30	3.4	33%
Multi-race	0	-	0%	3	-	3%	0	-	0%	2	-	2%	2	-	2%
< 13 years	1	0.3	1%	1	0.3	1%	0	0.0	0%	0	0.0	0%	0	0.0	0%
13-24 years	2	0.9	2%	8	3.6	7%	1	0.4	1%	5	2.2	5%	1	0.4	1%
25-34 years	11	4.3	12%	21	8.2	19%	21	8.1	23%	30	11.4	32%	18	6.7	20%
35-44 years	37	13.3	41%	45	16.0	40%	34	11.9	37%	28	9.7	30%	25	8.5	27%
45-54 years	29	9.9	32%	26	8.8	23%	24	8.0	26%	23	7.6	24%	28	9.1	31%
55+ years	11	2.1	12%	12	2.3	11%	13	2.4	14%	8	1.5	9%	19	3.5	21%
MSM	50	-	55%	65	-	58%	46	-	49%	50	-	53%	44	-	48%
IDU	9	-	10%	9	-	8%	11	-	12%	10	-	11%	2	-	2%
MSM/IDU	4	-	4%	8	-	7%	11	-	12%	8	-	9%	9	-	10%
HRH	10	-	11%	12	-	11%	5	-	5%	7	-	7%	10	-	11%
Pediatric	1	-	1%	1	-	1%	0	-	0%	1	-	1%	0	-	0%
Other	1	-	1%	1	-	1%	0	-	0%	0	-	0%	0	-	0%
NIR	16	-	18%	17	-	15%	20	-	22%	18	-	19%	26	-	29%

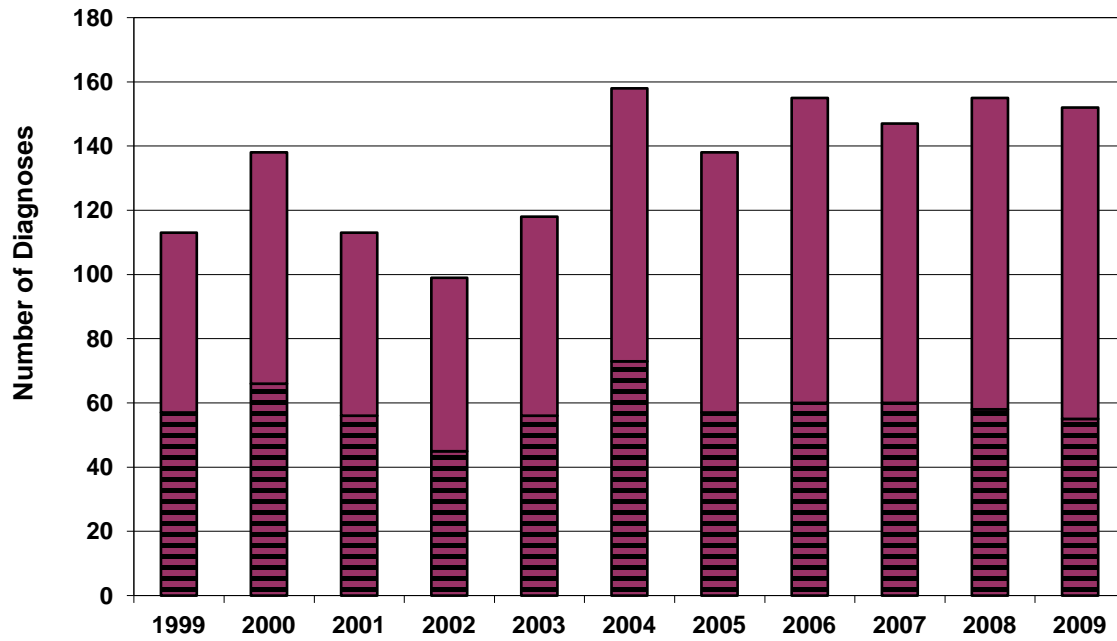
Due to rounding, percentages may not total to 100%.

Persons diagnosed with HIV infection who progress to AIDS within 12 months of their initial HIV diagnosis are considered to be concurrently diagnosed. The percentage of concurrent diagnoses in NM (Table 1.3) is approximately the same as the percentage at the national level (38%). The proportion of new HIV diagnoses concurrently diagnosed with AIDS has decreased from a high of 41% in each of 2005, 2006, and 2007 to 38% in 2008 and 39% in 2009. Additionally, among persons who were diagnosed with HIV infection in 2009:

- A smaller proportion of women received concurrent diagnoses than men (27% *versus* 41%). While the proportion of males has remained relatively stable since 2005, the proportion of females with concurrent diagnoses has fluctuated between a high of 57% (2006) and a low of 21% (2008).
- The proportion of Hispanics concurrently diagnosed (46%) was higher than that of other races.
- The proportion of AI/AN concurrently diagnosed with HIV and AIDS decreased by almost half, from 58% in 2008 to 27% in 2009.
- The proportion of adults aged 35-44 and 55+ receiving concurrent diagnoses decreased from previous years, whereas there were increased proportions of adults in the 25-34 and 45-54 age categories who received concurrent diagnoses.
- Persons within each transmission risk category were almost equally likely to be concurrently diagnosed.

The public health implications of concurrent HIV and AIDS diagnoses are three-fold. First, persons diagnosed with HIV when they are already symptomatic and/or immune-suppressed may miss opportunities to delay the progression of HIV by timely initiation of anti-retroviral treatment. Second, given that late diagnosis may be an important contributing factor to morbidity, concurrent diagnoses hinder the administration of prophylaxis for opportunistic infections. Third, because they are unaware of their HIV status, 'late testers' may unknowingly transmit HIV to others.

**Figure 1.9. Incidence of HIV infections and number of concurrent HIV/AIDS diagnoses, by year of diagnosis
New Mexico, 1999-2009**



Persons Living with a Diagnosis of HIV Infection or AIDS (Prevalence)

At the end of 2010 there were 3,318 people with HIV living in New Mexico, 2,025 of whom had progressed to AIDS (Table 2.1). Prevalence rates of HIV (non-AIDS), AIDS, and HIV or AIDS was 62.7, 98.3 and 161.0, respectively, per 100,000 New Mexican residents. Other 2010 year-end prevalence estimates include:

- The percentage of those living with HIV in New Mexico who are females (13%) is small relative to that of the U.S. in which women accounted for 25% of those living with HIV infection in 2008.
- Most individuals living with HIV are White (45%) or Hispanic (39%). AA and AI/AN each comprised 7% of all persons living with HIV infection in New Mexico.
- AA had the highest HIV prevalence rate at 400.3 persons with HIV infection per 100,000 AA in New Mexico, almost four times greater than AI/AN and 2.5 times greater than Whites and Hispanics.
- HIV positive individuals that had progressed to AIDS tended to be older than those who had not.
- The majority of persons living with HIV in New Mexico were MSM (60%). CDC estimates that MSM accounted for 49% of people living with HIV infection in the U.S. in 2008 (the most recent year prevalence data are available).
- 9% of those living with HIV in New Mexico were identified as IDU, whereas persons who used injection drugs represented 17% of those living with HIV in the U.S. in 2008.

Table 2.1. Prevalence of HIV or AIDS by Selected Characteristics, New Mexico, 2010

	HIV (not AIDS)			N	AIDS			Total		
	N	Rate	% of total		N	Rate	% of total	N	Rate	% of total
TOTAL	1293	62.7	100%	2025	98.3	100%	3318	161.0	100%	
Male	1088	107.4	84%	1807	178.4	89%	2895	285.7	87%	
Female	205	19.6	16%	218	20.8	11%	423	40.4	13%	
African Am.	111	194.0	9%	118	206.3	6%	229	400.3	7%	
AI/AN	101	44.9	8%	137	60.9	7%	238	105.9	7%	
Asian/PI	9	24.8	1%	12	33.0	1%	21	57.8	1%	
Hispanic	526	60.6	41%	772	89.0	38%	1298	149.6	39%	
White	538	61.5	42%	963	110.0	48%	1501	171.5	45%	
Multi-race	8	-	1%	23	-	1%	31	-	1%	
< 13 years	3	0.7	0%	2	0.5	<1%	5	1.2	0%	
13-24	7	3.0	1%	8	3.5	<1%	15	6.5	0%	
25-34	177	65.5	14%	55	20.3	3%	232	85.8	7%	
35-44	314	106.7	24%	256	87.0	13%	570	193.7	17%	
45-54	415	134.3	32%	842	272.5	42%	1257	406.8	38%	
55+	377	68.5	29%	862	156.6	43%	1239	225.1	37%	
MSM	746	-	58%	1250	-	62%	1996	-	60%	
IDU	109	-	8%	183	-	9%	292	-	9%	
MSM/IDU	90	-	7%	237	-	12%	327	-	10%	
HRH	140	-	11%	190	-	9%	330	-	10%	
Pediatric	7	-	1%	12	-	1%	19	-	1%	
Other	2	-	0%	14	-	1%	16	-	0%	
NIR	199	-	15%	139	-	7%	338	-	10%	

Due to rounding, percentages may not total to 100%.

Incidence and Prevalence of HIV or AIDS by Region in New Mexico

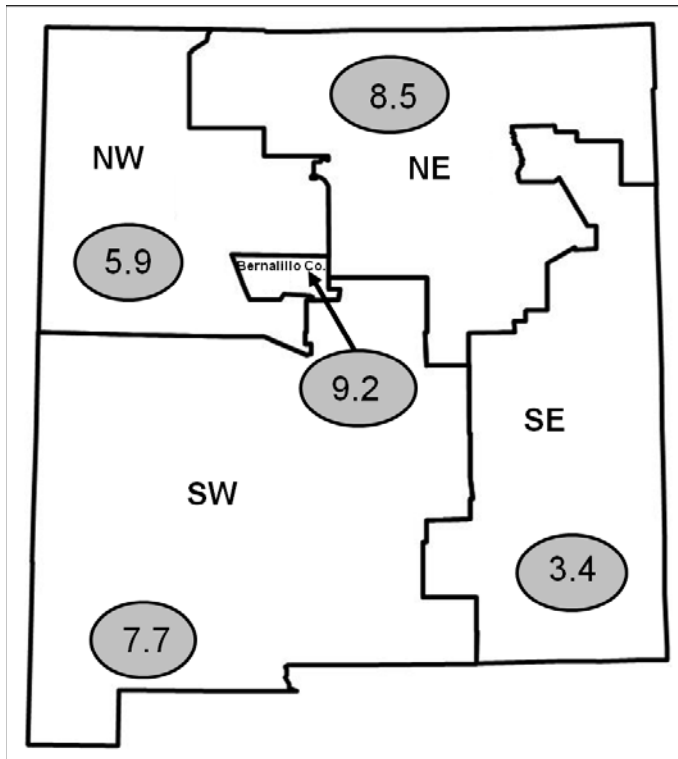
New Mexico is a relatively large, rural state bordered by five other states as well as Mexico. The state's residents are widely distributed, with only five of its 33 counties having more than 100,000 residents. Albuquerque (Bernalillo County) is the state's largest city, with a little greater than a half-million residents. New Mexico regional incident trends from 2007 through 2010 as well as year-end 2010 prevalence estimates (Tables 3.1 through 3.3) are the following:

- In 2010, 40% of new HIV diagnoses occurred in Bernalillo County. Approximately 43% of persons known to be living with HIV in New Mexico resided in Bernalillo County.
- Bernalillo County had the highest average annual HIV incidence rate (10.5 persons per 100,000) and HIV prevalence rate (213.8 persons per 100,000).
- Southeastern NM continued to have the lowest average annual rate of HIV incidence (3.2 persons per 100,000) and HIV prevalence rate (71.8 persons per 100,000).
- The rate of new HIV diagnoses decreased in the NW and Bernalillo County, but increased in NE and SE New Mexico.
- Among the new HIV diagnoses in NW New Mexico, the largest proportion continued to be AI/AN (48%), while NE and SW New Mexico reported the largest proportions were Hispanic (50% and 61%, respectively).
- NW and SW New Mexico reported the highest proportions of new diagnoses without any identified risk (37% and 31%, respectively).

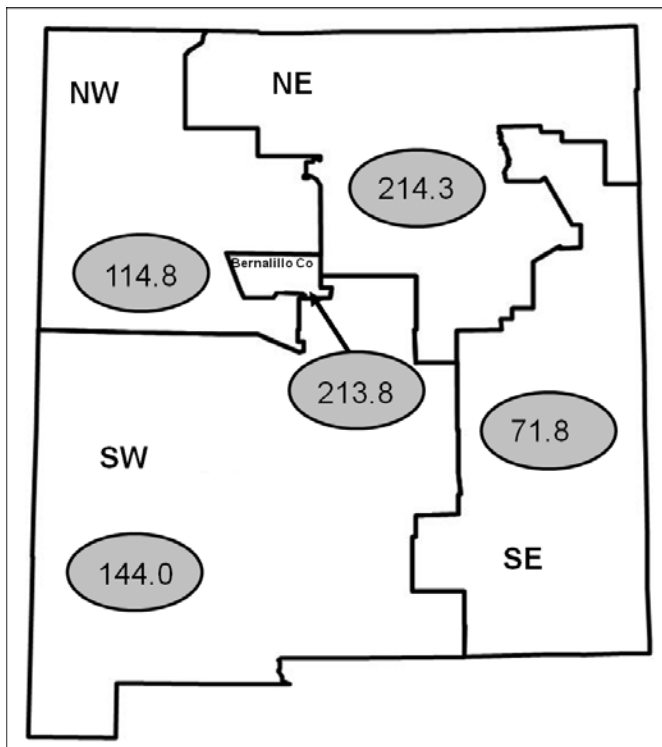
Table 3.1. Incidence of HIV Infection by Year of Diagnosis, 2007-2010, and Prevalence of HIV or AIDS, 2010, by Region in New Mexico

	2007 HIV Incidence		2008 HIV Incidence		2009 HIV Incidence		2010 HIV Incidence		Prevalence of HIV/AIDS			
	N	Rate	N	Rate	N	Rate	N	Rate	HIV	AIDS	Total	
									N	N	N	Rate
Northwest	26	6.3	26	6.2	37	8.6	26	5.9	202	300	502	114.8
Northeast	19	6.6	18	6.2	23	7.9	25	8.5	225	402	627	214.3
Bernalillo Co.	73	11.9	69	11.1	63	9.9	61	9.2	540	874	1414	213.8
Southeast	7	2.7	10	3.8	8	3.0	9	3.4	73	117	190	71.8
Southwest	20	5.0	33	8.3	35	8.7	31	7.7	253	330	583	144.0
New Mexico	145	7.4	156	7.8	166	8.2	152	7.4	1293	2025	3318	161.0

HIV Incidence Rate per 100,000 population by Region 2010



HIV or AIDS Prevalence Rate by 100,000 population by Region 2010



Unmet Need 2009-2010

Population Sizes		Value		Data Source(s)
Row A.	Number of persons living with AIDS (PLWA), diagnosed by December 31st, 2009*	1,986		eHARS: the enhanced HIV/AIDS Reporting System, person dataset
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, diagnosed by December 31st, 2009*	1,187		eHARS: the enhanced HIV/AIDS Reporting System, person dataset
Row C.	Total number of HIV+/aware diagnosed by December 31st, 2009*	3,173		eHARS: the enhanced HIV/AIDS Reporting System, person dataset
Care Patterns		Value		Data Source(s)
Row D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period of 1/1/10 and 12/31/10	1,261		eHARS (person database, document database - lab and document tables), CareWare, lab data
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period of 1/1/10 and 12/31/10	619		eHARS (person database, document database - lab and document tables), CareWare, lab data
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period of 1/1/10 and 12/31/10	1,880		eHARS (person database, document database - lab and document tables), CareWare, lab data
Calculated Results		Value	Percent	Calculation
Row G.	Number of PLWA who did not receive the specified HIV primary medical care during the 12-month period of 1/1/10 and 12/31/10	725	37%	The number of PLWA known to be currently living in NM who did not have a CD4 or Viral load lab between 1/1/10 and 12/31/10
Row H.	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care during the 12-month period of 1/1/10 and 12/31/10	568	48%	The number of PLWH/non-AIDS known to be currently living in NM who did not have a CD4 or Viral load lab between 1/1/10 and 12/31/10
Row I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need) during the 12-month period of 1/1/10 and 12/31/10	1,293	41%	The total number of HIV+ persons known to be currently living in NM who did not have a CD4 or Viral load lab between 1/1/10 and 12/31/10

Descriptive characteristics of unmet need population in New Mexico, as of year-end 2010

	PLWH (not AIDS)		PLWA		Total	
	No.	%	No.	%	No.	%
Diagnosed in NM						
Yes	379	67%	355	49%	734	57%
No	189	33%	370	51%	559	43%
Sex						
Male	477	84%	642	89%	1119	87%
Female	91	16%	83	11%	174	13%
Race/Ethnicity¹						
White	243	43%	391	54%	634	49%
Hispanic	218	38%	238	33%	456	35%
AI/AN	32	6%	29	4%	61	5%
African American	69	12%	59	8%	128	10%
Asian/PI	4	1%	4	1%	8	1%
Multi-race	2	0%	4	1%	6	0%
Age at Diagnosis						
< 2 years	2	0%	3	0%	5	0%
2-12	3	1%	3	0%	6	0%
13-24	134	24%	42	6%	176	14%
25-44	374	66%	574	79%	948	73%
45-64	52	9%	97	13%	149	12%
65+	3	1%	6	1%	9	1%
Current Age						
< 2 years	0	0%	0	0%	0	0%
2-12 years	1	0%	1	0%	2	0%
13-24 years	14	2%	7	1%	21	2%
25-44 years	308	54%	221	30%	529	41%
45-64 years	223	39%	456	63%	679	53%
65+ years	22	4%	40	6%	62	5%
Mode of Exposure²						
MSM	284	50%	416	57%	700	54%
IDU	56	10%	86	12%	142	11%
MSM/IDU	43	8%	97	13%	140	11%
HRH	43	8%	66	9%	109	8%
Pediatric	3	1%	6	1%	9	1%
Other	1	0%	4	1%	5	0%
NIR	138	24%	50	7%	188	15%
Region at Diagnosis						
Out-of-state	189	33%	370	51%	559	43%
Region 1 (Northwest)	55	10%	41	6%	96	7%
Region 2 (Northeast)	63	11%	82	11%	145	11%
Region 3 (Bernalillo County)	137	24%	132	18%	269	21%
Region 4 (Southeast)	20	4%	26	4%	46	4%
Region 5 (Southwest)	104	18%	74	10%	178	14%

2010 Epidemiological Profile Discussion

New Mexico is a relatively low morbidity state for HIV/AIDS with about 150 new infections being diagnosed each year. More new infections are impacting Hispanics and Native Americans relative to other groups. The majority of new infections is in men who have sex with men. Adolescents, youth, women and IV Drug Users represent fewer diagnoses than in the rest of the U.S. Geographically, the central Albuquerque metropolitan area/Bernalillo County, and the Northeast have the highest incidence and prevalence rates, followed by the Southwest and Northwest, with the Southeast last.

Nearly 40% of HIV diagnoses have an AIDS diagnosis with 12 months, or concurrent diagnosis. This is an indicator that too many cases are being diagnosed too late and that more work is needed to find them sooner.

The number of people with Unmet Needs is calculated at 1,293 or 41% of the total number of PLWHA. This may be an over-statement of the problem – tests for people who actually received care may not have been reporting to the State, and people may have moved out of state without reporting it to the Department. However, it is clearly still a significant gap.

EIHA – (Unaware of HIV positive status) estimate for CY2009

As of December 31, 2009, there were there were 3,290 persons living with HIV or AIDS in New Mexico. Using the Estimated Back Calculation (EBC) methodology, the estimated number of PLWH unaware of their status is approximately 875 individuals.

Description of Part B HIV Services Program

The administrator and manager of Ryan White Part B is the HIV Services Program, in the Infectious Disease Bureau, Public Health Division, New Mexico Department of Health. Other programs within the Bureau are HIV Prevention, STD Prevention and Control, Hepatitis, TB/Refugee Health, Harm Reduction and Immunization. There is close collaboration between these programs where feasible and advantageous. In particular, STD and HIV Prevention are closely tied to HIV Services.

The HIV Services Program Manager is responsible for writing the Ryan White proposal, managing the budget, implementing and overseeing contracts, assuring timely submission of reports, and managing relationships between providers, clients and staff. A staff of four includes a) CQM and Data Coordinator; b) Dental Program Coordinator; c) AIDS Waiver Coordinator, and d) ADAP Coordinator. The Bureau has Medical Director who oversees the ADAP Medical Advisory Committee, carries out clinical quality assurance audits of all providers annually, and provides clinical direction. The HIV Epidemiology Program in the Epidemiology and Response Division provides epidemiological support and produces the annual HIV Epi report, Unmet Needs estimates, and EIIHA calculations. HIV Epi also interacts the HIV Partner Services by entering all new HIV diagnoses into the disease investigation database to initiate field investigations.

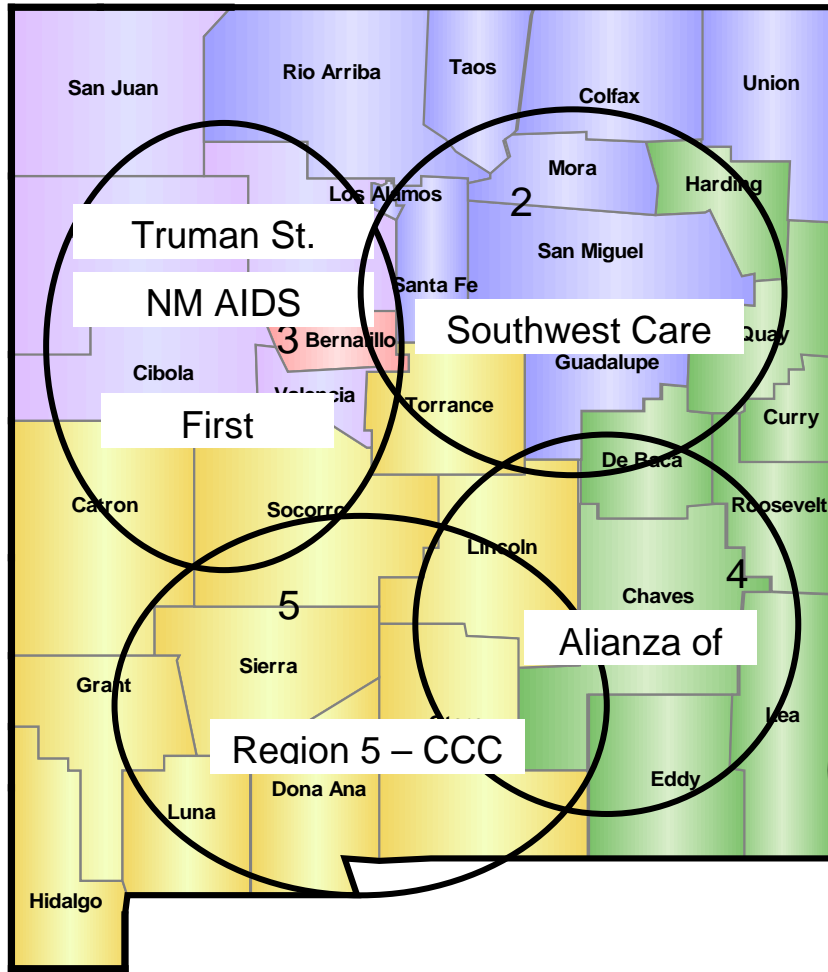
Budget management support comes from both the Division and Department levels.

Description of current continuum of care

New Mexico has a system of contracted Regional agencies, which supply continuum of care to clients in the area. These are called HIV Service Providers, or HSPs. There is some overlap and freedom of choice for clients to move from one HSP to another. There are also structures for sharing of information and best practices across the system so that care is for the most part standardized, with Program Policies and Procedures maintaining standards across the state. See map below.

Additionally, a broad range of service categories are offered across the state, with local variations according to need and resources. The diagram below presents funded services across the state. Some of these are unevenly distributed and may represent local or regional gaps for clients who live in areas with fewer resources. This is the subject of the next section.

New Mexico Contracted HIV Service Providers - HSPs



Linkage to Care

Counseling, testing and Referral – EIIHA (HIV Prevention Program)

Enrollment Eligibility and Referral

Outreach **

Access to Care

Early Intervention
Health insurance premium/cost sharing assistance
Home health

Home and community-based health services **
Medical case
Case management (non-medical)
Housing
Medical

Support Services

Emergency financial assistance
Food bank/home-delivered meals

Health education/risk reduction **
Legal
Psychosocial

Care Services

Outpatient/ambulatory medical care
AIDS Drug Assistance Programs (ADAP)
Oral health

Mental health
Medical nutrition
Substance abuse services, outpatient
Treatment adherence counseling **

HIV Services Continuum of Care – New Mexico

**In Plan but not currently funded

B. Priorities for Allocation of Funds

The HIV Services Advisory Council appointed an Ad Hoc Prioritization Committee to create a draft document for review and approval by the entire body. The Committee was composed of top leaders of three HSPs and two consumers. It was staffed by the HIV Services and HIV Prevention Program Managers of the Department of Health to ensure coordination.

The Committee created the following model and prioritization. It was approved on February 28, 2012. This draft model was circulated to consumers for review by the UNM Needs Assessment team, which gathered and summarized feedback. Based on this input, one priority category was revised; Health Insurance Premium and Cost Sharing Assistance was determined to fall into the top tier of Care Services. The updated and final model was adopted by the HIV Services Advisory Council on April 24, 2012.

The committee first considered what type of prioritization model to adopt. These potential options vary in how complex they are and how long they'd take to apply in New Mexico.

- **Tiered model** (each service category falls into one of 2-3 priority groups)
- **Ranked list** (each service category is ranked into a single numbered list based on priority)
- **Weighted list** (each service category has an unmet needs estimate, which is then weighted based on its priority)

The committee decided to use a **Tiered Model with either 2 or 3 priority groups**. This model was considered the easiest and quickest to complete. Given that New Mexico is not facing immediate challenges in re-prioritizing services based on a significant increase or decrease in dollars, it was decided that a simple model will provide enough guidance for funding decisions in the immediate future.

To decide on how many tiers there should be and how they should be defined, the committee decided to first develop a list of Shared Values/Guiding Principles that directed the development of this model.

Shared Values/Guiding Principles

1. Maintain and enhance positive health outcomes as the most important priority. This includes efforts to promote consistent engagement in care and treatment adherence.
2. Support stable housing which allows access to medical care, as persons without the necessities of life are less likely to engage consistently in care and be adherent to treatment.
3. Ensure access to care regardless of whether clients live in urban, rural or frontier areas, either by sustaining systems of care, locating new services in these areas, or offering transportation assistance.
4. Provide services in the most cost effective manner that is feasible, such as purchasing health insurance or using innovative strategies such as telehealth to enhance care.
5. Enhance services by soliciting consumer involvement both in planning and delivery.
6. Reduce health disparities for persons living with HIV/AIDS (PLWH/A) by ensuring that providers are expert in HIV care and culturally competent in working with impacted populations including ethnic/racial minority groups, gay/bisexual men and other men who have sex with men (MSM) and injection drug users (IDU).
7. Reduce unmet need for HIV care by helping people learn their HIV status, engage in HIV care and maintain consistent engagement in care.
8. Ensure that persons with HIV and their partners have access to risk reduction and other HIV prevention services, as well as routine screening for hepatitis and sexually transmitted diseases (STD). Coordinate these activities with community-wide infectious disease prevention and intervention efforts through collaboration and appropriate referrals.

Based on these Shared Values/Guiding Principles, a **Tiered Model with Three Ranked Categories** was proposed. The following are the categories with their definitions.

1. **Care Services** – Direct provision of essential health care to maintain or improve HIV-related health outcomes.
2. **Access to Care Services** – Services that improve access to and retention in care.
3. **Support Services** – Services that enhance quality of life.

The committee reviewed the list of **Ryan White Program Services Definitions**, which is the full array of activities that is allowable under Ryan White according to the federal Health Resources and Services Administration (HRSA). The first discussion was whether each service category was currently funded in New Mexico, whether we should eliminate anything we are funding, and whether we should add any categories that were not funded in the past.

- No service categories that are currently being funded were proposed to be eliminated.
- The following service categories that have not been funded in the past were added as new activities that can be funded in the future, pending availability of resources and requests from HIV Service Provider (HSP) agencies:
 - Core service H: **Home and community-based health services**
(this overlaps with the currently-funded Core service G: Home Health Care)
 - Support service S: **Health education/risk reduction**
 - Support service X: **Outreach services**
(to include Linkage to Care activities)
 - Support service AE: **Treatment adherence counseling**

The final prioritization step was to apply the Tiered Model to the service categories that were fundable in New Mexico. The proposed prioritization and ranking is shown in the following table.

Priority Tier	Service Categories
<p>Care Services – Direct provision of essential health care to maintain or improve HIV-related health outcomes.</p>	<ul style="list-style-type: none"> • A: Outpatient/ambulatory medical care • B: AIDS Drug Assistance Programs (ADAP) • D: Oral health care • F: Health insurance premium and cost sharing assistance • J: Mental health services • K: Medical nutrition therapy • M: Substance abuse services, outpatient • AE: Treatment adherence counseling
<p>Access to Care Services – Services that improve access to and retention in care.</p>	<ul style="list-style-type: none"> • E: Early intervention services (EIS) • G: Home health care • H: Home and community-based health services • L: Medical case management services (including treatment adherence) • N: Case management (non-medical) • T: Housing services • W: Medical transportation services • X: Outreach services (including linkage to care)
<p>Support Services – Services that enhance quality of life.</p>	<ul style="list-style-type: none"> • Q: Emergency financial assistance • R: Food bank/home-delivered meals • S: Health education/risk reduction • U: Legal services • Z: Psychosocial support services

C. Where Do We Need to Go? Goals and Strategies

Proposed care goals

Goal: Achieve, maintain and enhance positive health outcomes for persons living with HIV/AIDS in all parts of New Mexico through efforts to reduce unmet need, engage and retain persons in care, and ensure treatment adherence and quality care. Reduce health disparities and ensure access to care for all persons, regardless of whether they live in urban, rural or frontier areas.

Strategy #1 – Early Identification of Individuals with HIV/AIDS (EIIHA): Reduce unmet need and engage more persons in care through Early Identification of Individuals with HIV/AIDS (EIIHA) efforts that reduce the number of individuals who do not know their HIV status.

Objective 1a – Rapid HIV Testing: Increase the number of people who know their HIV status by increasing the proportion of all anonymous HIV testing that is performed using the Uni-GOLD rapid test device rather than conventional tests so that all clients get their results.

Activities: 1) Continue to deliver two sessions of the Fundamentals of Rapid HIV Counseling and Testing course per year. 2) Provide technical assistance to HIV counseling sites to help them develop rapid testing protocols and secure CLIA waivers to allow them to perform rapid HIV testing.

Timeline: Ongoing, starting in 2009 and expanding annually.

Objective 1b – Expanded Partner Services: Increase the number of new HIV cases found through Partner Services (PS) by increasing the number of newly diagnosed persons and individuals in care with new “sentinel events” who are offered and interviewed for PS.

Activities: 1) Utilize new resources secured through a competitive grant from CDC under PS12-1201, Category C. 2) Refer newly reported individuals from the HIV and Hepatitis Program to PS, as allowed under the New Mexico HIV Test Act which was amended in 2010 to allow this sharing of information. 3) Increase the number of referrals of clients in ongoing care who have sentinel events by providing incentive payments for such referrals to HIV Service Provider (HSP) organizations.

Timeline: Ongoing, starting in January 2012.

Strategy #2 – Reduce Unmet Need: Reduce unmet need by linking more persons to quality HIV care through evidence-based interventions that incorporate peer advocates to engage those who have not accessed care.

Objective 2a – Identify Evidence-based Strategies that Incorporate Peers:

Research strategies used around the nation to determine which effective and evidence-based models are most appropriate to the culturally diverse and primarily rural state of New Mexico.

Activities: 1) Provide funding to the Consumer Advocacy Council (CAC) to allow them to review models and secure patient input. 2) Identify models that utilize peer advocates and are feasible to initiate during the pilot phase.

Timeline: January – June 2012.

Objective 2b – Pilot Projects: Implement pilot projects in the three regions with the greatest number of HIV cases.

Activities: 1) Fund three pilot projects to be implemented by HSP agencies serving Public Health Regions 2 (Santa Fe and Northeast NM), Region 3 (Albuquerque metropolitan area) , and Region 5 (Las Cruces and Southwest NM), with resources apportioned according to amount of unmet need. 2) Collect information on the number of persons linked to care to evaluate the pilot project.

Timeline: September 2012 – June 2013.

Objective 2c – Statewide Implementation of Services: Utilize results of the pilot project to expand linkage-to-care projects to all five Public Health Regions.

Activities: 1) Fund expanded projects in all five regions. 2) Continue to evaluate this effort through data collection and feedback from consumers through the CAC.

Timeline: Ongoing, starting in July 2013.

Strategy #3 – Retain Clients in Care: Reduce unmet need by reviewing and piloting models to re-engage individuals who had been in HIV care services but are currently not receiving care consistently and/or not being adherent to treatment.

Objective 3a – Identify Reasons for Clients Not Remaining in Care: Utilize case management committee and CAC to determine key reasons for clients dropping out of care from peer and provider perspectives

Activities: 1) Continue discussions within both the case management committee convened by HIV Service Provider agencies and within CAC. 2) Determine most

common reasons for client drop-out based on this data. 3) Identify effective strategies for retaining clients in care. 4) Begin implementation of pilot projects to retain and re-engage clients by summer 2013.

Timeline: Ongoing, starting in July 2012.

Objective 3b - Quality Improvement of Case Management: Enhance both medical and non-medical case management programs to have increased focus and impact on treatment adherence and other medical goals for patients.

Activities: 1) Develop a work group of NMDOH HIV Service Program staff and HIV Service Provider agencies to develop best practices and policy documents for both medical and non-medical case management. This will utilize existing documents and expertise within HSP agencies. 2) Identify expert trainers on medical and non-medical case management and contract with them. 3) Host an initial series of intensive trainings and ongoing follow-up trainings for all statewide case managers. 4) Identify ongoing challenges and provide trainings to respond to key issues.

Timeline: Ongoing, starting in summer 2012.

Strategy #4 – Enhance Quality of Care and Support: Enhance treatment adherence and reduce social isolation among persons with HIV/AIDS through improvements in the quality and consistency of the care system in all regions of New Mexico.

Objective 4a - Expanded Support Services: Expand available support services, such as groups for newly diagnosed individuals.

Activities: 1) Identify organizations and mental health professionals or para-professionals who can host and facilitate expanded support services across the state. 2) Implement support services, with an emphasis on newly diagnosed individuals and underserved populations such as women with HIV. 3) Partner with other consumer groups, such as the New Mexico Consumer Advocacy Council (CAC), to promote these services and expand peer support.

Timeline: Ongoing, starting in summer 2012.

Strategy #5 – Recruit, Train, Mentor and Retain HIV Providers: Reduce gaps in HIV care by recruiting, training and retaining clinical and support services providers in rural parts of New Mexico.

Objective 5a – Recruitment: Recruit providers in rural areas of New Mexico.

Activities: 1) Continuously prioritize by need the areas of the state where there are actual or anticipated shortages of providers with training, ability and interest to care for clients with HIV/AIDS. 2) Form a small group composed of HIV Services Program staff, AETC, contracted HIV Service Providers and clients, to identify health care providers in target areas, recruit them, and arrange for training/mentoring and ongoing support to help retain them.

Timeline: Ongoing.

Objective 5b – Training: Provide clinical training to providers.

Activities: 1) Partner with AETC to provide intensive orientation and clinical training to newly identified clinical providers in rural areas, including trainings delivered across New Mexico. 2) Continue to deliver weekly update trainings via the HIV ECHO telehealth training and consultation clinics, operated by AETC in partnership with UNM's Project ECHO.

Timeline: Ongoing.

Strategy #6 – Secure Expanded Funding to Improve and Expand HIV Clinical Care in the Southern Half of New Mexico (Public Health Regions 4 and 5): Southern New Mexico formerly had Ryan White Part C funds but lost them due to an agency's collapse, as discussed in the Needs Assessment section. Work to prepare organizations in this region to compete successfully for new funding opportunities, such as Part C funding, by providing technical assistance and promoting inter-agency partnerships.

Objective 6a – Convene Stakeholders and Develop Proposals: Form a partnership between providers in Public Health Regions 4 and 5 to develop goals and objectives that will be the core of strong proposals based on patient needs and focused on measurable system changes and benefits to consumers.

Activities: Convene meetings of key stakeholders to identify gaps in services and expand partnerships. 2) Develop goals and objectives that will be the basis for a strong proposal, prior to new funding opportunities being released.

Timeline: Ongoing, starting in October 2012.

HIV Services Advisory Council – UNMET NEED Framework

	Linked to Care	Engaged in Care	Retained in Care
Target population to be reached	Persons who don't know they have HIV	Persons who know they have HIV but have never entered care	Persons with HIV who have been in care but are not consistently in care
Category based on HRSA definitions	Early Identification of Individuals with HIV/AIDS (EIIHA)	Unmet need	Unmet need
National monitoring standard for measurement	<u>Linked to Care</u> means that the individual attended their initial visit with an HIV primary care provider.	<u>Engaged in Care</u> means that the individual had 2 or more medical care visits in the 12 months following their initial visit.	<u>Retained in Care</u> means that the individual has had 2 or more medical care visits in each 12 month period.

	Linked to Care	Engaged in Care	Retained in Care
Relationship to HIV Prevention and HIV Services Programs	<p>A component of <u>prevention</u> strategies</p> <ul style="list-style-type: none"> • Counseling, testing and referral services (CTRS) • Routine testing in primary care • Partner Services (PS) 	A component of <u>care/services</u> strategies	A component of <u>care/services</u> strategies

	Linked to Care	Engaged in Care	Retained in Care
<p>Brainstorming question #1:</p> <p>Why do persons have unmet needs?</p>	<ul style="list-style-type: none"> • Lack of education. • Fear of knowing their status. • Low perception of risk. • No access to testing. • Lack of knowledge of testing. • Poverty and not knowing they can afford the test. • Partners dishonest about their status. • Stigma of HIV and being tested. • Don't have access to rapid testing in their area. • Need options for test sites where clients feel safe. • Fear of confidentiality at test site. 	<ul style="list-style-type: none"> • Lack of transportation. • Denial. • Fear of confidentiality. • Stigma, particularly in small towns. • Fear that if they start, they'll be on treatment for life. • Pharmacy issues. • Cost. • Education, in terms of knowing the benefits of care and treatment. • Blood banks and other screening sites don't give good referrals. • Don't know about HIV Service Providers (HSP) and other providers. • Don't get warm hand-off from testing. • Diagnosed out-of-state. • Cultural issues, such as fatalism. 	<ul style="list-style-type: none"> • Lack of transportation. • Stigma of HIV. • Cost. • Co-occurring mental health and substance abuse issues. • Fear of confidentiality, such as seeing people they know in a waiting room. • Challenges with pharmacy, such as the Medicare donut hole. • Insurance paperwork. • Frustration with paperwork and systems. • Long term survivors have treatment burnout or disenfranchisement with system. • Lack of consistency of HSP agencies, programs and/or staff. • Health literacy. • Language barriers. • Lack of culturally competent services. • Feel well so they don't go to the doctor. • Side effects or fear of them. • Turnover of doctors means they have to repeat their history. • Dually or triply diagnosed individuals are dealing with a lot of doctors. • Program requirements for documentation and re-registration.

	Linked to Care	Engaged in Care	Retained in Care
<p>Brainstorming question #2:</p> <p>What strategies can be used to respond to these unmet needs to link persons to consistent care?</p>	<ul style="list-style-type: none"> • Peer-based strategies such as MOSAICA. • Promote health literacy, such as that treatment will make you better to reduce feeling of helplessness. • Need a Linkage-to-Care plan for the state and for each region. • Ensure linguistically appropriate services. • Take the word “AIDS” out of the name of agencies. • Mainstream HIV testing and care activities into other health care organizations. • Offer provider education, particularly on HIV testing and linkage to care. • Bundle HIV and STD testing in one setting, to make HIV testing more routine. • Expand HIV Partner Services (PS). 	<ul style="list-style-type: none"> • Peer-based strategies such as MOSAICA. • Promote health literacy, such as that treatment will make you better to reduce feeling of helplessness. • Need a Linkage-to-Care plan for the state and for each region. • Ensure linguistically appropriate services. • Take the word “AIDS” out of the name of agencies. • Mainstream HIV testing and care activities into other health care organizations. • Offer provider education, particularly on HIV testing and linkage to care. • Look at root causes. Forms and data might not clearly illustrate client issues. • Use information from Clinical Quality Management (CQM) data to inform retention strategies. • Case management. • Proven models such as Comprehensive Risk Counseling and Services (CRCS), adherence counseling, and ARTAS. • Train people in patient navigation. • Ongoing training for case managers to increase emphasis on adherence and retention. • Outreach to raise awareness of HIV Service Providers (HSP). • Better linkage for out-of-state clients (for those moving in and out of New Mexico). 	<ul style="list-style-type: none"> • Peer-based strategies such as MOSAICA. • Promote health literacy, such as that treatment will make you better to reduce feeling of helplessness. • Need a Linkage-to-Care plan for the state and for each region. • Ensure linguistically appropriate services. • Take the word “AIDS” out of the name of agencies. • Mainstream HIV testing and care activities into other health care organizations. • Look at root causes. Forms and data might not clearly illustrate client issues. • Use information from Clinical Quality Management (CQM) data to inform retention strategies. • Case management. • Proven models such as Comprehensive Risk Counseling and Services (CRCS), adherence counseling, and ARTAS. • Train people in patient navigation. • Ongoing training for case managers to increase emphasis on adherence and retention. • Effective and active Consumer Advisory Board (CAB) in each HSP agency to allow discussion of successes and challenges.

	Linked to Care	Engaged in Care	Retained in Care
<p>Brainstorming question #3:</p> <p>What are the research and planning questions we can explore in the HIV Services Advisory Council and through the UNM needs assessment team?</p>	<ul style="list-style-type: none"> • Access to mental health and substance abuse services impact access to care. What is available and what are barriers in each region? • Look at the accuracy of our unmet needs estimate from NMDOH HIV and Hepatitis Epidemiology Program since it informs this discussion. <ul style="list-style-type: none"> - Perhaps the program can split between persons who are not engaged vs. not retained in care. - Look at other methodologies to develop this estimate so we can compare results. - Look at data for unmet need by clinician or by HIV Service Provider (HSP) agency. • Review should first examine persons who have dropped out of care in the last year. They'll be easiest to find and determine reasons for dropping out. • Survey or interview persons who have dropped out of care to get qualitative description. Clients might share more with an entity outside their HSP, such as UNM, NMDOH or a peer through a group like the Consumer Advocacy Council. 		

Proposed solutions re: overlaps in care

New Mexico does not believe there are any overlaps in care that pose a problem. In such a large, sparsely populated state the challenges tend to be more about gaps in care. Where some overlap exists it is a positive thing, but it gives clients some limited choice of providers. For example:

- In Bernalillo County and to a lesser extent the Northwest, clients can choose between New Mexico AIDS Services and First Nations for case management and support services.
- Santa Fe and Albuquerque being just one hour apart, some patients from Albuquerque choose to go up the hill to Southwest Care Center, while others drive from Santa Fe to New Mexico AIDS Services/Truman Street Clinic for care.
- In the south, there is some overlap between Region 5-CCC in Las Cruces and Alianza of NM in Roswell with patients being served by either or sometimes both when not all services are available from their main HSP.

Potential future developments in this area are:

- Alianza of NM, which services Region 4, may open an office in Las Cruces, starting with HIV Prevention Services. It may expand to offer HIV Services as well. Because Region 5 – CCC is part of the state Department of Health, it has some limitations, such as the inability to fundraise and provide private funding to supplement client needs that aren't met by public funds. The HIV Services Program is in support of this change.
- Truman Street Clinic is currently co-located with New Mexico AIDS Services (NMAS), and they function as two halves of a whole HIV Service Provider. Truman Street Clinic primarily offers medical care and medical case management; NMAS offers enrollment, case management and support services. However, Truman Street Clinic plans to move into its own location in July 2012. This is likely to create challenges for clients who will now have additional travel between sites. There may also be less willingness on the part of the two agencies to function as parts of a whole service, and one or both may attempt to become full service agencies. If the latter happened, it would create duplication in service. The question is what impacts – positive or negative – it would have on clients. The HIV Services Program will work with the HSPs and make sure the best interests of the clients are at the forefront of any systems changes.

Proposal for coordination between parts of the health care system –

There are several mechanisms to coordinate between parts of the health care system, although this remains a challenge due to the fragmentary nature of the

system itself, often with at least the perception of competing interests. The following are proposed means of coordination.

- a) Continue at least quarterly meeting of the HIV Services Advisory Council. This body has brought together, in a very constructive spirit, representatives from many areas impacting HIV care. The challenge will be to bring them together without the immediate task of writing a plan, and keep members interested and motivated. Another means to do this is described in the next bullet.
- b) Explore combined meetings of HIV Services Advisory Council and the Community Planning and Action Group, which does HIV Prevention planning. New Mexico has not combined these groups, but we plan to schedule at least two joint meetings in 2012 – 2013 to begin to experience a combined group and evaluate its effectiveness. This will be a powerful connection between prevention and services planning.
- c) HSP Leadership meetings on a quarterly basis. This group is composed of leadership members of the contracted HIV Service Providers, state Program staff, and sometimes guest speakers. It has an operations focus, as well as some focus on planning and policy. Primarily this assures coordination between providers, which include Ryan White Parts B, C and D (there is no Part A in New Mexico).

How Will we Monitor Progress?

The HIV Services Program will use several methods to monitor progress. These include:

- 1) Continue to contract with the University of New Mexico researchers to conduct participatory research using tools such as surveys, interviews and focus groups. These will bring a robust sampling of patient voices into the monitoring of Program strengths and weaknesses. It has the advantage that they may be able to hear from people who do not join the advisory council or attend public meetings, but are willing to speak or write their issues in a more private and safe setting. The researchers are also able to quantify and help the Program identify trends.
- 2) Surveillance and Epidemiology reports which are developed by the Department's Epidemiology and Response Division. These reports help track changes in incidence and prevalence, and most importantly for this Plan, Unmet Need. We plan to push the percentage and number down through expanded testing and linkage to care projects described in the Goals and Strategies section. The Program has also had discussions with the HIV Epidemiology Program about the possibility of using the list of people with HIV/AIDS and not in care to do outreach. The purpose would be to confirm or disprove that they are indeed residing in New Mexico and not in care, and secondly to offer the chance to enter care if confirmed. This would enhance accurate monitoring and also strengthen the strategy of bringing people into care who are not currently in care.
- 3) Program and Clinical Audits - New Mexico has been very consistent in implementing program and clinical audits of nearly 100% of its providers and sub-grantees. These audits are very useful in monitoring quality of case management, quality of care and other compliance and quality issues.
- 4) Improved use of Client Level Data – The Program will purchase a SAS license for our Data Manager to provide the tools to improve analysis of client level data. This will help to improve our understanding of patterns related to utilization, timing of entry and exit from Care, turnover by provider, and other indicators that will greatly add to our ability to monitor strengths and weaknesses across the Program.